

A Study on

The

Socio-economic Determinants

behind

Infant Mortality

&

Maternal Mortality

Sponsored by The Planning Commission of India



**A research study conducted by
The Indian Trust for Innovation & Social Change (ITISC)**

*Socio-economic
Determinants behind
IMR & MMR*

*A research study by
The Indian Trust for Innovation & Social Change (ITISC)
EB-166, Maya Enclave, New Delhi-110064*

CONTENTS

1.	INTRODUCTION	(i to iv)
2.	INFANT MORTALITY	1 to 29
	◆ SOCIAL PROFILE	
	◆ ECONOMIC FACTORS	
	◆ CULTURAL PRACTICES	
	◆ SOCIO-DEMOGRAPHIC FACTORS	
	◆ ENVIRONMENTAL CONCERNS	
	◆ VISIBLE CONSTRAINTS IN REDUCTION OF IMR	
	i) Role of National Rural Health Mission	
	ii) The infrastructure and glaring gaps	
	iii) Needy villagers indifference	
3.	MATERNAL MORTALITY	29 to 72
	◆ WHAT IS MATERNAL MORTALITY	
	◆ WOMEN AND HEALTH	
	◆ HEALTH POLICIES: HOW EFFECTIVE	
	◆ GENDER BIAS OR POLICY MISMATCH?	
	◆ WOMEN HEALTH CARE: A HOLISTIC APPROACH NEEDED	
	◆ SOCIO-ECONOMIC CAUSES & MATERNAL FACTORS AS DETERMINANTS BEHIND MMR	
	◆ SOCIO-ECONOMIC STATUS OF WOMEN: FAMILY & HEALTH	
	◆ REPRODUCTIVE DECISION MAKING: WHAT MAKES IT?	
	◆ EDUCATION: IMPACT ON WOMEN'S HEALTH	
	◆ RITUALS & FOOD PRACTICES	
	◆ GENDER VIOLENCE: IMPACT ON MMR	
	◆ VILLAGERS AVERSE TO INSTITUTIONAL CARE BUT NOT TO SEX DETERMINATION TESTS WHICH LEADS TO MMR	
	◆ WOMEN HELPLESS IN AVAILABILITY OF INSTITUTIONAL CARE: SOCIAL AND PHYSICAL DISTANCE: A BARRIER.	
3.	LACK OF EMPOWERMENT OF WOMEN: A MAJOR CONSTRAINT	73 to 81
	◆ WHY THIS PATHETIC SITUATION?	
	◆ SOME HELPFUL EFFORTS.	
4.	CONCLUSIONS AND RECOMMENDATIONS	82 to 112
	◆ HEALTH SERVICE DELIVERY SYSTEM	
	◆ ROLE OF ANGANWADI WORKERS & ANMS	
	◆ WOMEN'S EMPOWERMENT: ENERGISE RELEVANT DIRECT & INDIRECT PROGRAMMES	
	◆ OTHER IDEAS AND STEPPING UP OF TRAINING AND INTENSIVE MASS AWARENESS PROGRAMME: OFFICIAL AND BY ACTIVE NGOS	
5.	ANNEXURES	

INTRODUCTION

The Planning Commission vide its letter No.-15012/07/06-SER dated 6th September 2006, has entrusted the Indian trust for innovation and social change a Research project entitled, ‘the Socio-Economic causes and Determinants behind Infant mortality and maternal mortality.’

This Research Study is based on empirical inputs provided by this Trust’s investigators and its allied Research institutions located in different States. This study covers a number of districts of the States of Tamilnadu, Andhra Pradesh, Maharashtra, Rajasthan, Uttarakhand and Haryana.

This study also involves personal interviews and discussions with several MLAs, MPs, Women Leaders, Social Welfare Boards, prominent members of NGOs etc. I was privileged to have detailed conversations with some former and current Cabinet Ministers of the Union Government and some learned Judges and Public figures of the States surveyed in this study.

The Broad Methodology:

- a) Field investigations, empirical surveys, direct interviews with villagers specially women, young mothers, traditional dais, Anganwadi workers, the Auxiliary nurse midwives, doctors and Self Help groups, Panchayat sarpanchas and members.
- b) Extensive scanning of published material on the subject.
- c) Scanning of a few previous and current Five Year Plan Provisions to reduce IMR& MMR. A Special attention was given to the Mid-term reviews not only of the Planning Commission but also of Reports of some Ministries viz: Ministry of Health and Family Welfare, Ministry of Women and Child of the Centre and the States; National Rural Health Mission, selected local feed back

from Panchayat Raj reviews and a few members of the Panchayats of the concerned States.

- d) This project also drew the benefits of studying how such a serious matter is being tackled in other Asian and African countries.
- e) Internal Researchers attached to us continuously focussed their attention, in internal brainstorming sessions, to seek answer to a “MAJOR QUESTION” What **new** can we do to supplement the existing Schemes and Programmes on reducing and reversing wherever possible, the existing picture of mortality.
2ndly, is it not IMR/MMR, interalia, because of the lack of empowerment of women in India, can we either through new direct methods or a number of indirect strategic approaches, invigorate connected and unconnected systems as well as many sub-systems; as also other behavioural determinants, practices and decadent traditions; so that the strategic synergy could converge to a single goal of decelerating IMR & MMR. All this is reflected in the subsequent Report under five key facets as given below:-

- I. Aspects of Infant Mortality (IMR)
- II. Aspects of Maternal Mortality (MMR)
- III. Some prominent features of socio-demographic environmental factors.
- IV. Key Constraints:- Social-economic-cultural-environmental-administrative,nutritional,health delivery services;
- V. Aspects of empowerment of women and the girl child to have a say on important matters of their lives and survival.

Behind all our deliberations, questionings,discussions and formulation of new direct or indirect inputs for the search of alternate policy supplements, we have tried to remind ourselves constantly of the Key sociological features pertaining to India. These are as follows:-

- a) India is a large human system.
- b) Poverty status of India prevails all over the country.

- c) Indian society exists simultaneously in different centuries with its concomitant living patterns and practices. (there are still people in our country, some of whom are in the 2nd century India, 9th century and some others are knocking at the emerging 21st century India)
- d) Arising from the above three factors we display a unique cultural pluralism wherein superstitions co-exist with science.
- e) We are also practicing technological plurality. India similarly Lives in bullock cart economy as well as space era. (Here hardly any technology vanishes or is replaced totally by technological advancements. We are a Museum piece of technological non-violence).

To conclude, in order to grasp the merit of this report, as a prefatory observation, one has to say the following: (1) A great deal of remedial measures to curb IMR/MMR as the Indian Society exists today, will be those which are already known and are being implemented through the various policy provisions, official grants-in-aid and through the modern inputs, as and where they have reached.

We will be re-emphasising even earlier schemes and ideas, which are not new, and which are well known. There is nothing profound about this except that they are still useful and relevant in places and therefore, deserve to be continued.

Nevertheless, all our efforts of social reform through education, legislation, higher literacy rates, better personal income and general overall development in the health and governance mechanisms, still remain inadequate to demolish taboos, practices and traditions which constitute an ugly spot on 21 century modern India.

We need not comment on the enforcement failures be it that of a local administration, the Police system or the ,”law enforcement” mechanism, to crack down on such elements of society who pretend as keepers of decadent social norms and practices. In passing, can we just add that even judiciary, could have helped and has not quite lived

up to the expectations of those who suffer caste, community, religious and other unfortunate traditional adverse practices involving horrific murders as INFANT MORTALITY & MATERNAL MORTALITY.

Finally, this Report provides a qualitative and quantitative input. We have tried to stay away from the statistical jugglery and by no stretch of imagination pretend to provide magical recipes to liberate a large nation like ours from IMR/MMR. Our advice, in remedial policy options, cannot constitute “the last word on the subject”.

I thank every one, too numerous to be named here for their technical and intellectual contribution. I particularly thank Dr. Syeda Hameed, Member Planning Commission and the Advisors of the Planning Commission, for giving this Trust an opportunity to carry out this study. May I add that the time given to us could have been a little longer to improve upon the contents of the Report.

In any case, the problem of IMR & MMR is part of the Indian, “Social Complexity”. To totally bring it down we need to take vigorous direct and indirect systemic reform steps.

No research survey, including this report, can hardly put forward the definitive steps on this subject, realizing that we are seeking a, “mind-set” change for a billion plus people.

In any case, it is high time, we took not one but several, “first steps” some of them have been recommended here as we have to walk a thousand miles to bring down IMR/ MMR in India.

(PADMA SETH)

Executive Director ITISC &

Director of this Project

Former Member National Commission of Women
& Senior Adviser, UNICEF.

INFANT MORTALITY

ASPECTS OF INFANT MORTALITY: A SOCIAL MALAISE:

In the context of Infant mortality, the study of Six States of Andhra Pradesh, Tamilnadu, Maharashtra, Rajasthan, Uttarakhand and Haryana, we have focussed on the qualitative research-survey. It was indeed laborious and time consuming. From the information and data collected it revealed that the root cause for stagnating and perpetuating of infant mortality has been, the rural belief system, their cultural practices, and many a superstitions and taboos. These in short, influenced their rural health behaviour and health choices. This complex mixture of myth and magic even today continues to cast its spell on the rural people. The casualties are children and women. A thorough examination of the village psyche and its populace. Socio-economic, cultural and demographic features it is necessary to understand the root causes accelerating Infant Mortality.

Infant mortality is an indicator of the health status not only of infants, but also of the whole population and of their poverty ridden social and economic status in the country. They face excessive vulnerability, as underprivileged, to a hostile environment and suffer, malnutrition and serious health problems; All this leads to high rates of infant mortality and morbidity. **Infant mortality i.e. deaths under one year of age in a year per 1000 live births, is an important indicator of child health and development.**

A decade and a half ago, it was recorded that there was rapid decline in infant mortality, but it has apparently stagnated for the past five to six

**VILLAGE SOCIAL
PROFILE &
DOMINANT
BELIEFS**

Education for children & girls not needed

People are Poor & there is lack of employment

Pregnancy is common affair and no external intervention needed

Delivery is pollution-to be attended by low-caste traditional Dais only

Women have no reproductive rights

Women cannot decide size of their family

Domestic violence is very common

There is Male domination & women have no empowerment

Villagers prefer male child to girl child

No concept of nutrition or danger of malnutrition

Village women do not demand institutional service & care

Total belief in Tantrics Priests & magic & sorcery

No concept of safe motherhood

Practise witch craft and fear of ghosts & evil spirits

No new ideas are welcome

years. The current period of slow decline has made it difficult to achieve the National Child mortality goals by 2000.

The reduction in infant and child mortality was declared as the major goal of our official strategy to achieve Health for All BY 2000. One of the main objectives of the Government of India's Population Policy 2000 was to reduce the present level of high infant mortality and bring it down to less than 30 per 1000 live births by the year 2010. As per the figures available in 2002, Infant Mortality rate has been 63 per 1000, which is reported to have come down to 59 in 2005-6.*1 However, Neonatal Mortality declines rapidly from about 70 in 1981 to 40 in 2001.*2 This was attributed to the focus given by the planners and policy makers to a reduction stance of Neonatal Mortality.

SOCIAL PROFILE:

A pertinent question however, we need to ask is: "why is the decline in Infant mortality rates slowing"? Many research studies conducted so far have explored the causes and determinants of infant mortality in India. The key findings, besides pointing at the medico-clinical causes, indicate that the SOCIO-ECONOMIC factors like household income, female education, access to health services and immunization programmes are important determinants to assess status of infant mortality. Some studies also identify a strong inter-relationship between mortality, fertility and gender bias. Others, emphasise, how demographic factors impact on infant mortality, and vaguely touch on many other socio-economic factors that have contributed to high infant mortality: These include proximate factors, such

as medical care of the mother during antenatal period, care at birth, preventive and curative care in the post natal period. Maternal factors, ie: age at marriage, age at first birth, parity and birth intervals, household and community level factors: They felt that better water, drainage, sanitation, housing could increase access to a minimum package of essential services and could significantly reduce infant mortality rates. Besides, reproductive health services, perinatal care, improved breast-feeding practices, immunization, home based treatment of diarrhoea were also suggested.

An elaboration of the social profile of the villages is necessary to explain how socio-economic factors are the main causes and determinants behind IMR. Community norms, values and practices are assiduously followed by the rural folk. Their perception of various developmental indicators and their views on women, pregnancy, child birth etc. are given below:

1. Modern education is thought to be redundant and hence not pursued.
2. There is total absence of scientific temper and non acceptance of new ideas.
3. Pregnancy and child birth are considered a natural phenomena that require no medical intervention or attention
4. Girls are to be consigned to home based chores and they need to adhere to the Patriarchical imposed, norms and customs.
5. Women are not supposed to make decisions on any issue in the family.
6. People have a boy preference as against girls; because they believe that boys will alone can atone their earthly faults and become an

“old age” aid.

8. Girls do not deserve attention since they have to go away to her husband’s family. (They are called, a ‘Paraya Dhan’ (other property and wealth).
9. Deliveries are considered as pollution and hence low-caste dais alone are thought fit to handle the deliveries.
10. There is no concept of safe-motherhood practices.
11. Total belief in Tantrics, faith healers Ojha’s and priests.
12. Tardy or no co-operation offered by villagers to governmental health and educational programmes. This credibility gap still fails to disappear.
13. Majority of people suffer from poverty and lack of employment as there are no sustainable vocations, available for villagers locally.
14. There is no concept of nutrition among the villagers nor do they understand the dangers of malnutrition.
15. Crude ways of handling the new born and no understanding by Dais on dangers of infection persists.
16. Absence of toilet facilities, sanitation and hygiene, particularly menstrual hygiene is totally absent.
17. Belief in witchcraft, sorcery and magic abounds in the nooks of corner of India.
18. No concept of clean drinking water exists. Non-availability of potable drinking water universally in the country - is the worst failure of the state.

Women have no right over Resources of the Household

When Father is the Head of the Family how much this diminish female role

Is parents income helping or affecting maternal & child survival

If mother is an earning member can't it lead to better child care

Lack of economic empowerment of women?

KEY ECONOMIC CAUSES AND DETERMINANTS BEHIND & IMPACTING ON IMR & MMR

Does the family have economic capacity to seek health care

Can they afford vehicle for emergency transportation

Lack of owning a house can indirectly affect child health

Are both man & woman skilled workers this can help child survival

Number of members to be fed in the family

Can they cope with feeding all the members of the family?

Do they own land and reap its benefits

Are they wage labourers? can they afford health care

The status and standard of living of the family

OTHER FACTORS:

To what caste they belong?

Can they support the family & children

Do they live in Joint or nuclear family

Is the family a BPL card holder?

What is the cooking fuel? Do they have electricity in the house

Is mother literate? does she have employment opportunities

Child care rests on the financial status of the family

Can economic developments reduce IMR & MMR

Is mother a member of any Self-help group generating income

ECONOMIC CAUSES AND DETERMINANTS: BEHIND INFANT MORTALITY

- (i) Economic factors influence infant mortality in a big way. Child survival depends on the ability of the parents to offer good care. If they are in the BPL category, their capacity for child care is minimal. Also, illiteracy and ignorance of the needs of child care are glaring. Many studies have highlighted that the degree and quality of survival of the infant lie with the quality of care providers. The numerous economic factors have both direct and indirect impact on the survival of children and on infant mortality. Some of them are as follows:
- a) The status of economic development of the household/village.
 - b) Poverty and its various deleterious manifestations.
 - c) Number of families holding a BPL (below poverty line) card.
 - d) Number of members to be fed in the family
 - e) Is father the head of the house hold.
 - f) Household income. Occupation of the parent
 - g) Is the mother an earning member
 - h) Type of house they live in?: Own house or is it on rent?
 - i) Is the father a cultivator or a labourer?
 - j) Standard of living of the family.
 - k) Does the family has any vehicle for transportation.
 - l) Are both man and woman skilled workers?
 - m) To which caste do they belong?
 - n) Dependant or self-supporting?
 - o) Nuclear family or joint family
 - p) Social participation in economic activity.

- q) Land holding/farm power
- r) Is the mother educated
- s) Financial ability to seek medical care
- t) Is the mother, member of any self-help-group
- u) Women's access to earning and employment opportunities.
- v) Any specific coping strategy used to ensure food security, health and nutrition to the whole family?
- w) The type of cooking fuel used by the family
- x) Do they have electricity in the house?
- y) How helpless and dependent the women are, on the mercy of the family and their assistance.

The general standard of living and life style of people, the persisting poverty in every household, the feeble capacity of the head of the household to provide food for all the members and women and girl children of the family, and allied environmental and social factors do influence adversely the infant mortality in a community. Factors which are remote to the existing life styles, e.g. the availability and utilization of medical health facilities, also fall under socio-economic imperatives.

The education of the mother is considered important for the health outcome of children. The empirical evidence and health statistics do show that the educated mothers are usually healthier and give birth to healthier babies. They also provide healthier environment to children and their own health care. Even the illiterate but informed women can take better care of the child. Majority of them do not have "Akshar Gyan". Accessing official

health services do involve financial expenditure. Earning mother can ensure better investment on infant and child care. Economic factors too or thus important indicators to assess and understand the cause and determinant of infant mortality.

The word economic is too heavy a word to depict the assorted darkness that people, living a penniless and a marginal existence. Their existential status cannot be captured by Plan panel's economic indices. The Planning Commission's Technical notes may highlight a macro-setting but it cannot totally capture the misery of millions of men and women of our village and tribal settlements, who have neither a social persona or an economic persona are even an awareness persona, of what is good and what is bad in terms of child health. Not only that, their only life guiding thrust comes from what they have heard, from their forefathers or what they have seen them practising. It is an unfortunate and tragic gap and chasm in appreciation of this stark naked truth which diminish the values of the well informed modern programmes and recipes of welfare and development. Our researchers went beyond the economic questioning and in Villager's local language tried to get a rough and approximate measure of their sensitivity and insensitivity to new information, new awareness, its acceptance and nonacceptance. Amongst other things they found that in some villages that are in closer proximity to modern cities they had a higher level of mixed minimal appreciation versus those villagers and settlement dwellers who are not in such a proximity. In many a villages in Haryana women were keen to go to hospital for medicare but in Hamirpur and Bomdoli villages they indicated there economic inability to spend money on

transportation for going to the government hospital. In Uttarakhand village women were keen to go but were angry that for days there are no doctors found in the hospital. In Andhra Pradesh many were asked to go for ultrasound first. All these expenses cannot be borne by the villagers. Imagine within our country there are 620,000 villages. How does one take modernity, social or economic to such denizens? Planners have to pay attention to the fact that each region, needs region specific, culture specific and language specific measures.

The Ballabgarh experiment of AIIMS, we may recall here, which says that Economic Development is not a surety for infant survival. They also said that “environmental, social, educational, improvement, in development is likely to be a slow process and bringing down IMR cannot wait for that long”. Though specific and focussed medical intervention for a long period may reduce IMR but it cannot remove the root cause of socio-economic and cultural factors. There is no dichotomy nor conflict between the **socio-economic** factors and medical causes. While the belief culture is deep and the diseases are shrouded by cultural practices, the medical services offer remedy only to the symptoms. The Ballabgarh report also refers to low birth weight babies and malnutrition but, it overlooks the cultural practice of marrying off girls at young age when they are not mature physically; where discrimination is practised in the nurture of girls versus boys; the girls are deprived of nutritious food and care. The young married girls are not adequately fit for going through pregnancies. The economics of marriage expenses, the dowry costs are integral to their deviant behaviour and cultural practices. The demand and utilization of health infrastructure basically

VILLAGE CULTURAL PRACTICES LEAD TO IMR & MMR

PROMINENT SUPERSTITIOUS DETERMINANTS UNAFFECTED & UNDIMINISHED BY CURRENT POLICIES

Superstitious beliefs that traditional Ayas alone have to attend to deliveries	Praying for the birth of male child who is insurance in old age	Superstition: Faith in supernatural • irrational fear of unknown • misunderstood reverence • unquestioned ideas & practices enforced by caste & religion •		Girls are married young & pressurized after marriage to conceive early	Faulty feeding and weaning practices
Older women believe if the Pregnant woman is excessively hungry the baby in the womb will be a girl	Based on their belief they pressurise women to get foetus aborted by Dais/quacks	Resorting to foeticide to get rid of the girl child	Infanticide of the girl child is very common	Frequent Purgation is thought of as cure to many ailments.	
Applying cow-dung to the cut end of the umbilical cord.	Immunization and vaccination of pregnant women and children	Folic acid and iron tablets given to pregnant women are considered hot and thrown away	New born is not allowed breast feeding-colostrom is considered bad milk harmful to the infant	Honey is water or sugar mixed in water is fed to the new born with unsterilised swab or cloth for 6 to 12 days.	
If the woman is in long labour and takes too	Pregnant women are half fed-fearing the baby in the womb will grow very big	Lactating mothers are given only tea with a pinch of milk. Fear that milk may cause puss in the body	Man does not follow family planning. She can adopt only if the husband permits as also by in-laws	Even if the woman has four to five girls, she cannot adopt family planning until she bears a male child	
Long to deliver, she is considered by same as dishonest wife	Woman has no autonomy nor choice	Even in emergencies until the woman is permitted by husband she cannot seek medicare.	In complications in pregnancies leading to still birth or low birth weight babies; it is believed as the act of spirits punishing the women	Men drink, gamble and engaged in wife bashing	
The girl child is discriminated in many ways and is at a disadvantage	Neglect of the girl child - no good food nor nutrition given to her.	Practice of dowry is prevalent: The main cause for child marriages.	The fear of expenditure on girl child throughout life makes them commit foeticide and infanticide.	Girls are not allowed to go to High School in other Villages while boys are encouraged to study.	

depends on the peoples own faith and on disbelief towards the modern medicare system. Their ability to seek and access medical facilities is constrained both by ignorance, social beliefs, values and practices and by economic disabilities. Therefore, the need for health care is invariably linked to a chain of SOCIO-ECONOMIC FACTORS as articulated in different regions through a gamut of local customs.

CULTURAL PRACTICES

Cultural practices are based on tradition and beliefs imparted to people by their forefathers

The Rural profile and cultural practices have been found to be thriving even today. Our surveys in the villages in six states confirm the aforesaid characteristics that still prevail unchanged. Not discounting the medical indicators behind infant, neonatal and post-neonatal mortality, the deep rooted causes and determinants lie deep in the village belief systems and cultural practices and taboos. If the cures to ailments by modern medi-care is necessary and welcome, to tackle the attitudes and behaviour of the people steeped in superstition and fear of modern medicine however is also crucial. ***The root cause of nonacceptance of modern medicare is unfamiliarity, the lack of awareness and the fear of the unknown.******

Cultural Practises are mostly based on 'superstition'. Attributing infant mortality to supernatural forces and also to evil spirits has been a part of the village belief system. It assumes numerous dimensions and negatively

impact on infant survival. Our findings during our field study in six states indicate the following factors:

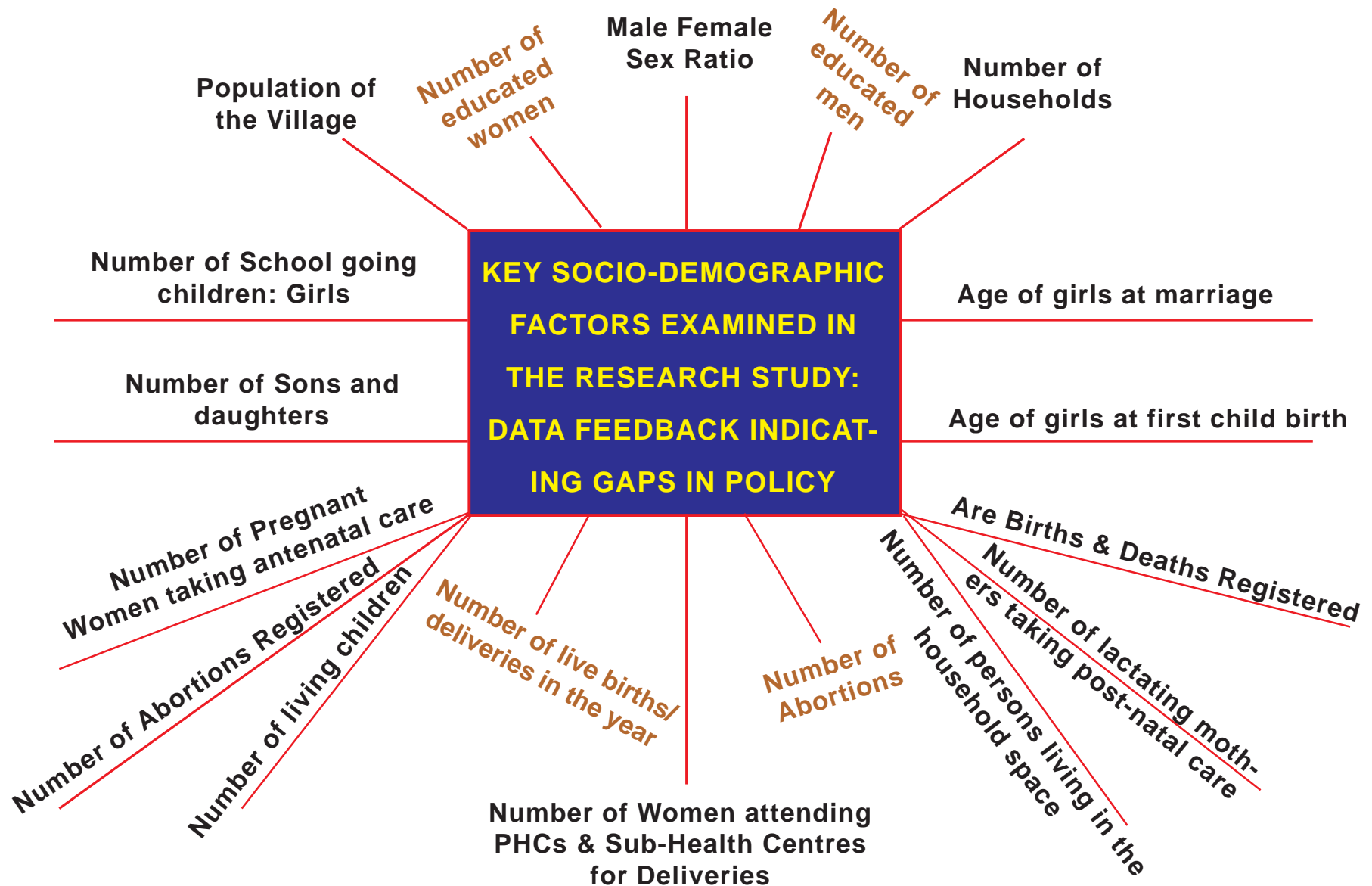
1. Girls are married young/ child marriages are common in villages (Rajasthan leads here).
2. There is community and family Pressure on young married women to conceive early after marriage. This often leads to mortality or low birth weight babies.
3. Praying for the male child, who they believe alone can atone their earthly faults is universal in all Villagers.
4. Traditional ayas/dais alone can attend to deliveries well.
5. Resorting to foeticide to get rid of the girl child still is a common practice.
6. Older women arrogate and profess that they can predict the sex of the baby in the womb: When pregnant women are excessively hungry, they predict that the child in the womb will be a girl and hence advise the pregnant woman to go in for infanticide with the help of dais quacks.

Before we add more points of our findings. It is worth a pause here to assess and correlate our current Plan schemes and women related programmes to know the gravity and mismatch of two factors: (i) if all the above mentioned points and those that follow are met by the current Plan programmes and (ii) Have we noted the wide gaps in women's empowerment as a key factor for maternal and child health and survival and the Plan provisions currently made for Women Empowerment. The additional points to be taken note of are as following.

7. Infanticide of the girl child is a known practice and continues.
8. Pregnant women are not fed adequately due to superstitious belief and a fear of growth of the foetus, lending the delivery difficult.
9. Applying cowdung to the cut end of the umbilical cord and branding the child all over the body with hot needles to drive away fever are part of village practices. Also frequent purgation is one of the cures attempted at.
10. Faulty feeding and weaning practices still continue.
11. Immunization of pregnant women is avoided as also the vaccination of the child. Pregnant women though they receive folic acid and iron tablets from the anganwadis, they throw them away, considering them to be hot and dangerous to their bodies.
12. The new born is not allowed to be breast fed for a minimum of 6 to seven days and a maximum of even 10 to 12 days. Cholestom is thought of as bad milk that is dangerous to the child's health and that if fed it will curdle in the baby's stomache.
13. Honey mixed with water or sugar water is fed to the baby with unsterilised swab or cloth.
14. The lactating mother is starved and given only tea or coffee with a pinch of milk fearing that, if milk is given to her, it will lead to formation of puss in her body and that will be harmful to the child.
15. Family planning is not opted by men. Only women undergo family planning procedures that too with the permission of the husband and the in-laws. The woman is not allowed to take to family planning until such time she bears a male child.
16. Even if she has delivered four to five girl babies and even if she is

- anaemic, she is expected to conceive in the hope of a male child.
17. Woman has no autonomy and no freedom of mobility. Even to visit her maternal home in the village, she is not free to do so, until she is permitted for the same by the husband or the in-laws.
 18. Even in emergencies, the pregnant woman has to wait for her husband's permission to seek medi-care.
 19. ***In case of complications in pregnancy and if the child is a still born, it is attributed to the wrath of the spirits, or supernatural act of punishment. The family does not regret the delay in seeking institutional care.***
 20. Practice of dowry giving and demanding it is prevalent everywhere.
 21. Discrimination and neglect of the girl child abounds. She is deprived of good food, unlike the favoured diet for the male child.
 22. The girls are not allowed to pursue education in the high school, situated in the nearby village. Boys alone are encouraged to go to school situated even at a distance. In the Jaisalmer District it is rigourously observed.
 23. If the woman is in labour for long hours, and if she delivers late, some villagers do not hesitate to consider her as impure & guilty of infidelity (a dishonest wife). This view was reiterated by village women in Andhra Pradesh in the villages of Rangareddy and in the Chittoor districts as also in tribal areas of Maharashtra in Nashik district and some remote areas of Uttarakhand.
 24. Men drink, gamble and carry on with unabated wife bashing. It is deemed as customary and necessary domestic violence.

SOCIO DEMOGRAPHIC FACTORS & DATA BASE DO NOT INCLUDE MANY DISAGGREGATES AND INFORMATION ON NUMBER OF LIVE BIRTHS AND NUMBER OF ABORTIONS



The Rural social profile and their many a cultural practices inimical to women continue even today. Our surveys, in the villages in the six states, confirm the aforesaid characteristics that prevail unchecked and undisturbed. Not in the standing the medical reasons for infant, neonatal, postneonatal mortality its deep rooted causes and determinants lie more in the village practices and belief systems and taboos. We need to extend and step-up modern medicines, for cures to ailments but it is extremely important to also tackle the attitudes and behaviour of the people steeped in superstition and fear of modern medicine and medi-care. The root cause of non acceptance is because of lack of familiarity, lack of awareness and fear of the unknown on the part of Villages and tribals and remote area denizens.

Can we say that our current medical indices and social indicators have been fully taken into account, the above mentioned features of poverty and superstition that guides the life of rural and of tribal area inhabitants.

SOCIO DEMOGRAPHIC FACTORS (Also called Maternal Factors)

Demographic factors also fall under the over all socio-economic ambit. For purposes of enumeration and for reasons of measurement,, quantification and classification, they are brought under what is called, “demographic factors”. The following demographic factors are the outcome of the socio-economic causes.

There is difference between indicative change and absolute accomplishment. Statistics do not cover it. It may be a mere indicator of an

ameliorative change, but does not represent the total local practices. The following factors least recorded amply bear the above statements:-

1. Age at marriage- Marriage of adolescent girls below 18
2. Age of woman at conception.
3. Maternal age at birth-when mother is not mature.
4. Live birth or foetal death-
5. Preceding birth interval
6. Number of persons living in one room
7. Number of previous abortions
8. Number of living children/sons
9. Ante-natal care if attended by ANMs or Dais
10. Non-registration of births, marriages and deaths
11. Adoption of family planning practices by men and women
12. Place of delivery.

For the items cited under the above demographic factors; these two become intense due to rural beliefs and cultural practices. The practice of giving away children and adolescents girls in marriage before the legal age of marriage at 18, has lead to early conception, that is common knowledge. The low birth weight babies are the outcome. Both congenital deformities and underdevelopment of the child are some of the handicaps that the young and immature mother has to handle. There is no data available on the number of adolescent marriages solemnized since there is no compulsory registration of marriages. However, infant mortality, both neonatal and post neonatal are common occurrences because of early marriages followed by early motherhood. How can we ensure safe motherhood and child care in such a situation? Added to these this lack of

data on crucial maternal factors inhibits authentic assessment of the unmeasurable propensity of risk to the infant survival and mortality.

As shown by various empirical research studies, the proper childcare processes cannot be overlooked in order to save infants from mortality, until and unless we can ensure safe motherhood and child care. In such circumstances. The unscientific and faulty infant feeding practices and depriving the young mother of nutritious food after delivery, are sad and unfortunate manifestations of local cultural practices. A birth interval, which means a spacing between the first child and the following ones is an important factor not only for mother's health but also in deciding the prospects of child survival. Frequent deliveries by the anaemic mothers leads to continuous malnutrition and infant mortality. Also deprivation due to food intake based on households and community beliefs and practices do threaten both the maternal and the child survival.

For medical termination of pregnancy (MTP) though legally permitted and to be conducted by specified medical practitioners, but a majority of pregnant women seek help only of dais and quacks in the village. In a majority of such cases crude ways used for abortions do result in maternal mortality and killing of the foetus. Abortion though indicated as a demographic factor is often not recorded. ***Hence any record maintained of infant mortality, without record of abortions give inadequate and a distorted picture.*** At present oral pills are available for easier abortions. It is regretted that qualitative research like the present study is handicapped for want of sufficient official data on miscarriages and abortions, besides foeticide and infanticide.

**ENVIRONMENTAL
FACTORS AFFECTING
INFANT AND
MATERNAL MORTALITY
ANOTHER POLICY
MISMATCH**

*There is total Lack
of
hygiene in villages*

*Delivery rooms are
not ventilated*

*Dais use rags for
women
during delivery*

*Refusal disposed of
in the court yard*

*There is Overcrowding in
the household space*

*No-immunization to mother
No- vaccination to infants*

*Animals are kept next
to the delivery room*

*They are Unmindful of correlates
to infant mortality*

*Villagers consider
Colostrum as bad
milk for infants*

*As a practice
Infants are
not breastfed
for days after
birth*

*Villagers do not
have the habit of
using toilets*

*If built-up
toilets are their
Villagers use
them for storage*

*Immediately after
birth, Infants are fed
only sugarwater
with unsterilised
cotton or swab*

Policies on infant and maternal health do not penetrate into peoples behaviour and practices

It is not a practice in our Villages that the pregnant women of the villages go in for antenatal care thrice before delivery. Post natal care is a misnomer altogether. Most of the deliveries that take place are at home and they do not utilize the antenatal and post natal facilities or receive required sanitary health care from the local midwives.

When most Women and families prefer to have a male child and not a girl child. This boy preference does reveal the discriminatory story of the girl child which persists for her through out her life cycle from her birth, growth, adolescence, marriage and motherhood etc. All family and social norms are duly obeyed by women. The demographic indicators are part and parcel of the village culture and practices that have contributed to infant mortality.

ENVIRONMENTAL FACTORS

The public health depends a great deal on environmental factors. The number of studies conducted by both the Indian scholars and the foreign researchers do touch on environmental sanitation; but more as a corollary to the medical factors and as supplementary cause for infant mortality. The lack of hygiene and sanitation are taken as part of village life. Local initiatives are mostly absent in cleaning up their habitat. All blame is put on government for the unsanitary conditions of one's own village. Our teams local interrogations revealed local belief in the God given life wherein the environmental conditions, such as, access to safe water and sanitation facilities, access to electricity and use of clean cooking fuel were not deemed

as part of their Karma. This lack of local insensitivity has important health impact on young children. Above all it is a failure of the State apparatus that could not provide these basic amenities even after sixty years of independence. Some of the familiar factors, or the catalogued by us were:

1. Overcrowding and lack of ventilation, sanitation and hygiene.
2. Rampant spread of Infectious diseases
3. Lack of care during and after child birth the traditional habit of giving “Gutti” to infant reveals child care after birth.
4. Near total indifference to hygiene for the infant. The delivery room where the child was born was totally plugged of all holes to protect the male child from ‘evil eye’.
5. Family planning measures adopted were conditional to the survival of children.
6. Ignoring of immunization and vaccination. Many pregnancy women confessed that their mothers in law do not allow them for these procedures.
7. Waste disposal in their own courtyard results in infection. This reflects the total absence of public health authorities and their unconcerned for environmental health.
8. Lack of drainage in the village lanes - This shows absence of political will for necessary action.
9. Villagers do not use toilets-but they go to the fields. This only shows how they refuse to change their habits.
10. Use of dirty rags during delivery. This is highly dangerous, but the idea the delivery pollution as per villagers belief is main reason for such practice.

11. Feeding sugar water to the infant with unsterilised swab. This is doubly harmful (i) by depriving the child of mothers milk and (ii) refusing nutrition that will enhance immunity to the child.
12. Animals kept adjacent to the delivery area.

A prerequisite for living in a healthy habitat is good ventilation, sanitation and personal hygiene. How is it possible in a room that has to accommodate all the members of the household and some times even the cattle? Do these purely fall under medical issues? Are'nt they not part of village life styles and also their economic necessity. It is both ignorance of the need for sanitary conditions and the lack of resources to provide ideal shelter for the pregnant and lactating mother. Some researches on religious practices and ethnicity also reinforce the above, facts as causes and determinants behind infant and maternal mortality.

LACK OF POTABLE WATER SUPPLY IS A KEY PUBLIC HEALTH ISSUE

The lack of adequate water supply is an urgent issue. But there is no one to monitor the supply of water or usage or wastage of available water. There exists competition amongst villagers to draw as much water as possible by each household unmindful of the requirements of other villagers. A sense of belonging to ones village and one community too is an issue that needs attention. Caste discrimination as to who will draw water first from which well or taps, stares at us as an evil discriminatory practice that lingers on even today. Civic consciousness being absent, no one removes

the puddles of water in front of their homes that harbours mosquitoes, spreads malaria and other infections. Such behaviour may not be attributed to cultural practice but to the ignorant and indifferent people and their way of life. ***Well being of others does not seem to be a community value: Villagers rich or poor are solely concerned with their own interest and well being.***

ROLE OF SELF HELP GROUPS

Improvement in human ecology shows a ray of hope by women voluntarily forming themselves into Self Help Groups. These groups not merely focus on their economic betterment but act as an almoner in times of emergency. E.g. when a woman in labour with complications and has to be rushed to a medical centre or to a hospital. Women from these self-help groups deposed before us that they pool money for bearing transportation charges for helping women in distress. In village Harsaroo in Gurgaon District of Haryana, the village SHG has offered help to pregnant women by taking them to the government hospital or private clinics; thus they assisted in saving the unborn from mortality and also helped the woman from maternal mortality. At the instance of District Rural Development Agency (DRDA) SHG are getting formed. And they become eligible for getting sizeable amount as loan to start economic enterprises. In Madurai and Salem District of Tamilnadu SHG's have pooled money and have received four times the loan from the Bank. They have sponsored education of poor girls with the loan money. This is one way to stop women from infanticide of girl child causing IMR.

Under the rural development project (DRDA) (Swarna Jayanti Gram Swa Rozgar Yojana) women are encouraged to form themselves into groups of 15 or more where in they contribute a monthly sum ranging e.g. of Rs.50/- or more. Once the group is able to collect a sizeable amount of e.g. Rs.5000/- they are entitled to get six times loan from the bank on easy pay back instalments and on easy interest. These SHGs then start one or more economic and income earning activities and then distribute the profits amongst the members; at times in emergencies they do lend an amount sought by one of the members who is needy. **These self help groups have brought change in the village help-line.** A small dent is being made by the formation of Self Help Groups of women whose members act as social workers and volunteers at times of emergency. They should be multiplied in all states they will act as a resources and arrange transport for the pregnant woman, mother or infant to be rushed to the hospital, or to the health centres or to private doctors in the neighbourhood. Our researchers met the SHGs in Villages Harsaroo in Haryana and in Magudanchavadi in Salem district of Tamilnadu and felt inspired by local SHG's activities.

ALL VISIBLE CONSTRAINTS IN REDUCTION OF IMR

Role of National Rural Health Mission:

The National Rural Health Mission of 2005 with the Reproductive Child Health II programme promises better infant and maternal health and reduction in infant mortality, than the earlier safe motherhood programme under RCH-I. The existing infrastructure of Primary Health Centres and the Sub-centres with the introduction of ASHA worker is a welcome innovation. But to make a new entrant's life and work in the village

successful, special efforts have to be made to bring under one umbrella, all the different agencies functioning in the village i.e. ICDS project with its Anganwadis, the Primary Health centres and the Sub-centres, their medical practitioners, nurses and ANMs and ASHA have to work cohesively and in collaboration with one another; The ideal situation will be to work under the leadership of an enlightened village Panchayat. Once linkages are established, the work environment will improve and interaction will become effective. Each functionary will have to know ones individual and collective responsibilities. The constant presence of these functionaries working by rotation and harmoniously in the village will enhance better local participation in our efforts to reduce IMR. Such a collective effort is the true answer for human development that can ensure better survival of infants and reduce infant mortality.

The many expectations as cited above if we face reality they are absent even today. ASHA have yet to be appointed in many health centres. Though they are to be trained by doctors in the civil hospital, their actual role and performance is very limited. They are neither trained in nursing nor are they professionals. They can at best act as conduits between the pregnant women and the institutional machinery. i.e. the Primary health centres and the sub-centres. Some times they do rush the women in emergency to the Community Health centres or hospitals also, even though they are situated at a distance. ASHA's effective and timely performance can contribute to the reduction in IMR

Caste/religion/class/poverty: The complex village culture has an added dimension by way of caste, religion and class on one side and poverty and deprivation on the other. There is lack of employment avenues leading to poor households suffering economic disabilities. Coordination amongst the various service providers in the village have to be brought in, to improve the condition of families and thus help in improving their health status of infants/children, pregnant and lactating mothers.

THE INFRASTRUCTURE AND GLARING GAPS:

The ICDS structure with the Anganwadi workers is expected to serve as a forum in the village where creche for infants and preschool and nutrition is to be provided for children of three to six years age. Here the pregnant and lactating mothers are also to be attended to for their antenatal and postnatal care. Adolescents come to receive nutritious snacks folic acid and iron tablets. In southern states of Tamilnadu and Andhra Pradesh, midday meals are given to children, pregnant and lactating mothers who come to the Anganwadis. This is a great incentive for children and mothers who are below poverty line families to visit the Anganwadis. In northern Indian states, dry nashta is given. Our team of field staff and I personally saw those white maize balls which are hard to bite. Even this poor and so-called nashta is still attracting children with their mothers. This can be the first step and an opportunity for local functionaries to interact with women of the village and counsel them on the best health practices and child care. The Primary health centres and sub-centres are expected to work in close collaboration with Anganwadis. But the work area of ANMs is dispersed

and they have to make periodic visits to centres and to the villages around. Their main job is to immunize and vaccinate pregnant mothers and children and to offer help in deliveries, emergencies and antenatal care. But the ANMs visit a village sub-centre only on a fixed days in a month. The occasional visits by the health centre staff and not to find them in the village daily, creates apprehensions in the minds of the villagers. Therefore they revert back to their old practice of depending on the traditional methods provided by the local faith healers.

In such a scenario where there are no medical staff nor doctors available to the villagers at times of need. This discourages the rural folk in accessing medicare services. In Umrare gaon in Nashik district of Maharashtra, our team and I personally went to the PHC and met the patients admitted for not only delivery but even those who had tubectomy also. Such centres are far and few in numbers. Trudging long distances, mud roads prove to be a disincentive for villagers seeking better health care.

The conceptual framework of the health delivery services in the villages is welcome first step. But many gaps remain in the recruitment policies of the Anganwadis, the ANMS, the doctors and the multipurpose workers. The Anganwadi worker - a tenth pass girl/woman from the very village where she will work first gets recruited. But she hardly has proper training. With this handicap, she is supposed to attend to many chores i.e. keeping a number of Registers. There is no **creche** for 0-3 year age group. Secondly, the ANGW is also expected to visit women's homes, and meet the pregnant women and enquire about the infants health and counsel them

on a variety of subjects in particular food and nutrition intake and the iron folic acid tablets to be taken regularly. Due to lack of proper and adequate training, the Anganwadi workers finds her work exhausting and unmanageable.

Another handicap in the village is the caste segregation. In Hayatpur village in district Gurgaon of Haryana State the Sarpanch an SC refused to interact with an anganwadi worker, a non SC. It is for the local governance to take leadership role and monitor the working of the various functionaries in health the ANMs, education and public health sector. But if these public functionaries do not see eye to eye with each other, the National Rural Health Mission cannot function satisfactorily and to arrest the rise in IMR/MMR. What is required is 'change' in the recruitment and training policies of the Anganwadi workers, the ANMs and ASHAS. The Panchas and Sarpanchas too need orientation and training. Besides, all these village level workers and functionaries, need "on the job training" continuously, for one and a half to two months, without any break.

In many of these PHCs we found ANMs appointed on contractual basis. The ANMs though are expected to stay in the village and be able to attend to women and infants cases, but they often live in distant villages and, therefore, are not able to attend to emergencies. Villagers are left to their own fate thus.

The NRHM scheme is lofty but the implementation machinery, if we can call it as a synthesized entity, has many holes and gaps. The

Panchayatiraj personnel, including the elected ones, is almost a challenge. Many presidents of the Panchayats who have become neo rich by selling away their prime cultivable lands do not show interest in attending to any training programme. They do not attach any value to learning or training. Only money making/ earning is considered important and worthy of their attention.

To sum up unless administrative requirements of fine tuning of recruitment policies and rules are taken up with a sense of urgency, the laudable objectives of the NRHM will be in peril. Both in Maharashtra villages and in Andhra Pradesh as also in Uttarakhand, Rajasthan there were no ASHAs yet recruited. In Haryana, we could see a very few ones are in place; some of the Dais also offered to act as ASHAs.

States do not seem to follow the guidelines of the Centre as they are free to frame their policies and rules. Their bureaucratic machinery can no more deliver goods at the ground level. **What is imperative is to have a multi-sectoral approach that is needed to be adopted and a central monitoring mechanism is essential to make the Mission's goals attainable. With this limping infrastructure available in the villages and with the indifferent Panchayat raj functioning, unaware of their role and responsibilities, and the illequipped and ill staffed Primary Health Centres and sub-centres do not send healthy signals.** In such circumstances, the villagers withdraw themselves and find refuge in their own dilapidated, archaic, socio-economic determinants that cannot salvage IMR and MMR.

Habits and attitudes do not change overnight by Erecting health and educational infrastructure at the village level by starting the Primary Health Centre Sub-centre and a Primary school cannot automatically change the die hard habits, behaviour and attitudes of the village community. Definitely, an educated mother will be able to understand the prerequisites for child-care and if she is also an earning member she can contribute, to better growth of the child.

LACK OF CONCERN AND INDIFFERENCE OF VILLAGERS

In most Villages it was observed that a great many individual homes are swept clean. But all the waste water is thrown out in the street/lane. The roads are thus flooded. There is no drainage system in the village. Village health environment adversely influences infant and child mortality; Even the Sarpanch and Panches have shown little, if any concern to approach the public health authorities to get their villages in shape.

The Statement that Development is not a surety for infant survival is very true. Haryana is a rich state where industrial development has touched heights. But the public health system has taken a back seat. A technical issue like drainage can easily be solved if there is political commitment and a will to engage experts to fix the drainage. Mo-bikes and latest cars zoom in the narrow lanes of the villages; but the level of education of people and their civic consciousness is abysmally low and is almost nil. Women's status remain poor & static. Even school educated girls once they are

married. are not allowed the freedom of movement or decision making even in women's personal matters.

TO SUM UP

Based on our limited study, we do feel emboldened to seek an answer from the Planning and Health policy of the government whether the following life expectancy indicators of infants/children have been checked, monitored and achieved?

They are:

- The age of the girl at marriage
- The age at first child birth
- Delivery conducted at home/ or at the PHC/Hospital
- Fertility status of the woman
- Spacing of birth of the children
- Acceptance of family planning devices by the couple
- Woman's education/ and level.
- Woman's employment and economic status
- Woman's reproductive and child health rights.
- Woman's empowerment.

However, whatever be the new remedial measures we may introduce in the 11th and 12th Five Year Plans, let us also pay attention to the dangers to infant survival and find ways and means to cope, to alter or totally eliminate them:

- Irrational Rural beliefs and village health culture.
- Villager's lack of faith in modern medication
- Rural faith and belief in external i.e. supernatural factors, the evil spirits, and evil eye
- Cultural practices affecting the birth of the girl child, her retarded growth, foeticide
- Infanticide and villager's preference for sons as against girl child
- Dowry demands, child marriages and adolescent -rig pregnancies
- Blind sacrifices of children based on predictions by the priests.
- Low value attached to women whether it is for their productive work or their reproductive obligations.
- Unhealthy environment, lack of sanitation, potable water and stinking drainage.
- Lack of awareness of nutrition, dangers of malnutrition.(known but not fully catered to.)
- Caste and religious discriminations and crude practices, deserve new legislative remedy, besides the fine tuning and effective management practices which are region specific.
- Unfair customary Practices depriving the pregnant, lactating mother and infants of nutrition and food.

MATERNAL MORTALITY

Maternal mortality is an issue of great concern both in the national and international health agenda. For many decades, there had been a single focus 'on fertility regulation' it viewed women's health with a narrow perspective, as limited to their reproductive system between 15–45 years of age. Mothers health in the past Indian Policy has been particularly of measures to improve infant and child health we are happy that now the current health policy lays additional emphasis on reducing maternal mortality.

WHAT IS MATERNAL MORTALITY

The maternal mortality has been defined by WHO as death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death (and) is intended for countries that wish to identify deaths occurring in pregnancy, child birth upto 6 weeks after the end of pregnancy but where the cause of death cannot be identified precisely. (WHO cited in Royston, Mauldin, 1994).

How do we assess the status of Maternal mortality?

The tragedy of maternal mortality affects mainly the poorer sections of society. In our Research study conducted in the villages of Gurgaon and Rewari districts in Haryana we were informed that it is the chowkidar of the village who keeps the record of births and

deaths in the village. We do feel astonished that important records of infant mortality and maternal mortality are kept by a junior village functionary like a chowkidar, who is either illiterate or at best neoliterate. Fortunately, we could find records kept by the Anganwadi worker and ANM of the primary health centres in the villages: i.e. Akeria and Kapadivas in Block Daru Heda in Rewari district of Haryana state. They have kept records of pregnant and lactating mothers and also a register showing births and deaths occurred during the year and a year earlier. We could see and examine those available records. so far the Registration of births and deaths has not been made compulsory. Hence, the data available from these records on maternal mortality and infant mortality are quite inadequate. The reasons entered in the records for deaths were sketchy, vague and incomplete. This scenario is almost the same in most of the villages we surveyed. It is not at all a habit for villagers to go on their own to the Anganwadis and Primary or Sub-health centres to inform them of births and deaths. Our experience in the State of Rajasthan and Uttarakhand had been worse. In the tribal villages i.e. Rasegaon and Umrle in Maharashtra state (in Nashik dt, Dindori taluqa) where the Gram Sewak keeps the record of births and deaths. Here too we found that the Anganwadi worker/ANM make entries in the register and also feed this information from time to time to the Gram Sewak. Again we could see the limitations in keeping of these records.

WOMEN & HEALTH

To understand the causes of MMR & IMR we have to look into the traditional belief about health and disease that villagers in Haryana attribute to the Supernatural forces and to the wrath of evil spirits. These ideas were told to our field investigators in the other states too. The attitude of villagers towards health and customary behaviour reflect the rural health culture of the women and the village folk. They have been studied by us in great detail and highlighted. Our findings from the empirical study conducted in the 48 villages in the twelve districts of Six States give us a clear picture of women's health and **the Socio-economic causes and determinants that lie behind Maternal mortality and Infant mortality**. These do confirm what has been earlier found in the research publications. It is so believed that "the traditional Indian systems of medicine are male oriented and male dominated. They largely ignor the women's diseases. The only traditional medicine available to women was in the hands of dais who dealt mainly with pregnancy and delivery" (Jeffery et al. 1983) It needs no two opinions to state that what was true in 1983, is due to local customs and tradition is still prevalent in the nooks and corners of India. We found this as true in Bassi and Bateri villages of Jaipur district in Rajasthasn. Irrespective of the medical system, the prime gap remains in the lack of enough number of maternal delivery shelters.

It may be of some interest to recall here that in the year 1994 when I was a member of the first National Commission for women, we arranged a programme to celebrate the International Women's day the on the 8th of

March at the India International Centre, New Delhi. The then Deputy Director General Health Services Dr. Raja Ram publicly stated that even if near all the telephone booths are mobilised as a maternal delivery shelters even then they will be inadequate to cope with the need spectrum of maternal health at the time of deliveries and post-delivery care of mother and child and their safety.

HEALTH POLICIES: HOW FOR EFFECTIVE?

It may be argued that the above may be yesterday's phenomena let us turn to today where in India we believe firmly that the Health is a basic Human Right. Besides the Constitution of India provides for equal rights and equal opportunities in all areas to its citizens irrespective of sex, race, caste or religion. Based on these basic tenets, it may be recalled here that the National Health Policy of 1982 was formulated. It came with its overall goal of, "universal provision of comprehensive primary health care services" The shortcomings of the past were traced as, rapid population growth, high mortality among women, infants and children, extensive malnutrition, onset of various infectious diseases and lack of access to rural people of potable drinking water and basic sanitation; the only relief available to women was the untrained traditional birth attendants; earlier the right emphasis on the prevention of maternal mortality was lacking. The poor health situation was looked at by many as the outcome of few and far between the hospital based curative approach to provide health services.

National campaign on Health for all by 2000:

To fulfill the promises made, a National campaign on, 'Health for all' by 2000 (initiated by WHO) was announced. Instead of building awareness and self reliance amongst people, this approach by India also some how did weaken the community's capacity to cope with its own health needs. The situation is gradually changing. In three villages by name Thottappanayakanur, Uthappanayakanur and Alligundam of Madurai district in Tamilnadu today, there are 18 Self Help Groups formed by women to help themselves and other women in need. Under the Tamilnadu government's Magalir Dittam scheme, Rs.10,000 loan was given to individuals to start any enterprise that would earn them a reasonable income to feel independent and take care of their health and that of their children; also to save themselves from maternal mortality. They were also encouraged to access and avail of institutional facilities for deliveries. The village women spoke confidently and said that they feel happy to be economically independent of their husbands and that with their earnings they can take full care of their households. They also take independent decisions to go for sterilization and tubectomy, force their friends and other women, to get sterilized after two children are born.

But as a contrast we have found that in some of the north Indian states women still feel dependent and are not able to have access to the various government schemes started for the benefit of women and girl children. The above mentioned experience that we had in Madurai villages has been quoted here to show how the economic empowerment strategy

has emboldened women to shun archaic values of dependency on the male head of the household. They need not continue to be waiting to receive doles or alms. These Madurai region women have asserted themselves to attend to their reproductive health needs and contribute to the reduction of maternal mortality and infant mortality. But surely we can't say it for women even of Tamilnadu. Such success stories, however small, need to be replicated state by state.

The official assessment of maternal mortality:

The National Health Policy of 2002, though came with a focus to study and examine the poor health scenario and to face the challenges in the provision of health care in India, the grim picture of maternal mortality persists. Its confirmation came from the Sample Registration Survey of 2003 which brought to notice the high incidence of maternal deaths as 420 per 100,000 live births. This implies that 15% of all deaths among women in reproductive age are pregnancy related. For details see Sample Registration Survey's Maternal Mortality in India 1997-2003, - Trends, causes and risk factors. The Registrar General of India., New Delhi states, " Under the prevailing conditions and the presumption of decline being too linear, the MMR would be around 231 by 2012. Using conservative estimates, the MMR would be 195 by then. Appropriate and strong governmental policies would then be required to meet the targets of NRHM and MDG."

ARRIVAL OF THE NATIONAL RURAL HEALTH MISSION 2005

It is well known fact that many a gap exists between plan targets and its implementation of the same by the governmental machinery.

Our plan schemes have been very serious on coping with IMR/MMR. In the tenth five year plan started with a focus on i.e. social empowerment, economic empowerment and gender justice. This is based on the national Policy on Empowerment of women (2001). Amongst many monitorable targets adopted for the 10th Five Year Plan and beyond, reduction of Maternal Mortality rate (MMR) TO 2 per 1000 live births by 2007 and to 1 per 1000 by 2012 is significant.

Realising the slow pace of reduction of both Infant mortality and Maternal Mortality, the National Rural Health Mission was launched by Hon'ble Prime Minister in April 2005.

The NRHM sought to reduce Maternal Mortality (MMR) in the country from 407 to 100 per 100,000 live births and the total fertility rate from 3.0 to 2.1 within the 7 year period of the mission. The significant feature of the Plan of Action for NRHM is to make the public health delivery system fully accessible and accountable to the community. Having launched with a plan outlay of Rs.6075.17 crore in 2005-6, NRHM received an increased outlay of Rs.7155.97 crore (RE) as plan funds in 2006-7. This has further been increased to Rs.9801 crore(BE) in 2007-8.

Besides, one of the major goals of the Government of India's Department of Health and Family Welfare has been to reduce maternal mortality and morbidity.

The focus has now shifted from individualized interventions to improvement of overall maternal health. This is also a major goal in The Millennium Declaration of the United Nations. The MD goals speak directly of the rights and needs of women and children. It seeks to reduce the maternal mortality by three quarters by 2015.

The UNICEF too has pledged support to the Government of India and the State governments in accelerating the second phase of the National Reproductive and Child Health Programme –(RCH II) for the period 2004-2007. The dilemma is that how in spite of the PLAN outlay, commitment, policy framework and investment on reproductive health, the MMR is not showing signs of reduction?

GENDER BIAS OR HEALTH POLICY MISMATCH?

After all, when Health policies and programmes though are focused on women, why do they often perpetuate gender stereotypes and fail to consider socio-economic disparities and other differences among women? Clearly, the health specific policies may not fully take into account the lack of empowerment of women as contributing towards their health.

The policy stances, and provisions however lofty they may be yet they fall short of meeting with the realities of the Indian villages. In our

research study we have found some quaint contradiction. What we have found is that our policies do not negate catering to the needs of a pregnant woman's health care but prove feeble external assistance. This mismatch situation prevails in majority of the villages that we surveyed. In village Harsaroo and Hayatput in district Gurgaon, which are near the capital of the state within 10 to 16 kilometers away, were devoid of any health care provisions. Local life is too difficult here to get potable water; these villages have to fetch water from outside the village.

Household after household we heard, how women are dependent on the male head of the family for all her needs including food, health, finances for her whole survival and that of her children. We have earlier pointed out how in Tamilnadu, in MADURAI and Salem districts, rural women employed either as farm labour or construction labour, have asserted themselves and gained some freedom of action and of movement than their counterparts in the other Indian states. Even in villages of Maharashtra (of Nashik district and Nagpur district) though the women were engaged in income earning vocations, they lacked freedom even to cook what they wanted. They could not even visit their parents, without the permission of their husbands and in-laws. So we find a disabled women who cannot by her own volition avail of modern health care in our view it is indeed a mismatch. Such limitations, it is been suggested here, do provide a state of mismatch in availing the benefit of they health policies of the government. Thus the infanticide of girl children is still prevalent amongst the tribal in Salem District of Tamilnadu as also in Rajasthan and Haryana. The governmental programmes have not yet succeeded in eliminating these abnominal practices.

OUR TEAMS KEY OBSERVATIONS

Infrastructure has to have permanent staff available for 24 hrs. for deliveries we found them missing.

For BPL, National benefit scheme gives pregnant woman a one time payment of Rs.500/-3 months before delivery.

ANMs Village visit for one day in a month is felt inadequate. This reduces Women's faith in the health system.

For improving Maternal Health and to reduce IMR & MMR daily presence of health providers necessary

24 hours delivery services in PHCs & CHCs need effective monitoring.

Referral transport to indigent families through Panchayat must be made available.

Safe Motherhood Consultant Sought.

Doctors visit once in 3 months is too little as told by Villagers

Hiring Private anaesthetist as and when needed?

Provision for Primary Health Nurse

Appointment of Contractual ANMs.

Reproductive Child Health Programme RCH- II inadequate infrastructure

Provision for doctors trained in MTP as SM Consultant.

Do Doctors visit once a fortnight?

Distribution of free Contraceptives

If this is the Village reality even the well intentioned programme is ineffective in implementation.

Number of traditional Dais is dwindling for outreach services; training of new set of Dais is absent.

For child and maternal health immunization, vaccination plus polio reduction available.

Doctors engaged to visit - Paid Rs.500/- per visit their services should atleast be for 4 hours a day.

Tardy and inadequate Supply of Medicines have to be checked and maintained.

ANMs on contract basis is proved - a wrong practice. They cannot be held responsible to be not available

Very few NGOs are seen in villages. Only some active SHGs are seen but not all.

Eventually it is only the untrained and ill-equipped Dai who attends to deliveries

WOMEN HEALTH CARE A HOLISTIC APPROACH NEEDED

The Tenth Plan has certainly specified monitorable targets for certain indicators of social development in Health, Education and Gender Equality. But the targets remain unreachable so far. Again with the specific focus on reducing maternal mortality, the apprehension was gaining ground that the non-reproductive health needs of women during their pregnancy tend to be neglected. In passing we could say in the context of a holistic view of women's health.

It is relevant here also to state the World Bank's view expressed as way back in 1994, that, **“it is useful to consider the entire life cycle when addressing the causes and consequences of women's poor health. This allows for a focus on the particular problems which affect females at different stages of the life cycle and recognizes cumulative effects and life time problems.”** (World Bank 1994)

Some land mark International views:

For instance, the Cairo Conference on Population and Beijing Platform for Action 1995, recognized that women's health involves their emotional, social and physical well being and is determined by the social, political and economic context of their lives, as well as by biology. (UN 1995 (1) c).

The WHO estimates suggested that 199000 maternal deaths occurred in South Asia and near 74% were accounted for by India. This

amounts to 120000 maternal deaths which is far above the upper range of the Sample Registration Survey for that period (SR 1997-2003) The overall average rate of MMR in India during 1997-2003 has been 24% at this rate of slow decline, it may be difficult to achieve the National Rural Health Mission's target of 100 by 2012 and MDG's 109 as expected by 2015. Thus reduction of maternal mortality is one of the major challenges to improve the overall quality of life. The absence of reliable estimates of MMR makes the process difficult and complex. (SRS-1996) Such a viewpoint is not original a statement,. International literature on the subject quotes, " MORTALITY however is not a single factor to be expressed as a single number or index. The risk of death is something that must be measured in several aspects in many instances. These measurements might be provided by life tables and if there were enough life tables in existence. (George W.Barclay-Princeton University).

In terms of resource allocation, women's health care has often been channeled through maternal and child health services. (MCH) These services are usually limited to aspects of reproductive child health services. They do not cover all other women's health needs. IN THE PAST MCH SERVICES HAVE BEEN COMMENTED UPON FOR PUTTING TOO MUCH FOCUS ON THE CHILD. HOWEVER, MOTHERHOOD, REPRESENTS A PART OF CHILD, WOMEN'S LIVES AND HEALTH NEEDS.

A MORE HOLISTIC APPROACH TO WOMEN'S GENERAL AND REPRODUCTIVE HEALTH NEEDS MAY BE NECESSARY TO CREATE QUALITY OF CARE IN HEALTH SERVICES, TO INCREASE WOMEN'S

ACCESS TO AVAIL OF THEM. What we noticed during our surveys in the villages is that mere allocation of Funds for health services for villages do not necessarily reach them. This has been a common complaint in all areas of development. The right mechanism need to be designed and deployed to reach out to the needs of village women and children. Laudable policies seems to remain far away from the intended improvement of physical, social and emotional well being of women.

SOCIO-ECONOMIC CAUSES AND DETERMINANTS.

Perspective & behind Maternal Mortality:

The issue of maternal mortality can be approached from a number perspectives, either adopting a health/welfare rationale or a rights based rationale. The Population conference and the World conference on women held in BEIJING IN 1995 EMPHASISED THE IMPORTANCE OF WOMEN'S REPRODUCTIVE AND SEXUAL RIGHTS AS WELL AS THE COMPLEX, ECONOMIC, SOCIAL, POLITICAL AND CULTURAL FACTORS UNDERLYING WOMEN'S HEALTH. Thus, looking at maternal mortality in isolation will not yield the right answers.

Let us now turn to our socio-economic research by our field investigators; Whether it is in the villages of Rangareddy or Chittoor district in Andhra Pradesh or Jaipur or Jodhpur districts in Rajasthan, Gurgaon or Rewari districts in Haryana, Chamoli or Kumaon of Uttarakhand, Nashik or Nagpur districts in Maharashtra or even Madurai and Salem districts of Tamilnadu, ***the HEALTH of Indian women is seen as a chain of a number***

of linked and gender related concerns that manifest themselves in the socio-cultural, economic. Demographic, nutritional, educational, environmental, political, legal and other factors in the traditional Indian society. Specially younger adolescents, they are married young and dominated by the in-laws and husband. Their physical movement is restricted. They have no control over their own person, property or resources of the household. Because of the practice of demanding and giving dowry at the time of marriage of the girl to the husband's family, daughters are regarded as a loss to their parents' family. ***Their labour and work whether productive or reproductive are socially devalued.*** This inequity inherent in the social system is nurtured and perpetuated through a process of socialization. She not merely rationalizes but internalises this female status of disadvantage.

THE ECONOMIC DEPENDENCE

The prohibitive cost to emergency intervention in labour, women may even have no cash available in terms of seeking medicare in such emergency; this may be one of the causes for delay in seeking medicare and services. If community help is sought to reach the PHCs or Hospital, there were occasions, the women deposed before us, that community leaders might override even husband's wishes to save the woman from maternal mortality. Such incidents of community hold over individuals are experienced by villagers in Rajasthan and in Maharashtra tribal villages.

MEDICAL AND NON MEDICAL FACTORS IMPACT ON MMR.

Both medical and non medical factors impact on maternal mortality.

MATERNAL DEATH: Is often not only a result of technical incompetence or medical negligence, but is also caused by superstitions and cultural practices and deliveries attended by traditional birth attendants; also lack of easy access due to lack of transportation facilities has also been quoted as one of the contributing causes of MMR. Based on our field research, the points given below covers.

1. While reiterating that medical and non-medical factors influencing and impacting MMR; these are health behaviour: Actions people take or do not take for their health e.g. attending or refusing to antenatal care by pregnant women or seeking help only when complications arise.

Our studies have shown when Kishori in Gujarghatal village in Rewari district of Haryana told that the Mother-in-law stopped her from attending to antenatal check ups and that she could not disobey her. In Renigunta of Chittoor district in Andhra Pradesh, Maya Said that it is her husband's decision not allowing her to go in for antenatal. Even she was in advanced labour. In Khatawli village in Daru Heda Block PHC, when the pregnant woman's husband was away, it was the neighbours who had to take a decision to take Chaitri to the Health centre. It was a case of breach and the foot of the baby was already out and the male child died after two hours after birth. Lack of autonomy for the woman and her dependency on the

husband even at time of emergency has led to the death of the infant. And the woman started excessive bleeding. This could cause her death.

2. Reproductive behaviour that includes age at birth; pregnancy order and birth spacing and showing unwanted pregnancy, that carries stigma. Birth spacing is difficult for women since men refuse to adopt family procedures or take to contraceptives. This contributes to high fertility. Even when women are anemic and when the earlier child happens to be only 8 months old, they land up with another conception. This Boori from village Akera in Haryana said that she has five girl children in a row and the mother-in-law insists as also the husband that she cannot take to family planning until such time she bears a male child. Who is concerned about her health? All they want is a male child.

3. Young women below the age of 18 years getting married, forced into conception within a year, face obstructed labour, because their body is not mature for motherhood and even child care. Death due to a number of biological factors occur. First child birth is risky for the adolescent mother and many cases of young mother dying in maternity are many, though not figure in the Census records.

In Tamilnadu, in Madurai district, in Usilampatti village, the normal age of marriage is 14/15. Also these young girls are pressurized to conceive early. Many village women and the NGOs around informed us that early non-bearing of child is considered not merely a stigma but it psychologically affects the mother, when she is singled out, and jeered at, by all. In northern states stigma is attached to late conceptions.

4. Pregnancy order counts (parity) when women in their first pregnancy are likely to die than women having their second and third child. Again with the fourth child the risk rises. In Lonara in Nagpur district of Maharashtra and in Ambegaon in Nashik district of Maharashtra again, number of maternal deaths occurred.

5. BIRTH SPACING: many researches talk of the risk of infant and child mortality due to birth spacing but ignore the impact on maternal mortality. For instance in Harchandpura village of Bhonse Block in Haryana, refused antenatal care during all her four pregnancies and also ignored advice of the ANM to undergo sterilization. She was malnourished and there were very slim chances of her survival after the 5th child birth. Birth spacing does help the woman to recover from earlier child birth and recoup her strength. Birth spacing not only impacts on the infant, but helps maternal survival too.

6. Social pressure on women to bear male children; This boy preference, a ingrained socio-economic factor and forcing women to conceive again and again to try to bear a male baby may be a social requirement. But how about the woman's nutrition and health status. Not merely she is affected psychologically and emotionally, she has no value in the family until such time she bears a male child. Not merely this results in risk of survival to the mother but it leads to maternal mortality. Also the women whom we have met and spoken to also preferred male children to girl child. The perception that girl children are liable has been the root cause of infanticides committed in Usilampatti in Tamilnadu. Even today stray cases of infanticide are heard from Kallar community a tribe who openly profess killing of their girl children.

7. The Village view and social psyche are that girl child is a liability for life and that boys are income producers and also carriers of the family lineage.

Not only our research team interacted with Rajasthan women from Jaipur district and Jodhpur but also women from Tonk who they concede that they have to abort the female foetus because the innumerable problems the families have to face with a girl child. Therefore they marry their children young to avoid huge dowry and that they can absolve themselves of the girl's responsibility. When questioned if they die young in child birth how to save them, the women said, it is auspicious death if they die when their husbands are alive.

8. How is it that you women never go to the hospitals or Primary health centres? They answered that they do not feel comfortable there. Hence they depend on the traditional dais at home; that is not only inexpensive; but also helps our belief in home deliveries and to get religious rituals performed by dais during and after delivery for a number of days.

It may be a surprise to many that in Tamilnadu both in Madurai and in Salem districts, when the woman is pregnant, the family members approach the astrologers for "Jadakams" inquiring about the sex of the unborn and the prospects of survival of the mother. Their full faith in these predictors of their future, make them perform many pujas and rituals so that they can change the sex of the child in the womb. In tribal Andhra Pradesh, specially the women we have spoken to in Rangareddy district, they said they drink

during pregnancy to make the foetus move actively; and they drink liquor after delivery to revive their lost strength. Their nutrition levels do not improve with drinks and the toxicants are harmful to the unborn too. Many foetus die in the womb and various crude ways of abortions end in maternal mortality.

Legally both foeticide and infanticide are banned and prohibited. But for the rural folk their beliefs and customary practices are the law. They are not merely ignorant and unawareness of the duties imposed on citizens but social sanction is sacrosanct for them. Even threats of punishments are ignored. These strong the socio-economic controls over people draws our attention for serious scrutiny and examination.

9. Unwanted pregnancies and resorting to abortions through dais and quacks lead to complications and maternal death.

Most of the unwanted pregnancies end up as abortions to get rid of the girl child in the fetus form. Even though the women have no decision making powers, even the husbands get ready to take them to quacks to get rid of unwanted pregnancies. Though the villagers by and large are illiterate, they come to know of the PNDT technology and approach abortion clinics which are surreptitiously run in the villages and towns. Except for the women of Tamilnadu villages, all other states indulge in abortions. The Tamilnadu women go for preventive action of going in for tubectomy after they are satisfied having two to three children. Haryana beats all, in illegal abortions because the MEDICAL TERMINATION OF PREGNANCY through

MTP CLINICS, HOSPITALS AND DOCTORS have very little record of cases approaching them. For reasons of privacy and also to avoid embarrassment in public, and definitely to get rid of the prospects of a girl child, unwanted abortions take place. Illiteracy and ignorance do not seem to be any bar in accessing PNDT CLINICS and fraudulent persons parading as doctors.

Women approach these clinics at their advanced stages of pregnancy also. No government hospital will undertake such risks. And it is here, the private clinics make money, even at the risk of pushing woman to maternal mortality. Some cases were openly disclosed where some women who went for abortion came back as sterile women.

The Medical Termination of Pregnancy Act of 1971 has clearly provided abortion for women who are suffering from mental or physical problems due to unwanted pregnancies; where the growth of the fetus is stunted, where deformities are noticed in the foetus and where victims of rape do not want to continue with their pregnancies, women can opt for abortion in accredited hospitals, clinics and doctors. These certified hospitals and clinics and doctors keep regular registers of such cases that they have attended to. Unmarried girls and women also can seek access to such facilities. But the rural folk unaware of the safety net provided by this legislation and due to fear and apprehension of delays in government hospitals, they go to private clinics. These clinics and some of the private doctors take the risk of aborting even advanced pregnancies. The consequences are dangerous to the very life of women.

There are no records available of such abortions of unwanted pregnancies or and the outcome as maternal deaths. Husbands and mothers –in-law force the women to go for ultra sound tests to find out the sex of the fetus. If the unborn is identified as a female fetus, the women are pressurized physically, psychologically and emotionally to undergo abortions. Two women from the Rangareddy district confided that they had to go in for two abortions in a year. One can imagine the health and anemic status of these women. and who belong to the BPL families. How can we reduce maternal mortality when such unhealthy practices are rampant, and unaccounted for. How can our Plans and Policies mitigate these complicated issues where women are entwined by the SOCIO-CULTURAL AND ECONOMIC COMPULSIONS?

10. Our field staff could assess how complex a mixture it is, of the SOCIO-ECONOMIC & CULTURAL PRACTICES WITH MALE DOMINATION, conditioning the rural women to COMPLETE SUBMISSION AND SURRENDER. Women of Uttarakhand, unlike the rural women of other states did express their unhappiness over their plight as subjugated women.

11. Education of the mother has been emphasised by numerous researchers has a positive impact on the survival of women. But the villagers view education as a waste and unnecessarily time consuming. The girl child if she has survived has to mind her siblings and the older people at home.; they have to tend to the cattle and work in the fields also. But in Haryana even the women who are matriculates are treated as any other uneducated ones. Uttarakhandis most of them women are educated; but

patriarchy has not left them free from its hold. But Tamilnadu women though many of them are just neo literates have asserted themselves to the extent that they insist on their daughters to be sent to school and that no one can stop them from getting tubectomy done as and when they wanted and also they are free to form themselves into Self Help Groups and generate some work and money/ To some extent one can admit that these Tamilnadu women of the villages have partially succeeded in asserting their reproductive rights and child care.

12. Irrespective of their State or the language group or to the caste to which they belonged, women unanimously agreed that their lives are tied up in too many knots and it is impossible to be free from them. They said they respect their community beliefs and some of the practices. But when it affects their daughters, they were extremely unhappy.. They wanted their daughters to be educated.

13. NO MOTHER WOULD LIKE TO KILL HER OWN CHILD: IN Magudanchavadi village in Salem district in Tamilnadu, our field Staff, spoke to the SHGs who got a mother-in-law arrested for committing infanticide of her grand daughter in the presence of the baby's mother, (her daughter in law.) The baby's mother cited how her baby was strangulated. It was heart rending to hear the same said our team members. Women, once they are informed they could organize themselves into groups. The NGOs did a good job in training them in self-confidence and made them aware of their rights and duties. But similar infanticide was committed in the PHC premises in Daru Heda block. When the doctor and the midwife went out to wash

their hands, in a matter of minutes, the newly born healthy girl child was found dead. The mother of the child after delivery -fatigue was sleeping. No eye witness was there to complain. The case was not pursued. On questioning the mother-in-law who feigned ignorance of what ever happened. The constant presence of the NGOs in the village and because of the regular training programmes they conduct & encourage women to be self-confident and self-supporting have really brought change in their attitudes and behaviour.

13. High fertility means higher risk of maternal mortality. The risk of MMR after the birth of the third child is high. The fear that infertility would lead to divorce and even husband's threat to go in for bigamous marriage and polygamous marriages keep women captive in pregnancies. This is thought of as safeguard against those eventualities.

Empirical evidence show that illiterate women have high rates of fertility than the educated ones. This though true in all the States except in Haryana, where even 10th class pass women's fertility levels are as high due to compelling acceptance of their husband's dictates.

It is another story about the Uttarakhand women. While men go away to the plains in search of jobs, the women belonging to the labour class are almost kept in continuous state of pregnancy. This is thought of as safeguard against women going astray or getting exploited by other men. As a single parent the pregnant woman works hard, going long distances, fetching water, fuel and attending to the household chores and taking care

of their children etc. Kuaoni women start working after the 22nd day after delivery. Many of them confided to our research team women that they suffer from prolapse of their uterus. Without medical attention, many contract infections and even cancer resulting in death.

14. The Headmaster of Primary school Akera as also the Doctor of Daru Heda Primary Health centre suggested a remedial measure that will have the highest and maximum impact on fertility and survival of the pregnant women and prevent maternal mortality: That is to reduce the rate of girl child drop outs from schools. And educating them further.. Investment in education thus has been over emphasized as the best way to reduce fertility and to cut short the consequent chain of debility syndrome among women leading to death. This impact process through education may seem remote but it is a long lasting cure to eradicate irrational and deep rooted socio-economic beliefs and determinants that cause both maternal and infant mortality. In village Bamdoli in Gurgaon district of Haryana, school going girls requested us to talk to their fathers to send them for higher education because, the fathers want their young daughters to get married even though they are below 17 years (then) Educated girls will naturally raise their marriageable age in order to pursue education and this will be of immense impact on the mothers to be and their health and survival. But the parents specially fathers say that girls are ' Paraya dhan' and they ask, ' why to keep them for long'. Also it is risky to keep young girls at home unmarried.

15. All these views expressed by women and opinions of parents and suggestions made by the school master and the doctor to contain drop out rates of girls from schools show, how the symptoms of the socio-economic

malaise, are overlooked as part of village life style and the cultural grip over people and specially women. continue. The dangerous socio-economic factors determine and affect almost all aspects of a woman, through out her life cycle.

16. We questioned women in many of the villages we surveyed as how they passively abet the killing of the girl child either by the dai or by the grand mother. Their answer was that, bearing a girl child reduces their status in the family; That they cannot overrule the decision taken by their elders they said that. Family honour has to be guarded even if it meant sacrificing their girl child. They added, " after all we cannot expose our own people and we have to respect our elders for whatever they do". Again to our teams question," how is it they do not rebel against their husbands domination over all of their actions, they said, 'no' and added, "after all man is the head of the family; We must listen to him. How can we question him?"

SOCIO ECONOMIC STATUS OF WOMEN AND HEALTH.

1. When Planners have allocated funds for BPL families, it is pathetic to find that it does not reach the beneficiaries for whom it is intended for. In Gurgaon in Haryana, when I was talking to the DRDA officials, I had occassion to personally watch how difficulties surface in deciding who a BPL is? In spite of many possessing a BPL Card, So many questions were asked and many have been declared as not covered by the rules. Unless information about all dos and don'ts are given to them in advance, it cannot be expected of them to come

prepared. All that those women knew was the card was their passport to the various provisions that they are entitled to. There has to be some mechanism helping them to correct the flaws and articulate their answers then and there. Many pregnant women go disheartened and not even understanding why their cards were not honoured?

2. Poverty being the big issue and a disability, it complicates and compromises the health of the people, specially women and children. They though are covered under the below poverty line scheme, they were found caught up in the vicious cycle of lack of food, nutrition leading to anemia. Poor women were clamouring for jobs that can supplement their family income so that a little more can be put for child care and for their own well being.
3. Pregnancy and malnutrition being a deadly combination threatened many a lives and causing maternal deaths.
4. Economic causes shrouded in social ethos and cultural practices and vice versa. Which one takes priority over the other is hard to say. Poverty and lack of economic ability to buy food or access food leads to a variety of results adversely impacting on the health of people specially women and the girl child.
5. All these factors work simultaneously and thus the unbroken chain of causes emanating from the socio-economic determinants cannot be over ruled. "Girl children are under nourished in their life cycle because of gender bias and poor food allocation, resulting in stunted growth leading to complications in pregnancy" (Royston 1989)
6. Women's contribution to National development and national productivity are not valued. Their economic dependency hampers

their autonomy to seek medi-care or institutional care in private hospital in whom they lay faith are costly. When we explained to the women that when they work in agricultural fields, the country gets food. The day the labour force will stop work, the country's "FOOD BASKET" will become empty. They smiled but many did not understand the import of such a message.

7. In a nuclear family the woman is totally dependent on the husband and his income. But if she lives in a joint family where there are many hands who work and earn, sharing of better resources are possible. Though the women said they would love to have their independent homes, they said they still prefer to be in the joint families. They felt that it is better to have people at whom, who can mind the children when the women themselves are at work outside their homes.
8. Women of poorer households said that they were always on the look out for jobs so that they can earn and contribute to better care of their girl child.
9. Accessing institutional care even in emergencies is again a complex issue for women. She has to organize things at home for the family and her children and husband.. Things are complicated for her since she has no freedom to think or decide. Every little act needs permission. There does not seem simple answers for her problems and needs.
10. Once she is allowed to seek institutional care, the lack of staff, supplies and equipment in the PHCs and sub-centres discourage women from accessing the same. The women prefer home delivery..

11. It is a welcome policy to train Anganwadi workers as multiple workers including training in the basics of health and how to counsel women on safe motherhood and child care; also to handle medicines for cure for small ailments and to develop Capacity to convince women on the values of iron and folic acid needed by pregnant and malnourished adolescents.
12. Even if medical services are offered free in the Primary and Sub-Health centres, sometimes the logistics are not women friendly. A close scrutiny of the above give us silent clues which may be relevant to the fine tuning of our existing policies. (we have touched upon them in our recommendations)
13. ***Also just by erecting a basic health infrastructure in the village, women cannot be expected to rush to seek medical services. The complex system of village life does not promote easy access to any new structure even if it is available free of cost.***

ECONOMIC STATUS OF THE FAMILY

This is a complicated issue covering many factors including lack of adequate health facilities, besides, the economic status of the family, impacting on IMR & MMR.

The man as head of the household, whether he is an employer or a labourer to whom the pregnant woman belongs, the woman's employment status, whether she is an earning member of the family are some of the attributes of the SOCIO-ECONOMIC status. The low economic value

attached to girls along with the high economic liabilities with increasing demands of dowry at the time of marriage of the girls, put undue economic pressure on the household. To supplement family income, women seek paid work and become part of the informal and formal work force. Women though are paid much less than the men for equal jobs. Legislation provides equal pay for equal work similar done by men. But the plight of women labour continues to suffer inequality in payments. It is common knowledge that domestic work done by women are not counted, nor valued as economic contribution to the household.

REPRODUCTIVE DECISION MAKING

Women's control over their own sexuality and reproductive decision making is constantly affected by a range of forces as mentioned before, mainly due to lack of empowerment of women. The household and the community pressure on the women to bear many children (high fertility) closely relate to the village concept of economic and social security by bearing male children and gain status and respect in the household and the community. Also, son preference relates to lineage and inheritance to property rights or resources of the parents. Social and economic constraints coupled with, cultural practices and maternal factors named socio-demographic causes all put together have reduced the woman to a servile status where her life is constantly threatened.

Reproductive decision making is almost nil on the part of the village woman contained by social values: Cultural practices leave no room for

woman's freedom and decision making. Independence is almost a misnomer. Crippled by numerous constraints, woman is bereft of her own reproductive rights. A few women from Uttarakhand and strangely from Rajasthan also, dared to share with our team of researchers that, "they feel that they need to be treated better by her husbands and their mothers-in-law.

Having got used to this low profile, women with their own low esteem, do not consider their own pain and discomfort in their physique as worthy of complaint. Domestic violence adds to the sense of low esteem. To avoid any embarrassment to the family, the women suffer deprivations in silence. It may be too late when they openly seek medical care for their wounds due to violence perpetrated on them. Even when the family realizes the impending threat of complications in pregnancy, they hesitate to seek medical assistance for the pregnant woman. This is also due to their community's perception of modern medical care, and fear of the police case in case if they found wounds on the body of the woman. Though ignorant of the laws, the villagers are afraid of the police that they may be arrested and put in jail. One graduate woman in Hamirpur village of Haryana and a village woman from Nakkalpatti in Tamilnadu questioned, "why not? After all our husbands have a right to bash us when we do things without their permission" Where is 'empowerment' when women themselves do not want it?

EDUCATION: A POSITIVE IMPACT ON INFANT SURVIVAL & MATERNAL HEALTH

Education positively impacts on reducing maternal mortality and infant mortality in a number of different ways:-

1. In lowering fertility: With less number of pregnancies: women can deliver less number of children and thus reducing the risk of mortality.
2. Women's social status and self image get increased by education.
3. Help delay in early marriage and thus late child bearing.
4. Educated women can understand the anatomy of the body and physiology of reproduction.
5. Disposed to accept complications and risks in pregnancy.
6. Can opt for modern medication and refuse fatalism and superstitious practices.
7. Understand best child care practices.
8. will be willing to convince their husbands on family planning methods.
9. Less likely to accept dangerous practices during pregnancy and after delivery.
10. Women's education helps better employment prospects
11. Education influences quality of performance and can demand equal pay.
12. The nature and type of employment can help limit fertility.
13. Educated women can realize the harmful effects of heavy workload during pregnancy and after delivery.
14. Understands the need for rest for three months before delivery.
15. Can convince family members of the need for institutional health care; Can avoid seeking delays in institutional health care.

16. She can and will be able to prevent infant and maternal mortality.
17. She can convince other women on advantages of seeking institutional health care.
18. will be aware of safe motherhood practices; and avoid illegal abortions.
19. Can realize legal limitations to child and adolescent marriages and dowry demands.
20. Educated women can assert physical and social mobility.
21. Educated women can convince all and send girls to schools.

To sum up, an educated mother is an insurance against maternal and infant mortality. Where women's decision making capacity is denied by household and community power relations, maternal education helps to increase awareness to the need to seek medical intervention in emergencies. This will clearly be sufficient to increase their use of health services. Education can be a true aid in helping better implementation of governmental policies and programmes as also to assert themselves to think and act. Education alone can free them from the grip of irrational beliefs, inhuman practices and the SOCIO-ECONOMIC-CULTURAL FACTORS THAT have been reducing women to demonizing levels.

Areas where low female literacy rates are, areas where the fewest births are attended to by trained personnel. Garhwali women with whom we have long hours of conversation, majority of them are literate said that they had to reconcile to the hard labour they had to bear with because of the geography of the area. This they said is inescapable for them to walk long distances and fetch fuel and water. They did regret their high fertility

rate since their husbands refuse use of contraceptives or other family planning methods. Though governments offer Rs.1000 and more for men opting to undergo family operations, there are no takers not because of men's refusal but mainly because the women fear that their men will go weak with the operation though it is very simple.

Another problem the Uttarakhand women face is that the Health centres and hospitals have no doctors nor the required equipment or medicines for deliveries and operations. Since most of them are educated they are questioning why such neglect is prevailing in the health service delivery system? Due to these drawbacks, women's survival is not still certain in these parts.

RITUALS ENDANGERING WOMEN'S LIVES

Religious rituals are performed in order to assist the woman in labour. But it is only the traditional birth attendant who is asked by the family to perform these rituals. Pregnancy being considered 'impure', only this low caste Dai is allowed to do what ever has to be done. The woman who delivered is treated as an untouchable and no one is allowed to go to her room where she is cutting the umbilical cord and examination of the vagina, removal of the placenta are treated as rituals that the Dai has to perform. In other states, it is the mother who has the first right to cut the umbilical cord. Dais are not aware of hygiene or aseptic practices and techniques. They even fail to wash their hands and the instruments if any. Unclean objects are used during vaginal examination and in cutting the cord. This

leads to urinary infection, tetanus, genital infection and sepsis thereby putting women at risk of death and maternal mortality. ***Treatment of obstructed labour by untrained Dais is often dangerous. Herbal medicines are given for better contraction during labour. This is widely reported to cause uterine rupture.*** Our surveys recorded such occurrences in Umrale village in Nashik and in Lonara village in Nagpur district of Maharashtra, remote Rethoj and Harchandpur villages in Haryana, Nauta in Chamoli district of Uttarakhand. Insertion of caustic substances into the vagina of the delivered woman to restore it to normal vaginal conditions are other purification techniques adopted by the Dais. The Doctors in the Primary health centres reacted vehemently and called them utterly dangerous practices that definitely lead to maternal mortality. Also washing the baby with cow dung, putting cowdung at the cut edge of the umbilical cord and rub the child with red mud are other rituals that the Uttarakhandi villagers practice. Sprinkling of cow urine after the mother is given a bath with scalding hot water, with curds and other elements thrown into it is another ritual. One cannot find scientific significance to these practices.

FOOD TABOOS

Pregnant women are expected to make dietary changes that reduce their intake of foods high in protein, in calcium, milk and green vegetables. These are forbidden in many rural societies for reasons that the foetus is located in the stomach and that it may grow enormous. Thus pregnant woman receives fewer calories than what she is normally expected of to fully feed herself and the baby in the womb. Though massive intake of sodium is permitted by the traditional rural folk. While the Kumaonis have

definite list of prohibited for women during menstruation, in pregnancy and after delivery, even water is amongst the list of things not to be taken. In Haryana the quantity of food intake during pregnancy is slashed fearing the unborn will grow big resulting in difficult delivery. Rajasthan women are fed with methi, ajwain and hing to keep the stomach clear of flatulence.. Harchandpur village women of Haryana said that ajwain if given, the 'booth' will stick to the body and will not leave; while people in other villages in Haryana said, 'when ajwain is given to pregnant women, some persons have to be posted to guard her"

In contrast in Tamilnadu villages, where we actually happen to be present during one of the celebrations done at 6 months of the first pregnancy: of a woman. Many village women came with tasty sweetmeets for the pregnant woman to eat. Others decked her with bangles and lot of flowers. She was made to feel like a queen. This is a celebration for motherhood. The Tamil women believed that what ever the pregnant woman wishes to eat has to be given even if it is in the late hours of the night. Ofcourse the prohibited foods are papaya, and some of the gas producing vegetables.

Stranger still is the stories of Andhra tribal women, who drink during pregnancy. In Rangareddy district they told us that drinks will help the foetus to move freely in the stomach, and which is necessary for its proper growth. They also have no concept of nutrition or iron or folic acid nor understanding of their need for pregnant women. After delivery, alcoholic drink they believe is a must for the lactating mother to recoup her strength. The only taboo

they follow is giving up 'beedi' smoking during pregnancy. But the tribal women of Maharashtra take to alovera that is available in the form of cactus all over in those dry areas.

Our team of surveyors exclaimed that, "India is an anthropological wonder". Too many beliefs and numerous practices. Which one is right or bad is hard to say.

The one common factor that threads all the villages is male domination over women, absence of faith in modern medication and medicines and above all women's lack of empowerment and many ending up with maternal mortality. This they would rather attribute to fate or punishment given by the spirits for wrongs committed by woman either in this life now or in the past, 'janam'. Besides tampering with the health and well being of the pregnant woman, by these numerous practices, the unborn and the newborn infants get to be more vulnerable to infant mortality.

VILLAGERS THOUGH AVERSE TO INSTITUTIONAL DELIVERIES: PRE-SEX DETERMINATION TESTS WELCOME

Literacy and education may not be priorities in these villages of Rajasthan, Haryana, Maharashtra and Andhra Pradesh, specially for the girls. But even the ignorant knows about ULTRASOUND TESTS and the technology available to detect and reveal the sex of the unborn fetus. The law pertaining to prenatal diagnostics techniques (prohibition of misuse & Regulation) Act as amended as on today, restricts and prohibits the use of

ultrasound tests for disclosing the sex of the fetus. Private clinics surreptitiously revealing the sex of the fetus and are minting money; they are commercial shops who are unconcerned about the diminishing sex-ratio of girls versus boys. These tests instead of helping people to come to know of any deformities in the growth of the unborn, they are focusing on the sex of the fetus. This rush to these centres end up with women rushing to abortion dens run by compounders and mechanics who parade as practicing doctors. Otherwise the village women run to the traditional dais or quacks who create complications and resulting in women's death. These illegal clinics take the risk of aborting pregnancies even at advanced stages leading both the child in the womb and the mother to death.

There is no count of these illegal abortions because no one keeps a record of the same. Governmental enforcement machinery took strong steps to close such clinics who violate the legal prescriptions. However, the village women in Rethoj told our team of researchers that these ultrasound machines are some times stacked in the fields to avoid action by the enforcement. Though the women do not openly disclose as to where they had abortions, they did share with us that they had to abort the girl child.

Many women belonging to different States, who deposed before us, strongly felt that if unwanted pregnancies could be eliminated, fertility could drop to replacement levels. As per UNICEF, sources 2001, Indian women numbering 100,000 die of pregnancy related causes every year, which is about 18% of total global maternal deaths in addition to death many women are disabled by complications of pregnancy, abortions and

child birth. There is no data available on the number of abortions. Only a very few done as medical termination of pregnancy cases in accredited hospitals here and there may be the only data in the records. Most of the abortions are illicit and done through dais and quacks which have no count at all, many of them end in maternal mortality. These practices add to further difficulties in collecting the data as also assessing their impact on maternal survival and maternal death.

Though very few cases surface, it is relevant to quote the case of DR. Jacob George vs. State of Kerala, 1994 AIR SCW 2282, CRL APP R (SC) 214: 1994. death while causing miscarriage an accused homeopath doctor, caused death to the deceased while operating not for any permissible causes, the Court held the accused liable to conviction under Section 314 IPC. The convict was ordered to pay Rupees one lakh to the child left behind by the deceased. Even the Sample Registration Survey (SRS) declared that there are no available data on illegal abortions or on foeticide. Thus the count of maternal mortality rates are very much under estimates.

A positive trend we found was in Tamil Nadu, where a growing number of village women in Tamilnadu were opting for family planning procedures after having two or three children. It is a welcome change. This practice of seeking institutional services is contributing to reduction in maternal mortality. Earlier illegal abortions also went under cover of miscarriages and physical deformities of the foetus etc.

Through the PNDDT ACT, the government sought to arrest the growing undergrowth and deformities of the foetus and not to be misused or intended

to reveal the sex of the foetus. But this policy has almost failed. Instead FAST REDUCTION OF SEX RATIO OF GIRLS VIS A VIS BOYS IS accelerated by the Prenatal Diagnostic techniques tests conducted by private medical practitioners and clinics.

The State of Haryana tops the list of PNDT Test users and a number of clinics are conducting these tests. This practice of going in for tests reinforce their son preference. It has definitely impact on female mortality and female sex-ratio.

Beliefs and cultural practices detrimental to the health of the girl child and woman: In the states of Tamilnadu, Haryana and Rajasthan, people in villages carry on with the myth that girls are liabilities and are meant to be married young and sent away to their in-laws family. Thus the child marriages are rampant as sickness an When I was in the National Commission for Women, I could conduct the first investigation of the Saathin's case from Bateri village of Jaipur district, of Rajasthan. In due performance of her duties, the Saathin tried to persuade families in the village to stop child marriages. She instead became a victim for trying to uphold the State law and State policy prohibiting child marriages. Even the judiciary in Rajasthan could not rise high above the caste bias as they did in the famous case of BhanwariBai, a Saathin. She only had appealed to villagers not to conduct or solemnize child marriages. She was gang raped by those who conducted child marriages in their homes. The little said of Rajasthan the better, When enmasse child marriages are conducted during AKHA TEEJ, the government looks the other way. In spite of the political complexion of the

day, no one would like to touch these sensitive issues lest the political aspirants and politicians may lose votes in elections.

The key question arises here as to what should we call it - a Superstition, a myth, turned into a hardened practice or is it an economic determinant or a feature which militates against the law of the State namely the Child marriage prohibition act which lies in the shelves of the lawyers and Courts. States do not want to touch this issue because of 'Electoral politics'.

The feed back received from our Surveyors in Tamilnadu shows a new trend of putting an end to infanticide. In Salem district, it has been a cruel practice of killing the new born girl for fear of dowry demand made at the girl's marriage. The wrong belief although exists that boys alone are considered as caretakers of the parents in their old age and can perform the last rites after their death.

It may be relevant to talk of the diehard practices like Satipratha that has taken away innocent lives. Though law has banned such inhuman practices, no one seems to be afraid of the law nor honour the law. Social sanction still exists for such customs. Even judiciary in Daurala case where a young widow was drugged and coaxed to sit on the pyre of her dead husband to commit sati. Thousands of onlookers were witness to the incident but the Court did not convict any for want of proof. Whether to call the legal system as ineffective or biased, is hard to say. ***But this reveals the stronghold of custom and practices on the rural folk and in this***

particular case the judiciary also. Such similar incident occurred in Madhya Pradesh in 2004. Even after passing legislations to combat evil practices we are not able to eliminated inhuman practices like Sati, dowry burning, infanticide and foeticide? These cases only prove how in the name of custom, tradition and superstition, negative practices are nurtured by society for generations. This is ample evidence to show how deep seated superstitious practices are directly and indirectly leading to infant mortality and maternal mortality. Such are the causes that contribute to the slow pace of reduction in maternal mortality.

GENDER VIOLENCE MATERNAL MORTALITY

The issue of violence is to be firmly placed on the health agenda. Woman battered during pregnancy is twice likely to miscarriage and four times more likely to have a low birth weight baby than those who are not beaten. It has grave impact on malnourished women. Gender violence is amongst one of the significant causes of morbidity and maternal mortality. *Safe motherhood initiatives remain limited to the notion of reproductive health; there is danger of ignoring the importance of women's emotional, physical well being which are beyond reproductive autonomy (Heise 1993).*

Family planning though needed to stabilize population, AND HELP BETTER SPACING OF children, it is definitely not the concern of the village men living with their own beliefs and practices. The

village women in Hamirpur in Haryana, Usalimpatti in Madurai and in Rangareddy in Andhra Pradesh, Nandaprayag in Uttarakhand, Bateri village in Jaipur -Rajasthan and Nashik in Maharashtra equivocally said that it is their husbands who object to the use of contraceptives. With early marriages of young girls, males could control female sexuality and support higher fertility. Also lack of communication between husband and wife on matters of sexuality and the age old practice of holding male dominance in the household prevails.

WHY WOMEN RESIST TO SEEK MEDI-CARE: SOCIAL & PHYSICAL DISTANCE BIG BARRIER

Many of the women in groups, interviewed in the villages, have given a number of reasons for not able to access medical services through institutional health care. They are:-

1. The fear that Hospital staff may ridicule the tradition and practices of a community and impose unfamiliar food to eat. Because the mother after delivery is given almost nothing but black tea with only a pinch of milk at home.
2. Sloping posture for delivery by village women is not appreciated.
3. They feel that the dress they are asked to wear in the hospital is culturally inappropriate. Women prefer to opt to deliver in a known and sympathetic surrounding outside the health centres. (Prevention of maternal mortality network, 1992).
4. Cultural misunderstanding, lack of sensibility among health professionals can lead to a breakdown in communications between

women and health workers, which is not conducive to high quality of care. Women in Kwedal Kumaon and Nauta in Garhwal from Tonk in Rajasthan started giggling on hearing the same.

5. Women prefer home deliveries attended by dais. In their familiar habitat.
6. Operations of any kind are dismissed and stigmatized in their village community.
7. The irrational belief may be such that if a woman does not deliver normally, she is thought of to have failed in her essential role as a wife. Our findings are with a dai attending at home things would be better.
8. These may contribute to the, “social distance and causes” for village women, in accessing health services.
9. Other main reason in the Indian context rooted in strictures against contact with male health personnel; Village Women from Uttarkhand, Rajasthan and Andhra Pradesh openly said Maternal and child health staff, must be all women. This is a pre-requisite to expect women coming for institutional care for deliveries.
11. Poor quality of antenatal care and screening, discourage women from attending these facilities.
12. Delays in diagnostic treatment with decisions to go for c-section may also lead to fatal consequences.
13. Maternal health care should not be dehumanizing. A patient should be treated with respect and compassion by the health personnel. Unfortunately such expectations are not fulfilled. On the contrary, ***the women’s groups with whom we had long many hours of***

discussion stated that the governments, original recognition of, “the mutuality of the rights of the child and mother is a direct response to the implications of maternal mortality and Maternal morbidity”. (Nurske 1991).

14. *Child survival has a bearing on mother’s rights and vice-versa. Reducing maternal mortality is an appropriate measure to diminish infant and child mortality. Art. 24 of the UN convention on the RIGHTS OF THE CHILD) relates to maternal mortality in para 3, “all State parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of the children.” Therefore legal and international commitments to child rights, child’s physical, mental and spiritual and right of social development can be important in tackling factors affecting maternal mortality. But how do we expect an ANM & an Anganwadi worker or even ASHA to know about these international commitments.?*
15. *Generally, the villagers do not consider government hospitals as helpful care takers. Though they prefer hospitals to the primary health centres. The delays in government hospitals discourage women to approach them. Besides, many village women regretted that, “the first thing the doctors ask us to get an ultra sound test done. The cost and the delays involved discourages to approach the government hospitals. They said they prefer to go to the private ones if they can afford or go back to their dais at the time of delivery”.*

A WELCOME EXPERIMENT amidst the gloomy environment of maternal mortality and infant mortality has been the combined work culture practiced by the Anganwadi worker and the ANM from the Primary Health centre at the village level. Mutually linked child survival and safe motherhood, both find a place in a synthesized government project i.e. the integrated child development scheme. It is here in this infrastructure, is incorporated both child's and mother's basic need for nutrition. This infrastructure is meant to attend to to pregnant and lactating mothers besides children. Their joint role of synthesizing the ICDS with the Health service delivery system (through the Community Health Centre, Primary Health Centres and Sub-health Centres) are expected to show signs of success.

LACK OF EMPOWERMENT: A MAJOR CONSTRAINT

The lack of Empowerment of women thrives in a social environment where derogatory practices like foeticide, infanticide, child marriages, dowry demands, violence on women and the girl child, sexual abuse of women and the girls, where exploitation both economic, social and religious are perpetrated and where rule of law is ignored and disregarded, and above all, where the women are discriminated and their human rights are flouted, both at home and in the society. The Empowerment of women becomes a very big condition to diminish infant mortality rates and the maternal mortality rates which in our country still persist and is not showing any speedy decline.

WHY THIS PATHETIC SITUATION IS CONTINUING IN OUR COUNTRY?

The answer lies in the fact that both men and women are socialized in patriarchal norms and these values are nurtured for generations. But families who have chosen the path of education, developed rationality and a scientific temper, have realized their potential and have some protection from the laws that exist to protect them from all violations.

However, in a village situation, even today woman has a subservient role to play both at home, at work place and in the community. She has no freedom of choice from her growing days to forego the right to pursue what she wanted, whether to refuse for early marriage and motherhood, whether to refuse the greedy groom who demands dowry, whether to decide the number of children she would like to produce, whether she can persuade

her husband to use the family planning devices, whether to seek health care in the primary health centre, or, whether to have a share in the household resources, whether to decide to send her children to school, specially the girl children, and above all, whether she has the freedom of movement in the village and liberty to spend her meager means on herself and her children.

The Empowerment of women can remove gender disparities that manifest in various forms; the most obvious being the trend of declining female “SEX-Ratio” in the population for the last two decades.:

The underlying causes of gender inequalities are related to socio-economic structure, which is based on informal and formal norms and socio-cultural practices. Women, particularly those belonging to weaker sections of society, majority of whom are in the rural areas, are in the unorganised sector. Their access to education-health and productive resources among others is inadequate. Therefore, they remain largely marginalised, poor and socially excluded.

The Empowerment is an all encompassing concept wherein a woman can exert her freedom to take decisions concerning her health, her reproductive health rights and social behaviour, her child care needs. The ability to pursue vocations of her choice and be free to educate her children specially the girl children, too becomes a close possibility.

Once empowered she has a right to refuse practices that are derogative to her and her children. eg. Keeping girl child away from school

and play, getting her marry in her adolescent age or pushing her to conceive early and the family members greed to expect only a male child. Traditional food practices leading her girl child to abject malnutrition. And instead the mother can give nourishing diet that will be beneficial to her and her children's growth and well being. To take a simple example, an empowered woman can resume breastfeeding of the child immediately after delivery as advised by the doctors and are act not unoften prohibited in lakhs of Indian Village.

In short, once she understands, that no one other than her has a right to deprive her of her human rights to life with dignity and be not subjected to indignities or suffer domestic violence on her or her children she can to some degree escape distress and destitution in her life. Even though the lose of the land to endowed on her with equal protection against discrimination seldom every one obeys the laws.

Lack of empowerment breeds other ills. Being a illiterate and illinformed women she is subjected to her socio-economic and family imposed cultural constrains cultural constraints. She having internalized her socialization of women's secondary role in the household, in the community and the world at large, continues to suffer even though she cries for her rights to empowerment. This distorted self esteem is not merely the creation of her imagination or illusion. It is thrust on her in the name of custom, tradition and allied practice and expected of her role as a son producing machine. One can safely term it as superstitious belief that she attributes all her ills to her fate instead of realizing that it is the male psyche

of dominance nurtured for generations that she suffers the tragedy of both IMR and later of MMR.

SOME HELPFUL EFFORTS

The mother and child health programme as it has been evolved in the years highlights how changes have been effected from time to time, by government making efforts to design the programmes to help women and children at the rural level:-The milestones are:-

1. YEAR 1952 Family Planning programme adopted by Govt.of India.
2. YEAR 1961 Dept. of Family Planning created in Ministry of Health.
3. YEAR 1971 Medical termination of pregnancy act(MTP) Act..
4. YEAR 1977 Renaming of family planning to Family Welfare.
5. YEAR 1978 Expanded programme on Immunization (EP)
6. YEAR 1985 Universal immunization programme + National Oral Rehydration Therapy (ORT) Programme.
7. YEAR 1992 Child survival and safe motherhood programme (CSSM)
8. YEAR 1996 Target free approach
9. YEAR 1997 Reproductive and Child Health Programme:-1.(RCH – I)
10. YEAR 2005 Reproductive and Child Health Programme-2(RCH- II)

The National Health Policy 2002 and Vision 2020 India was directed to minimize the regional variations in the areas of RCH and population

stabilization through an Integrated, focused, participatory programme it was to meet the unmet demands of the population to get an assured and equitable quality services. The five year phase of RCH II, was launched in 2005, with a vision to bring about outcomes as envisioned integral to the Millennium Development goals. The National Population Policy 2000, the Tenth Five Year Plan.

Sadly though none of the targets of major policies and goals for the Tenth Five Year Plan (2002-2007) could be achieved: The details given below shows the unachieved goals:

Indicadoras	10th Plan Goals 2002-2007	RCH II Goals (2005-2010)	National Population Policy 2005-2010	Millennium Development Goals 2000-2015
Population growth	16.2% 2001-2011	16.2% 2001-2011	-----	-----
Infant mortality rate	45/1000	35/1000	30/1000	-----
Maternal mortality rate	200/100,000	100/100,000	100/100,000	Reduced by from 1990 level
Total fertility Rate	2.3	2.11	2.1	
Couple protection rate	65%	65%	Meet 100% needs	

A summarized view that emerges here is as given below:

What is Empowerment?

- Right to life with dignity.
- Right to equality & equal treatment
- Right to be loved.
- Right to decide Right
- Right to pursue education
- Right to seek health care
- Right to clean environment
- Right to invoke the laws
- Right to share family resources;
- Right to decide when to marry
- Right to decide when to be a mother
- Has a right to nutritious food and good health
- Right to family planning
- Right to shelter
- Right to livelihood
- Right to economic independence
- Right to work outside home
- Right to share in parental property
- Right to resist violence
- Right to refuse cultural practices & taboos
- Right to equal wages
- Right to minimum wages
- Right to support services from NGOs/Voluntary Organisations.
- Right to political participation
- Right to vote in elections
- Right to attend gram sabha meetings
- Right to information
- Right to free expression
- Right to safety

What is lack of empowerment?

- Not assured
- Discriminated at every step
- Reduces her to low status and Loaded with work
- No right to take decision
- No right to pursue education/ or late marriage
- No right to decide the size of her family
- Lacks nutrition
- Lacks good food
- Lacks right to seek health care even in emergency
- Deprived of sanitation
- No Hygiene nor potable water
- No idea to sterilisation
- Low status for delivering girl child
- Tradition-culture bound
- No right to breastfeed her child immediately after delivery
- Half fed in pregnancy
- Is malnourished
- Hard work in her daily life
- Lack of resources
- Lacks property rights
- No right of mobility
- No right in family resources
- No education
- No concept of good health
- No right to demand
- Ignorant of laws
- No idea & right to childcare
- No right to take decisions about her children
- Lack of opportunity to employment
- Lacks equal pay for equal work

-
- Socialised with belief in Evil Spirits sorcery, witches
 - Lacks right to resist abuse of her children
 - Lacks ability to feed her children
 - Lacks empowerment
 - No continuous voluntary support available
 - Lives in hostile surroundings lacks protection against abuse

<i>Rural Woman is kept tradition Bound against her life and liberty.</i>	<i>Woman is not considered as having any health problems.</i>	<i>She cannot resist the cultural practice of applying cowdung on the edge of umbilical card of the baby</i>	<i>She is loaded with household chores even during pregnancy and even immediately after delivery</i>	<i>New born is branded with hot object all over the body as a cure.</i>
<i>She has no say in household issues or about her Children's well being.</i>	<i>She is married young by giving dowry to the in-laws.</i>	<i>She is forced to conceive early after marriage.</i>	<i>Process of child birth is considered as pollution.</i>	<i>Only pregnancy and delivery are noticed and a untrained dai alone is to handle deliveries.</i>

WOMEN'S LACK OF EMPOWERMENT ACCELERATES IMR & MMR

<i>She is considered a reproductive machine</i>	<i>She is kept in unhygienic space during delivery and dirty rags are used for her and her baby</i>	<i>She has no right to feed her baby for days.</i>	<i>After delivery she is hungry but is given only dark tea and no-nutrition. This again is a cultural practice.</i>	<i>Until she delivers a boy she cannot opt for sterilisation or family planning</i>
<i>She is not to decide how many children she wants and conceive</i>	<i>She is looked down upon for bearing a girl child. She is respected only if she delivers a male child.</i>	<i>She is socialised into submission and nurtures low esteem including that of her girl child.</i>	<i>Husband is the decision maker along with his parents.</i>	<i>There is no concept of her morbidity levels.</i>

Select Ground Reality of Constraints and Determinants to be altered would be as given below:

- Woman is a bundle of duties.
- With no rights
- Village woman has no social or legal persona.
- She cannot cook what she wants without permission.
- She has no right to mobility.
- Custom, cultural practice govern all her life.
- No right to take any decision on family issues.
- She has no right to refuse to work, follow tradition, husband's dictats
- Only traditional dai can attend to her delivery.
- Cannot refuse branding on child with hot ironneedle as cure.
- Lacks nutrition, child care.
- She abets murder of her girl child by dai/inlaws.
- She has no voice against abuse, violence, exploitation.
- She can't say no to cow dung application to baby's umbilical cord.
- She cannot invoke laws.
- She has no means of protection.
- A total life of dependency.
- If belongs to SC/ST/OBC
- Lacks equal treatment
- By authorities.

To sumup, one can candidly assert even to day the lack of empowerment of women has increased the incidence of infant mortality and maternal mortality? The numerous disabilities that a woman suffers and experiences directly and indirectly influences the stagnating and undiminishing infant mortality and maternal mortality.

The mutuality of relationship and inter-relatedness of the mother and the child is affected in a number of ways by the lack of empowerment of women.

The child's total dependence on the mother from its survival, to growth without disease and debility is common knowledge. But in the name of custom, tradition and cultural practices, this mutual maternal and child oneness is interfered with and heavily impacted on their chances of survival. From the day the child is conceived in the womb, its proper growth depends on its nurture through the mother. But where is the nurture? The so-called cultural practice is depriving the nourishment needed for the child and the mother. Even before birth, the health of the unborn is affected by malnutrition of the mother and the consequent low birth weight of the baby. And in some cases they get born with certain deformities because of the inadequate growth inputs supplied through the pregnant mother.

The fear of the ignorant people that the foetus will grow big and hurt safe delivery has been the main reason for depriving the pregnant woman of good and nourishing food. This practice of starving the mother the lactating mother continues and no scientific medical advice is heeded by the rural folk. If hopeful the woman is educated or well informed and has some rights there may be a change in her asserting to follow the best practices and avoid the rural unscientific apprehensions. From the very start, the unborn child suffers because of lack of empowerment of the mother.

Thus continues the saga of deprivation, discrimination, distress and death leading to IMR & MMR. This threat to the very survival of both the infant and the mother remains uncontrolled even today. The visible and invisible pressures on the woman in the village have been explained in the text of this study and also through the empirical evidence collected during our investigations. They amply justify the contention that the lack of empowerment of women due to the socio-economic causes and determinants have been the main factors for the status of infant and maternal mortality as on today.

Whether one realizes the importance of the need for empowerment of women for reducing both infant and maternal mortality or not, the lack of empowerment is a stumbling block in maternal and child health and survival.

CONCLUSION & RECOMMENDATIONS

In the previous sections of this report, we have highlighted what our Research team, and, my State visitations, have revealed to us.. We have tried to reproduce the same in an objective manner. We have found several direct and indirect measures undertaken by the official apparatus right down to the grass roots level in the country. Consider that India has in several states arounds 62,000 villages including its hamlets and remote settlements in the countryside and add to it the remote areas & the coastal periphery, We also have people living in the mountainous areas at a higher altitude, & numerous tribal settlements all over India. Let us not ignore people living in Andaman Nicobar and Lakshwadeep group of islands. Thus India is a large human system with a cultural plurality characteristics of its people.

Against this back drop and reality of India, can our Planners and Policy makers honestly say, "we have reached all of them with our Plans and developmental recipice and progammes"? This report which covers only a few district and a few villages, therefore, can at best be just indicative in nature.

We shall not go into the issue of governance here. But if the Nineth Five Year Plan's midterm appraisal Volume III is looked at, then this study's logic compels us to agree with the official review that, "In large number of policies and rules act against the interests of the poor. There is need for putting pro-poor policies in place" We further agree that the government

needs to evolve a culture which help, promote, “the successful implementation of developmental programmes”.

The question is, are the current delivery systems in a position to optimally utilize funds and realise the goals with respect to IMR & MMR fully. The Experiential evidence, no matter of which official review, we examine, or look at our meager findings, they reconfirm that the Indian implementation of IMR & MMR reduction Programmes are not substantial enough. Specially, if we look at the schemes relating to ‘Primary Health, Primary Education, Watershed development, Employment of local people and Women in particular. All these, notwithstanding the role of Panchayats’ can be crucial. A key question that stares in our face is if the Panchayatiraj mechanism is in any way helping in minimizing the tragedy associated with the IMR & MMR?

The problems are far too many, if the implementation aspects are looked at, be it responding to the needs of women or the issue of accountability for effective grassroot functionary’s role including allied financial management. These do deserve to be made more effective. The question is how? People are people. In a country where malpractices thrive, can we say several ASHAs and a few invisible ANMs, can deliver “the direct welfare measure” and could salvage the local IMR/MMR tragedy? We need to look hard at the grass root functionaries versus needy people’s large numbers. Besides, health care, do these people have any recourse to a responsive legal system at the grass root level?. How can poor people invoke and seek assistance to any kind of justice system? After all infant killing is a heinous crime.

A word may be mentioned above administrative malpractice. An input that our field workers provided us from Andhra Pradesh was from Mehaboobnagar district. ; it said that an ANM - midwife was engaged in selling the new born babies on the side for a price anywhere between Rs.5000 to Rs.1,50,000/-. She would tell the poor mothers whom she delivered of, that the child was born dead. It is more than apparent that we have to stimulate and invigorate the Panchayatiraj system to ensure local vigilance, honest implementation of our Plan schemes as was stated categorically in ***the foreword of Volume I of the Five Year Plan, 2002-2007, entitled, Dimensions and Strategies, wherein it was said that, 'Effective delivery of basic social services to our people cannot be ensured unless the institutions that are charged with these functions are made accountable to the people themselves. For this it is necessary to empower the PR institutions by transferring to them both functions and resources. The PRIs must become the cutting edge of our 3 tier political structure and the focal point of democratic decentralization'.***

It would be insane and Churlish to suggest that the Planning Commission and the Policy making personnel are not trying to invigorate to the best of their effort for the most needy sector of Rural India. What is it then that the Government of India's plethora of schemes are missing? For the indirect steps, they are regulating ground water use, they are stepping up development by industrializing locally and also integrating agricultural markets. They have introduced the Kisan Credit cards and

allied reforms to strengthen the economic base for the poor people. Like this there are several **indirect attempts** which **inter-alia** may help the economic empowerment of our rural women as well.

However, when it comes to improving the quality of life, notwithstanding our schemes of financing health care. In the context of demographic picture of our nation, even when the 10th Plan, provided for and encouraged to provide certain health care services free of cost integral to the different aspects of National Family Welfare programmes, can we say it is enough or, that official indices concerning the health care infrastructure have been examined was in a satisfactory manner? A Plan review indicated that free welfare packet release and utilisation varied from district to district and from village to village; we too in our research noticed it. Ofcourse, now a realization and a change is visible wherein an effort to reassess the health Plan measures are being made to make district-specific health, nutrition and Family Planning needs.

However we need to face the crucial question, why a visible dichotomy and mismatch between good policies and the welfare of the needy specifically lingers on, when it is about IMR & MMR; Here, ***One cannot help but say that in spite of all our plans and our schemes, they have proved ineffective in coping with the stranglehold of traditions, taboos, personalized beliefs, caste considerations and religious constraints. Because these limitations and numerous societal cultural handicaps inbuilt in the life of the people do escape the benefits of economic development.*** Can we say our Plan provisions

Priyadarshini Scheme

CSWB awareness programmes and condensed course of Education for Women.

Support Programs

*Swayam Sidha
Suraksha Yojana*

Rashtriya Mahila Kosh for lending through NGOs.

Short stay homes for women in distress.

Working Women's Hostels.

Relief and Rescue of trafficked Women's Programme.

MIN. OF WOMEN & CHILD DEVELOPMENT PROGRAMMES SUPPORTING WOMEN'S EMPOWERMENT ARE FEEBLE

*Step Programme for Women
Swadhar homes for Destitute*

ICDS anganwadis

Ladli Scheme Balika Samridhi Yojana Rs.5000 per family of 2 girls given as Kisan Vikas Patra

*Rajiv Gandhi Creche Scheme for Children of Working Mothers.
on the anvil*

Integrated Child Protection Scheme on the anvil

Laws Protecting Women contain gaps that needs periodic review.

hve taken all the local factors into account? Do these social indices articulate each Plan's technical notes? Further more are our National targets in place. It not, then what is the missing factor, one or too many?

The above question arise because grassroots impact is in no way uplifting enough to curb IMR/MMR. Our policies have not quite alter our peoples mind sets? If this does not happen, then, our best efforts and programmes and strategies for equity and social justice, will fail to transform our society. Consequently, IMR & MMR will continue, even if it be at a reduced scale.

As referred to in the earlier sections also, this report only addresses two key factors. Firstly, we are asking, can we think of new direct and indirect innovative schemes to reduce IMR & MMR. This may help our Planners and Policy makers to fine tune their existing schemes and programmes which are praiseworthy but are not helping much (with great humility I must also say that in none of the State villages visited by us- they had any idea what Planning Commission is all about).

The second question that we are addressing here is based on our firm belief that we need to do whatever we can and as much as we can, in as many ways in which we can, we better empower the woman. If this happens and when it happens, we are confident that an empowered woman will become the most powerful auxiliary & support measure to reduce IMR & MMR

DIRECT AND INDIRECT PLAN SCHEMES, DESERVE FRESH LOOK AND NEW EMPHASIS:

We now turn to some ideas of the direct and indirect schemes which can help us in our mission of getting rid of this social malaise and scourge of Infant and Maternal Mortality. One small point we would like to repeatedly emphasise is that the Policy makers should continue to remember is that the Indian populace lives, simultaneously, in several centuries timeframe and concomitant practices. As hinted earlier, therefore, some Plan Schemes, all, propounded by the First Five Year Plan and by succeeding thinkers may still be valid in some parts of India. However, that does not prevent us from fresh creative thinking for and towards future.

What we found during our research in the villages of six states is that the villagers are not aware of what the National Rural Health Mission stands for, and what exactly do the health policies, offer to the poor rural folk. Out of curiosity the villagers have gone and seen the Anganwadis, the Primary health centre and the sub-health centre in the village. These village level workers shared with us their woes that it has been very difficult for them to convince the village women to believe that these centres are opened in the village only for their benefit. Is it case of credibility deficit?

The ANMs and Anganwadi workers narrated to our research team that it took more than a year and a half to make them agree to go for the immunization and vaccination of children and pregnant mothers, particularly in Rajasthan and Andhra Pradesh.. The women, though refused these procedures for themselves but agreed to have them for their children.

For people who are deeply rooted in superstition, and cultural practices that are inimical to the modern medical care, it has been a yeoman task for the village level anganwadi workers and the health workers to win village women's faith and confidence. Currently people are attracted to the *nashta* (snacks) given by the Anganwadis to the children and pregnant and lactating mothers. Our team found that the maize balls given as *nashta* to children and women are neither tasty nor filling. When we told the workers that in southern Indian states cooked nashta is given to children and women, they said they would also be doing the same in a few months. It is the poor families who were visiting the centres and not the upper caste women. (The most caste minded area in Haryana is NUH, where even the Muslims practise caste system. For them, the Centres, are of no use).

HEALTH SERVICE DELIVERY SYSTEM AND ALLIED INFRASTRUCTURAL ISSUES

Talking to village women, our team could realize how entrenched a life they are living, still caught in the age old customs and beliefs, and, in evil spirits and taboos, imposed by their communities generation after generation. In the 21st century their world exists in the shroud of the 2nd century. ***In this existence the women have also no freedom of choice, no decision making power or of movement without permission of their husbands and in-laws. In such a situation, unless the health service delivery reaches to their door step it would be ineffective; it is not easy for the local women to avail of these services though specifically***

meant for them, because of the many restrictions that they face day after day.

Let us now turn to a few inadequacies in the delivery system. We found that the health service delivery is through the Primary health centre and that the number of staff appointed are not adequate to cater fully to the village collective needs. The key person in the PHC is the ANM who visits each village once a month. The doctor visits once in three months that too for an hour and a half. The multipurpose male worker who is to dispense medicines is often found absent, or, he is out on a visit to the village households for collecting population related records. While the PHCs profess to provide 24 hours service for cases of delivery and for family planning procedures, the inadequacy of staff is one reason for villagers refuse to depend on their services. Apart from the problem of commuting distance locally. For them, an untrained, unskilled, local dai (midwife) remains still an, “angel of mercy”, Is she really?

Besides, Haryana and in other States visited by us, we also found that the dual appointment of both permanent and contract ANMs had created confusion in the minds of the village women. The policy of employing ANMs on contract, on retirement of the permanent ones, is not encouraging women to opt for the new ANMs services. They would prefer to revert back to their traditional dais in whom they have enough faith. Other reason is that being a contract employee, the new ANM may not stay in the village and may also attend to private delivery cases outside the assigned village. The ANMs are not easily available. Hence it is this recruitment policy that needs

change, because it is not matching with the requirements of the village women's needs and that of their children. Our team also found in the villages of Haryana, in Harchandpur and Rethoj, small children were having chest cold and there was neither a doctor nor even an ANM to attend to the children. When one of our team member told the women to apply 'ajwain oil', to the chest if nothing else is available, the women replied that 'bhoot'(ghost) will stick to the chest if," ajwain " is used'. It may appear irrational to the urbanites, but the key question is how to change such an old mind-set?

As far as ASHAs go, it is true that engaging ASHAs, as announced by the government, one for every village, is a welcome step. Yet in the places, visited by us, we could find only one ASHA in more than 10 PHC areas. In Maharashtra in the Nashik district, they have not yet thought of engaging ASHAs, and in other states, we were informed that they will soon be appointed. The least said about Uttarakhand would be better.

The point that is being made here is that even if the State is extending its health related assistance to the recipient expectant mothers, the State machinery has almost failed to establish a credible relationship. Surely we can sympathise with the Village health care workers who, sometimes, have long distances and difficult terrains to negotiate. It is typical of the State of Uttarakhand. Although typical of Uttarakhand, even in other places, we need to remedy a situation in hospitals where, doctors are seldom present and are on leave. Medicines invariably are just not available; On the one hand the supply side infrastructure for health care is awaiting for the needy to arrive; on the other hand the demand side "needy" does not feel motivated

enough to seek external assistance, and would rather depend on the known, and available traditional local dais. Even if the where Village women do muster courage, often they do not receive the required assistance, either from the PHC or, the ANM or the ASHA. Therefore, our policy makers should take due remedial attention to aforesaid all-pervasive phenomena in the Indian villages and several different remote areas. Ofcourse, the key question would remain on, “ How to convince their women folk?”If this is done, it may contribute towards some reduction in IMR & MMR. (As a contrast let us remember that even AIIMS, where 1000s of doctors are catering to more than 5000 patients each day. Here we have only an ANM and an ASHA. The Economically empowered Villagers who are do commute distance to come to AIIMS. In fact they form 50% of thousands. If patients, visiting big urban hospitals..... contrast it to the pathetic ratio of one ANM or an ASHA for 5000 plus population of a single villages and consider the become staff may often sense a Block that may have more than 100villages seeking health care.

ROLE OF ANGANWADI WORKERS AND ANM'S

We need to look at two additional points here. As they also deserve scrutiny and remedial measures to augment the role of Anganwadis and ANMs.

The Anganwadi workers along with ANMs are expected to attend to women for antenatal care and post natal care; care of infants and provide for women and children for immunization and vaccination needs. The

Anganwadi worker also counsels them on the advantages of these procedures and about the nutrient requirements. during pregnancy.

Our team, however, found that in all the six States, the presence of children in the Anganwadis was sporadic. In some villages they were 10 more or 11 kids but in other villages they even numbered 80 plus children. All the children were coming for the '*nashta*' only. They were seldom engaged by the Anganwadi workers in teaching them good sanitary practices, even through, " Role Play". It is apparent that for this we need to have highly trained Anganwadi workers. The ANM's have hardly any time for such activities.

Our Researchers also got the impression that the majority of women of the villages strongly felt that the ANMs are only occasional visitors. Hence they cannot entirely depend on them as ANMs are not available daily and certainly not during emergencies.

We need to extend our sympathies to the above mentioned Health-care workers for more than one reason. By virtue of their duties assigned to them and by their qualifications, the Anganwadi workers and ASHAs for all intents and purposes, are not necessarily health workers. Their role is limited to act as either Counsellors or as conduits between the pregnant woman in need and the PHCs or hospitals. The question does arise, if we can enhance the number of health-oriented ANMs and compensate them financially to stay in the village. We can then achieve ANM's better interface with village women? The real remedy thus lies not only in doubling up of their numbers, but also of the status of their training and skills? At the

moment, it is not only minimal, if not sub-standard, for them to qualify as the local health MESSIAH to reduce IME & MMR.

We, therefore, strongly recommend the following: Apart from increasing the strength of the ANMs, it is important to upgrade their female health related and allied knowledge level. Their presence in the village will enhance better assistance to village women. They will inspire more faith in modern medicine as against the Village women's faith in the local customary practices. Their frequent visits to the local tantrics, sadhus, priests and peers may thus gradually stop. If the ANMs are convincing enough, the village women not throw away as it happens today the iron and folic acid tablets women or offered as part of the nutrition programme.

We sincerely believe that the role of Panchayats would be the most significant input & turning point to reduce IMR & MMR. Every Panchayat firstly appoint A HEALTH COMMITTEE. If these committee's begin to with a creative zeal and compassion and takes conducive steps towards reducing IMR & MMR, WE WILL NOT ONLY BE ACHIEVING OUR GOAL of due reduction of IMR & MMR but we will also set up a yardstick to assess the effectiveness of the Panchayati Raj system.

We feel emboldened to recommend this because in many states visited by us, we did not come across a single Health committee that has

been set up by the local Panchayats. We think that all states should ensure it post-haste.

Other ideas: When we begin to search creative, direct or indirect remedial measures to reduce IMR & MMR we do realize that IMR & MMR is shrouded by numerous causes and determinants personal and local to a given settlement. There is no one single remedy that can be attempted to reduce the deleterious effect of these beliefs same. But numerous support systems can be thought. Besides the Public health system, **the self help groups**, and voluntary NGO support need to be activated. The most important of all tasks is how to influence grass roots customary social behaviour and gently influence, atleast, the leaders of the local community and castes towards elementary modernity. Hopefully they may further in turn motivate the rural folk.

STEPPING UP OF TRAINING AND MASS AWARENESS PROGRAMMES

The Government's plan to train PHC staff as multi- purpose health workers in curative skills is a welcome step. But what is ailing PHCs is lack of supplies and medicine, even for the qualified doctors, to dispense. There is an urgent need to equip near empty PHCs with medicines and other needed resources by way of staff, equipment to make them effective medi-care service provider. Equally important is the intensive training of the PHC staff to develop a more adequate health care delivery system. Even modern doctors need to be trained to make them more sensitive to the villager's needs. These doctors need to think of their as 'authority'

figure. This will enable them to pass on valuable health ideas to villagers in a manner the villagers can understand. Hopefully it may add to the villagers quality of life. Besides such sensitivity may have indirect and direct impact towards the reduction IMR & MMR. Responsive Health planning and medical orientation will require the benefit of anthropological research into regional health profile. This will help planners to assess their right manpower, and supplies. If training get supplemented by the region specific modules, then we can impart a new knowledge.

And above all to equip all Rural Medical Practitioners (RMPs) to be given better knowledge of allopathic medicines. They can become helpful change agents in the village, since villagers have faith in them.

(NGO'S CAN BE ADDITIONAL TRAINERS)

To some extent the health culture of a community gets reflected in the health behaviour of the rural people. The introduction of the rural health delivery system by the government, can be effective only ***if the villager's cultural perception accept, and sees the public health care interventions, as purposive and useful.*** We could encourage NGOs, assisted by the State; to help orient husbands and mothers-in-law to become more caring a person towards the expectant mothers and the girl child.

In a feed back from Rajasthan, our research group was informed how a local NGO introduced the 'Role Play' approach. It was made a tool

to train a group of husbands to sensitise them towards expectant mothers. These husbands were asked to dress like a woman, pillows were tied to their tummy to make them feel that they were heavy like the pregnant women. They were asked to cook with 3-4 children wailing around them. Simultaneously, they were to take care of the children while they were cooking. Besides their heads were totally covered, face not visible and they faced smoking chulha, too. Finally, they were asked, "will you agree to live like this for nine months? In just one hour it was reported that this short experience did make some impact on the participating husbands and their perception of woman did alter a wee - bit. Similar programmes can be designed for mothers-in-law, to not consider a girl, "a paraya dhan" and an expensive commodity or only a machine to produce 'boy' child.

A doctor in the group explained later, how a pregnant woman should be treated;" why there is an urge to kill a girl child when the woman has gone through the same pain and suffering as she would have gone through by delivering a male child." ***The truth of the matter is, and it is very significant that, invariably, the killer of the girl child, in majority of the cases, is the mother-in-law who demands of the dais to kill the newborn baby girl.***

It is now common knowledge that in the State of Rajasthan in Badmer district a single marriage took place after a period of 110 years. Here there are villages after villages, in the same region, where bachelors live who are aged 65 and 75 years old. In fact the dowry is given by the bridegroom to get a bride. But alas, there are no marriageable girls available.

They have long back been put to death and the practice of infanticide persists. In the State of Tamilnadu, however, infanticide was prevalent and for long it still continues in some hilly pockets. The law and the policy of the Government, however has failed to fully stop incidence of infanticide. But innovative approach of “**Cradle Baby Scheme**” has certainly saved hundreds of girl infants.

THE ‘PALNA’ OR CRADLE BABY SCHEME LET US START IT: IT IS A WINNER INDEED. OUR PRIME RECOMMENDATION TO THE CENTRAL AND STATE GOVERNMENT.

When incidents of female infanticide in some remote villages in Madurai and Salem districts were brought to the notice of the Government, by the media, responding immediately, the Government of Tamil Nadu started a reception centre at *Usilampatti in Madurai District*. It was run by the Indian Council for Child Welfare with the help of government funds during early 1990's. The services offered in Usilampatti were:-

- i. Running reception centres to receive un-wanted babies.
- ii. Counselling of pregnant mothers and their families.
- iii. Support services - education, training and creating need based opportunities for livelihood for women.
- iv. Sponsorship Programmes.
- v. Hostel facilities to complete schooling.
- vi. Local Day-care centre for working mothers.

During 1992 when such awareness creation was on in Madurai - incidents of female infanticide in remote rural areas of Salem district too were reported in the media.

To counter their menace of female infanticide in certain parts of Tamilnadu“ Cradle Baby Scheme.” It was first implemented, from 1992, in the Salem District. Under this scheme cradles were placed in important places such as the Government hospitals, Primary Health Centres, Collectorates / District Social Welfare Offices to enable the parents to drop their female babies if they are unable to bring them up so that the Government may take care of such babies. As per G.O. (D) No.11, Social Welfare and NMP Department dated 23.03.1993 it was stated that the Government have taken steps to curtail the female infanticide and all the Primary Health Centres and Anganwadi Centres were instructed to place cradles in Salem District to rescue the girl babies from being killed later on from the Government in G.O. Ms. No.88, Social Welfare and NMP Department dated 30.03.93 issued an order to set up cradles in Salem District near the Primary Health Centres in vulnerable areas of Salem District so as to facilitate the mothers to leave their unwanted babies in the cradles.

This was considered a measure to rescue the girl babies from the jaws of death. In the G.O. cited, the Director of Social Welfare, has been instructed to formulate and implement the programme and for creating awareness among the people. In the same G.O. it has been stated that “the children received, may be given in adoption” and it was instructed that, “the Director of Social Defence and the District Collector, Salem shall make efforts to encourage the adoption”. The children who could not be given in adoption they were advised, may be handed over to reputed Non-Governmental Organisations”.

It is interesting to note how, in the mean time, the Consulate General of Japan came forward to fund the programme to a tune of Rs.22,40,440 during March 1995. A building was constructed at the cost of Rs.5.50 lakh and a jeep, an Ambulance and an Audiovisual van were purchased for bringing the children, educating the mass and propagating the evils of female infanticide.

From the year 1992 to 5/2001 the Salem Cradle Baby Home has received 150 children as detailed below:

	Male	Female	Total
No. of children received	0	150	150
1. Children died to disease	0	40	40
2. Returned to parents	0	14	14
3. School going children in orphanage	0	23	23
4. In country adoption	0	39	39
5. Inter country adoption	0	28	28

From the year 2001 onwards the Government in G.O. Ms. No. 158 Social Welfare and NMP Department dated 24.10.2001 it was decided to “revitalize the cradle baby scheme”, and accordingly, reception centres, were started in Madurai, Theni, Dindigul and Dharmapuri. As per the Government instructions 188 cradles were placed in all the Primary Health Centres / Office of the District Social Welfare Officers in districts of Madurai, Theni, Dindigul, Dharmapuri, Namakkal and Erode. Further the Tamilnadu

Government also sanctioned a sum of Rs.12.96 lakhs for the starting of reception Centres in Madurai, Theni, Dindigul and Dharmapuri. The main function of the of the Reception centres was to receive, to provide shelter, “The Medical facilities and hand them over to the adoption agency”. The Government provided funds for the maintenance of reception centre on an annual basis.

At all the reception centres, in Tamilnadu they are having pucca infrastructure facilities along with Life saving drugs, Life saving equipments, telephone, water and Electricity facilities and with adequate staffs. Funds are also provided for the purchase of Medicine, clothing, feeding and for other contingencies. Apart from these 5 reception centres, cradles have also been placed at the Collectorates and District Social Welfare Office. They have been officially designated as “cradle” points.

As envisaged in G.O. No. 88 SW & NMP Dept., dt. 30.03.93, the children received in the reception centres are handed over to 21 licensed adoption agencies (both in & inter country) for rehabilitation through adoption programme. (At present there are only 19 licensed adoption agencies).

This ‘Palna’ called the ‘Cradle Baby Scheme’ can easily be replicated in all States. This is one of the visible and direct ways to protect the new born infant from death.

SOME ADDITIONAL THOUGHTS ON STATE - LOCAL HEALTH RELATED INTER-FACE

We strongly feel that a responsive Health planning and medical orientation will require deep anthropological research into regional health sectors, which will help planners to find tune the current schemes to grassroot, variable realities, from village to village, district to district and state to state.

OUR RECOMMENDATION

Since the PHCs play a pivotal role in the Government sponsored Rural Health Service System and as the empirical surveys reveal that they are in disarray and do deserve hightened training and orientation. There is adequate political will to develop rural health services. We should respond to several public health workers who have pointed out that in spite of their concern for the village women and children's health needs, there is still a lack of co-ordination and commitment of the official apparatus at the village level.

Our research team also felt that the Panchayats, the PHCs, ICDS, Health workers all work in isolation. There is considerable degree of unmet needs for maternal and child health services. There is no collaborative and co-ordinated functioning of these agencies and other institutions. Therefore the efforts have not helped in reduction of IMR & MMR.

Besides this, it is recommended that the recruitment of staff to the Anganwadis, Primary health centres and ASHAS to the PHCs, Sub-Centres need a thorough review. ANMs regular home visits to counsel women on maternal and child health care has to be regular and has to be constantly monitored

SOME LEGAL POINTS CONCERNING IMR & MMR

- 1. The practice of foeticide, the killing of the unborn child and later committing infanticide are cognizable offences. They are non-bailable too.**
2. Solemnising of child marriages is against the law prohibiting child marriage. Marriage of girls below the age of 18 years is also prohibited.
3. Dowry giving and taking are offences under the dowry prohibition act.
4. The prenatal diagnostic techniques tests with a view to reveal the sex of the foetus is banned by law.
5. Only the Medical termination of pregnancy ACT enables women to terminate pregnancies for certain valid reasons. The MTP ACT empowers accredited hospitals and doctors to undertake such operations.
6. Domestic violence perpetrated on women is prohibited by law so also is the torturing and abuse of children and women.

7. Registration of births, marriages and deaths have been initiated by states not merely for purposes of census records but to ensure a variety of safety measures to the infant/child, and the mother.

The lack of awareness of our laws is a negative feature. The National health and other policies on empowerment of women, alas, receive a scant or no attention from the rural community. Abetment to such offences are also cognizable and severely punishable yet it continues, in our large country. This was also confirmed by our field investigators. In the villages visited by them, none of these laws or policies, have been followed or obeyed by the local village community. One can attribute ignorance for such inaction, yet one cannot ignore the fact that the social disregard against the laws appear more powerful than the laws themselves. ***This dishonouring of the law is again the outcome of strong socio-economic causes and the cultural way of life and lack of awareness. Such a situation is not at all conducive to reducing infant and maternal mortality rates.***

One can deduce from such a village scenario which is bereft of the respect of law besides being indifferent to the modern medical care. What hope then can we have in preventing the rising/stagnating IMR &MMR. This state of affair does seem very bleak. ***It calls for innovative programmes and strategies towards multi-pronged attempt to change the behaviour of the villagers.***

<i>Right to life and her safety and of her children.</i>	<i>Right to question superstition and harmful practices.</i>	<i>Right to utilise governmental facilities created for Woman and the girl child.</i>	<i>Right to increase Woman's age at marriage.</i>	<i>Right to conceive at a mature age for safe motherhood.</i>
<i>Right to nutrition during pregnancy and after delivery.</i>	<i>Right to decide the size of her family.</i>	<i>Right to sanitation and hygiene and good environment.</i>	<i>Right to decision making on matters concerning her person and family.</i>	<i>Right to childcare as per medical advice specially of the girl child.</i>

**POLICIES FOCUSSED ON
WOMEN'S EMPOWERMENT NEED TO BE STEPPED UP TO
ENSURE HER NUMEROUS RIGHTS**

<i>Right to breast feed her baby.</i>	<i>Right of the girl child to pursue studies in Primary and High school</i>	<i>Right to cross the old patriarchal values and of women's subordination.</i>	<i>Right to resist violence and right to seek community support.</i>	<i>Right to seek medi-care services and intervention before and after delivery.</i>
<i>Right to employment out side home and contribute to better child care.</i>	<i>Right to economic stability and sustainability.</i>	<i>Right to equal resources and equal attention by members of the family.</i>	<i>Right of mobility and freedom to communicate with Parents and Friends.</i>	<i>Right to be aware of laws and invoke laws in her favour.</i>

WOMEN'S EMPOWERMENT: A SURE RECIPE TO REDUCE IMR AND MMR

- A. Healthcare empowerment: needs massive awareness and contact strategy.
1. Available health infrastructure specially in rural areas is too inadequate to cater to WOMEN WHO ARE HALF OF THE EXISTING POPULATION.
 2. ***The Indian planning being predominantly an economic process, offers a mis-match to respond to our tradition-bound superstitious rural ethos. This public policy is not able to break this superstitious life cycle handed over from one generation to another;***
 3. ***Behaviour modification is a big communication challenge to grapple with and there is need to retune the Planning process for the social sector.***
 4. Identification and removing of a plethora of handicaps suffered by women including lack of autonomy in decision making even about her own health and that of her infant are imperative and important.
 5. ***We, therefore, need to step-up ten times massive awareness programmes for the rural folk to make them grasp positive information about health to their own advantage.***
- B. **A triple insurance scheme for women's empowerment:** We need to introduce a triple insurance scheme ensuring **Health, Education**

and Employment for all women specially for those living below poverty line.

C. Offer nutritious and cooked meals to children of anganwadis and pregnant and lactating mothers.

Women's empowerment in the household and community, needs integrated Planning with multisectoral policy assuring economic cover and opportunities for free health, education, right to life and survival and freedom of choice and right to regular employment and income. ***Unless the woman is liberated and enabled to seek health care, any amount of superstructure with adequate infrastructural facilities will be futile. Empowering women to take their own decisions and to free them from the patriarchal hold is a top priority for Planners and Policy makers.***

FOR A SUCCESSFUL HEALTH SERVICE DELIVERY

From our study, it is our finding, that it is necessary to ensure greater synergy between ICDS and the Health system to fully involve Anganwadi workers in maternal, neonatal and postneonatal care at the household and community levels in the rural areas.

- Develop sustainable models of obstetric-neonatal services at PHCs, CHCs and district hospitals.
- Renewed efforts are needed to finish the unfinished agenda of routine immunization and ORT. We need to scale up community skilled birth

attendants scheme to meet the long standing need of providing skilled birth attendants in the community. Involve Panchayati Raj institutions (PRIs) in saving infants, neonats and post –neonats ;

- There is need to prepare advocacy and educational materials targeted to PANCHAYATIRAJ leaders at district,sub-district and village levels.
- Demonstrate sustainable models of public-private partnership for survival of infants.
- Establish a partnership of all concerned NGOs, ANMs, AWWs, SHGs in reducing IMR by involving them to serve as a platform for advocacy, strategic deliberations, programme support and experience learning.

EDUCATION: AWARENESS AND PEOPLE’S EMPOWERMENT

The social, cultural and health conditions related to low status of women in India have a negative impact on child survival; improvements in female education, nutrition and the use of maternal health care services would help in reducing infant mortality.

- Girls have higher mortality rate than boys from the age one month to 5 years and receive less health care. Eliminating gender difference in mortality rates would help reduce child and infant mortality rates.
- India needs to reassess the country’s child mortality reduction goals and go forward with enhanced integrated approach for child health and nutrition.

- Considering the difference in infant and child mortality performance between states, stratified child health policies are needed to take into account, state specified epidemiological and demographic patterns and key determinants.

NEEDED STRATEGIES

- Identification of high risk blocks showing high infant deaths especially female infanticide.
- Establish Health Co-ordination Committees involving Panchayat leaders, ward members, medical officers and health staff, revenue department officials, voluntary agencies, community leaders and other influential persons at village /block and district levels.
- Functions of this committee would be to (i) identify families with more than one female child.
- Encourage these to avail all health services for safe pregnancy, delivery and child survival and curbing infanticide practices.
- Highlighting government of benefit schemes for women and girl child.
- To involving adolescent girls groups and PRI groups for health issues related to body mapping, reproductive health, family welfare, girl child protection, institutional delivery, to eliminate sex determination tests and work for gender equality.
- To introduce the cradle baby scheme of Tamilnadu to prevent babies from infanticide.
- To Establish operation theatres in PHCs to facilitate family planning services and medical termination of pregnancies.

- To ensure early registration of pregnancies, and for early detection of high risk cases, improving institutional deliveries, providing skill development training to health staff on new born resuscitation techniques are important.
- To provide RCH training to medical staff, providing health management information system and also training for record management etc.
- To educate the mother of the merits of antenatal care, institutional delivery, importance of exclusive breast feeding, immunization, home care for diarrhoea; all these are meant to create awareness among family members to provide support to women during pregnancies and deliveries.
- ***Revive the concept of Delivery huts/waiting rooms for expectant mothers. Unifem earlier offered assistance to Haryana government and initiated this idea to start with in the State of Haryana; but this was for reasons not known have been discontinued. The delivery hut concept is innovative and at the same time of immense need for expectant mothers. This has to be revived if true efforts are on the anvil to reduce infant and maternal mortality.***

THE FINAL WORD

In so far as a set of recommendations go we have already catalogued the key ideas. One can multiply them by several hundreds. What can in reality get achieved is a separate matter. To give just one example the researchers of the study observed that “Sarva Siksha Abhiyan” has impact

on education of children and specially girls. Our team feels that a “Sarva Swastiya Aabyan” if started may step up the efforts to reduce IMR and MMR. This though deserves serious support, our implementation of Sarva Siksha Aabyan, still is not upto national expectations.

Since there are no absolute answers for a total elimination of IMR & MMR, the ideal solution is that, we find tune our direct and indirect interventions as reflected in our Five Year Plans and conferred policies that are being implemented by the Central Ministries and State Government, Administrative apparatus. And to reflect on the modes operandi to identify new ways and means, we need to reflect on the possible answers to an assorted set of question given below:-

1. Is development an answer or a recipe for reduction of IMR & MMR?
2. Can stricter implementation of laws reduce IMR & MMR?
3. Can change in educational delivery at people’s doorstep:-
 - a) through public communication system?
 - b) audio-visual presentation?
 - c) through NGO’s developing person to person contact and health?
4. Can incentives to poor families by way of :-
 - a) mid-day meals
 - b) food subsidy
 - c) subsidised shelter
 - d) free nutrition packets will help reduction of IMR & MMR?
5. Can employment to man and woman in the family help with support services like creche at work place, offered free or on nominal charges.

6. is not empowerment of the woman, THE ANSWER?
7. Can massive training with free board and lodge followed by some economic activity like the SHGs - help the situation?
8. Reinforced tripartite enforcement structure at the village level for health service delivery - won't it help? With intensive training for Panchayats, ICDS personnel (the anganwadi workers), health personnel (of PHCs, ANMs and ASHAs).
9. Can we not have a village campaign:-
 - a) for Palna scheme
 - b) our village Swasthya campaign
 - c) SHGs for monitoring compulsory education of children specially the girls
 - d) delivery huts
10. Can planning be?
 - a) women-centric
 - b) village-centric
 - c) development in a project mode
 - d) compulsory training for doctors in rural camps.
11. Can't we engage Local Committees:-
 - a) for health watch
 - b) education watch
 - c) foods security and distribution watch
 - d) public health watch

all these to be made accountable to the tripartite village structure/
committee
12. Can we float awards for best performing village/villagers

THE STARK AND FRONTALLY STARING TRUTH: LIES IN THE QUESTION:

Are our policies creating enough opportunities for transition of our people, when really they can create an appropriate modicum of transition, to freely move from one state of cultural web to a more Emancipated environment, where “dos and don'ts” can be less painful and modern ways, more acceptable. Therefore this question persists as to what are those additional new innovative, creative ways and means which can accelerate the acceptance of scientific temper as against the *vice-like-grip* of superstition and people begin to live in an environment which can promote scientific healing for ills and allied health ailments pertaining to female sexuality and biology. This may, we believe can help in the gradual reduction of IMR and MMR in India.

A search for new policy, demands the active existence of an accelerated transition process, be it for housing, occupation, technology, health care, education, and massive awareness for maternal and child welfare and survival. A multi-sectoral legal, health science and rationality.

We believe that the identification of new Plan schemes and programmes should have an organic character and forward movement. Once a system is installed, it should replicate itself. It should be sufficient and growing and with a evolutionary modicum. Ofcourse, it has to be sustained by due fiscal support.

A Nationwide support for technique and updated technology is a must. The important thing is that the real process of transition be focussed for people's accepting modernity notwithstanding the historical grip of customs, traditions and caste compulsions. It should lead people forward, for an ongoing quest of our people, for fearless acceptance of current know how. A storehouse of awareness and knowledge, is out there awaiting the attention of our people. Let new science, new technology and new management be hereafter our guide. Once this transition takes place India will surely be rid of IMR/MMR.

Help
Women
in districts
those left
their
infects

Take
Care of
Nutrition
Needs of
Children
to 6 months
& 6 years.

Do bring
Change
in attitudes
& habits.

Organize
Women's
Self-help
groups.

By
Their
presence
bring cheer
to villages.

Anganwadi
workers
ANGWs.

They come in direct contact
with village women & children.

They advise
women on
hygiene
& health

To
work
under
The guidance
of doctors

Teach women skills
Nest families
Panchayats
& Health
Committees

They
can
bring
change

Auxiliary
Nurse Midwives
ANMs.

To show
women
best child
care
ways

Panchayats
& Health
Committees

They
can
give
confidence
to women.

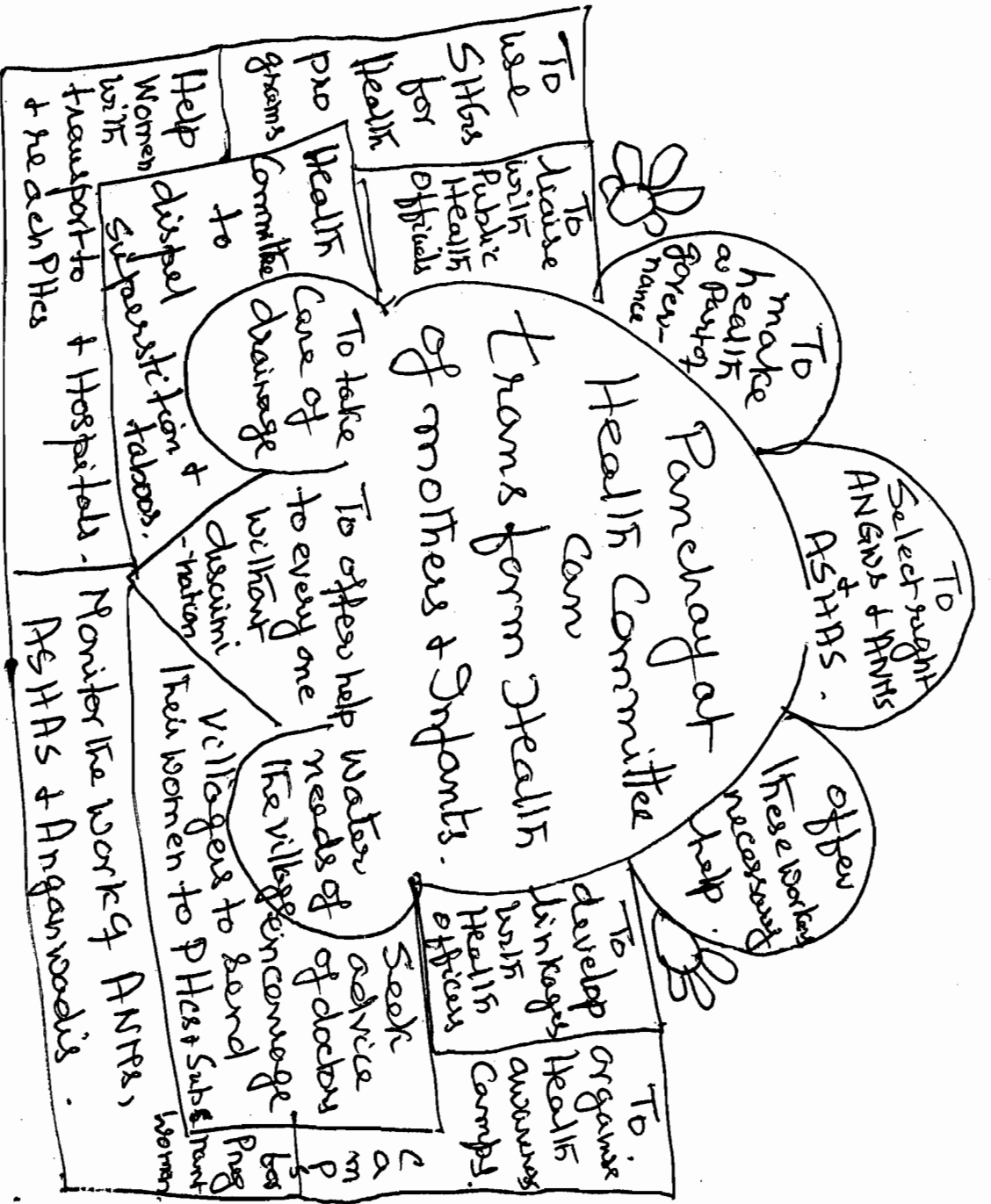
They can
convince
them on
benefits
of them

of few
their space
and
guidance

Help
ASHAs
to
be
active

They
can persuade
mothers for
immunization
or vaccination
for their children.

To
advise
adolescents



Ignorance and Isolation of Women.

Rt to question traditional & negative practices.

Rt to information and aware herself of best child care practices & women friendly approaches.

Also girl discriminated in her food and nurture

Her desire to attend school is thwarted

Rt to break away from traditional + ignorant

Put to work at work from nascent age.

She is deprived of freedom

Rt to exercise knowledge of education against custom depriving her dignity

Rt to see life

Rt to freedom of movement and friends

Rt to demand equal wages for equal work.

Rt to challenge negative practice during pregnancy & after delivery &

Rt against physical & moral exploitation & abuse.

Rt against neglect.

Has a rt to break up her household in the household and community

Rt to legal protection economic provisions.

RT to life with dignity and provision of equal rights to men & women under the Constitution are not honoured at all.

In the name of tradition & values women are subjugated & kept away from protective policies & legislative legislation.

Her immature body-mat. assaulted w/ baby who is shunted around is vulnerable to Revised young girl she neither stands inter-relationships, not sex, not conception - child care.

She has no economic rights in the family not can she demand.

She is at the mercy of p-p-in-law & husband. She is ridiculed and battered by hissing wife down.

She suffers due to delays in speaking doctors - friends or even or with the baby.

She unmarried becomes a source of family opposition & community norms. She is left out of no freedom of choice or decision making.

Woman isolated from protection of natal case and laws.

She can not demand best medical care. She suffers in silence or is subjected to spiritual & tambrics.

She has to bear the burden of reproductive health care - she has to bear the burden of reproductive health care - she has to bear the burden of reproductive health care.

protective laws against marriage

laws & provisions against infanticide & homicide are dishonored in community.

She has no freedom of movement - her husband is needed to seek permission to seek in emergency even in hospital.

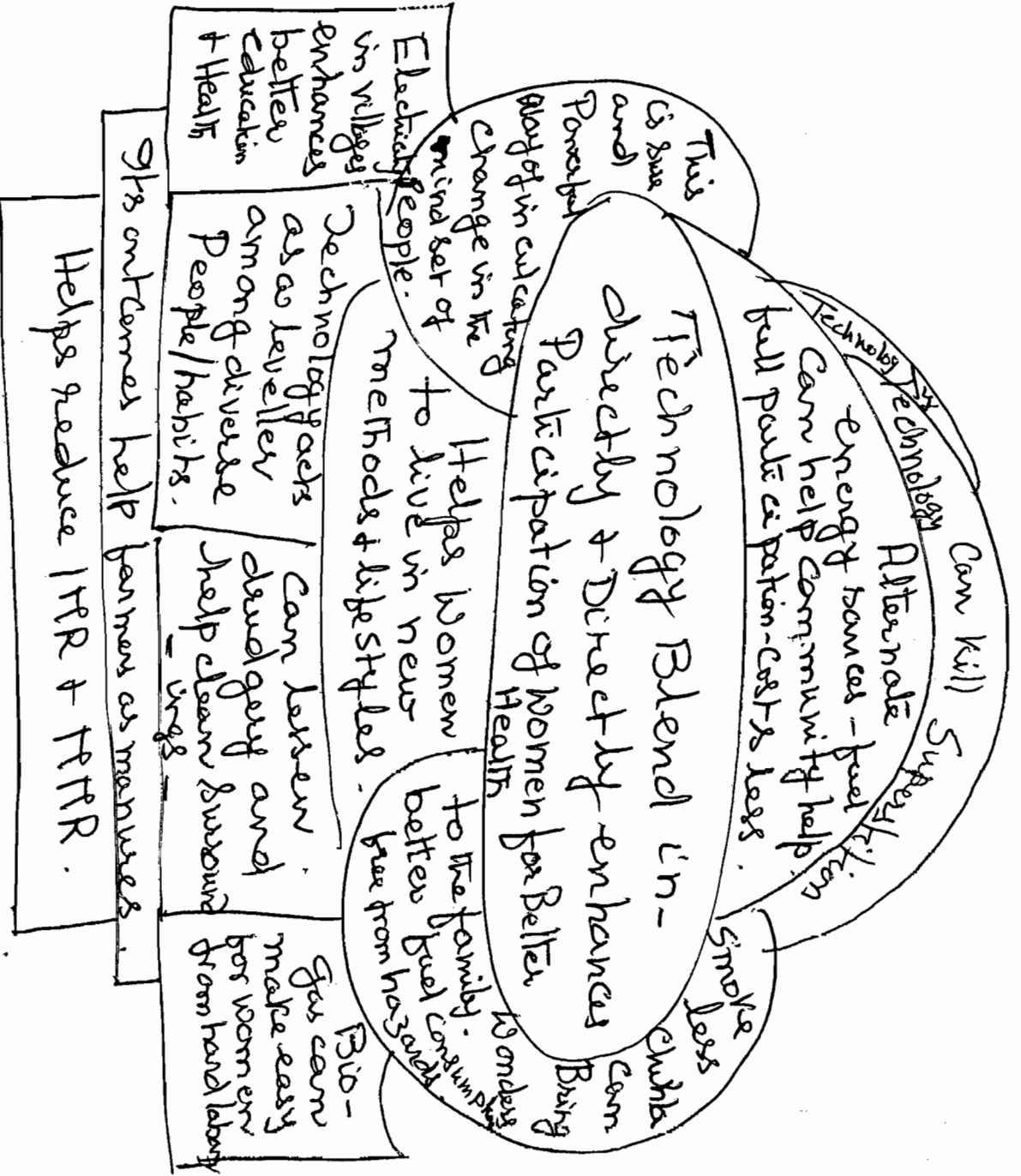
Even to visit a friend in the home she has to go as if she is not a person.

MTP is available in hospitals - But she is sent to a private hospital to abort. She is forced to abort in a private hospital. She is forced to abort in a private hospital.

Protecting Parents & girls from dowry demands are ignored and not involved.

Relations & children are suffering due to dowry demands. Women are suffering due to dowry demands.

All



Electricals in villages enhances better Education & Health

Technology acts as a leveler among diverse People/habits.

It's outcomes help farmers as manures.

Helps reduce IRR & TIRR.

Helps Women to live in new methods & lifestyles.

Helps to the family - better fuel consumption free from hassles.

Can Kill
Alternate Energy sources - fuel efficiency
Can help community help full participation - cost & loss.

Simple Less

Bid -
Gas can make easy for women from hand labor

BIBLIOGRAPHY

LITERATURE CONSULTED

1. Improving Women's Health in India (World Bank Publication) (Series Development in Practice-Washington DC-1996).
2. Pre-birth elimination of females. (A handbook of guidelines - centre for Women's Development Studies.
3. Report No.3 of 2004 (office of the Registrar General, India, Man Singh Road, New Delhi).
4. (World Bank) Indian Women - Their Health and Economic Productivity Meera Chatterjee (WDP-109).
5. Medical Certification of Cause of Death - 1998 (office of the Registrar General - India - Ministry of Home Affairs - New Delhi.
6. National Rural Health Mission (2005-2012) Mission Document.
7. Ministry of Health and Family Welfare NRHM (Action Points).
8. Child Mortality in Rural India (Bas Van der Klaavw - Limin Wang - April 2004).
9. Annual Report (1982-83) Ministry of Health and Family Welfare, New Delhi.
10. Annual Report (1993-1994) Ministry of Health and Family Welfare, Govt. of India.
11. Perinatal & new Born Care in Pakistan (extracts). Early Child Health and Survival in Pakistan.
12. Reduction of Infant Mortality and Trends in infant mortality.
13. National Library of Medicine - Impact of Development and Population Policies on Fertility in India. Jain A.K.
14. World Health Organisation (Regional Office for South East Asia (Maternal, new born and Child Health situation in India).
15. Reproductive and Child Health Project (May 27, 2005) (Document of the World Bank).

16. Age specific Death Rates in India - 1988.
17. The second integrated child development Services Project.
18. Child labour, nutrition and Education in Rural India (Alessandro Cigno Furio Camillo Rosati, Zafiris Tzannatos).
19. Diet & Nutrition - a holistic approach - Rudolph Ballentine, M.D.
20. Reaching out to the Child (South Asia Education Sector Working Paper No.1).
21. "Derlpt" essential to reduce infant mortality rate in India - experience from Ballabgarh Project.
22. Infant and Child Mortality in India. A comparative study in 3 selected States. (Sangha nitro Panda (25th April 2005) (Guide Prof. Subrata Lahiri).
23. India: Issues in Women's Health. Jan 25, 1996 - (South Asia Country Department II).
24. Sample Registration System - SRS Bulletin. (Estimated infant Mortality rate - 1998 (Provisional) 1998.
25. April 1999 SRS Bulletin.
26. SRS Bulletin 2000/October 2000.
27. SRS Bulletin 2001.
28. SRS Bulletin 2002 October
29. SRS Bulletin 2003.
30. SRS Bulletin - April 2004
31. SRS Bulletin April 2005
32. SRS Bulletin April 2006
33. NIAHRD study of social factors contributing to Maternal Mortality - Orissa State Report.
34. Poverty, class and Health Culture in India Debabar Banerji - Prachi Prakashan, New Delhi.

35. Transnatural Curing Page (236). David G. Mandelbaum.
36. Folk medicine in a North Indian Village R.S. Khare (266-285).
37. A north Indian Healer and the sources of his Power - Edward O. Henry. (286-307).
38. Traditional Health Practices of Kumaoni Women. Continuity and change Anjali Capila, Reader Lady Irwin College, University of Delhi 2004 (Concept Publishing Co. New Delhi-110059).
39. Infant Mortality in India ed. by Anirudh K. Jain & Pravin Visaria (Gujarat Institute of Area Planning, Ahmedabad).
40. Level trends and Determinants of Infant Mortality in Rural INdia - Seela Visaria.
41. Impact of RUHA's Health and Development Program on Infant mortality - Rajaratnam Abel.
42. Community based studies on Infant mortality in Haryana, Vijay Kumar and Neena Dutta.
43. Correlates of Infant Survival according to Cohort Study in Vadu Rural Health Project V.N. Rao & Banoo Coyaji.
44. Evidence from selected states Infant Mortality in Uttar Pradesh M.E. Khan.
45. Correlates of Infant Mortality in Madurai Dt. of Tamil Nadu, S. Gunasekaran.
46. Correlates of Infant Mortality in Rural Area of Tamil Nadu, C. Ramanujam.
47. Infant Mortality - an analysis of Recent Births in Gujarat - M.M. Gandotra and Narayan Das.
48. Factors associated with Infant Mortality in Rajasthan and Orissa - Tara Kanitkar and B.N. Murthy.
49. Infant Mortality - some evidence from Rural Madhya Pradesh.

50. Same Issues in the Selection and Assessment of the Determinants of Infant Mortality, K. Srinivasan.
51. A framework for the Study of Proximate Determinants of Infant Mortality in less Developed Countries: Moninag.
52. World Development Indicators - 2000.
53. Choose the Sex of Your Child, Dr. Inderjit Kaur Barthakur.
54. The endangered Sex - Barbara D. Miller.
55. The Wrongs of Indian Woman hood Mrs. Marcus B. Fuller, Oliphant Andersan & Ferrier 1900.
56. Health and Disease. An epidemoological Background, Kingsley Davis - World Urbanism (1950-1970).
57. Effect of gender of Head of Household on Women's and Children's nutritional status, Eileen Kennedy, Pauline Peters and Lawrence Haddad.
58. Number of Recognised Training Centres for different courses - 1990.
59. India the next 7000 Days - Dr. Satish C. Seth (Wiley Eastern 1985).
60. From Shadows to self India Women's Watch NGO Country Report Beijing + 10 Review (2005).
61. UGC Workshop on Capacity Building for Women Managers in Higher Education - Centre for Women's Studies and Development, BHU.
62. Task force on Women empowerment, Govt. of Karnataka (2001).
63. The Paradigm of Contradiction. The eclipsed Woman in Theories of (2002) BHU. Democracy - Centre for Women's Studies and Development.
64. Looking at Woman : Reevaluation of some of the ancient Indian texts - Chandrakala Padia BHU Centre for Women's Studies and Development.
65. Globalisation, Politics and Women U. Kalpagam, BHU Centre for Women's Studies and Development, 2003.

66. Reaching out to the Child An-integrated approach to Child Development - The World Bank (Human Development Sector South Asia Region - Sept. 2004).
67. Mapping India's Children - Unicef in action 2004-2005.
68. The Social Science Encyclopedia Edited by Adam Kuper and Jessica Kuper - Rontledge & Kegan Paul (London, Boston & Henley).
69. Superstition, Human Rights and Imperatives of future (ITISC 2004).
70. Five year plans - Three volumes (2002-2007) Vol. I, Vol. II and Vol. III.
71. Midterm appraisal of the Tenth Five Year Plan.
72. Sacred Rites and Ceremonies (Encyclopedia Britannica - Vol: 26 Pages 770-839).
73. Seventh Women's Global leadership Institute - Challenges of the New Millennium June 7-18, 1999.
74. We need a War against female foeticide - Dr. Sharda Jain President East Delhi Gynecologist forum.
75. Managing Development for Future - A Study in Transition - Satish C. Seth (Gyan 2001) Vol. I & II.
76. 10th Plan strategies for children.
77. India's five year Plans complete documents (1951-56 to 2002-2007 (Mid term appraisal) June 28, 2005 (Academic Foundation) New Delhi (Jain Book Agency).
78. Indian Ritual and Belief - The Keys of Power J. Abbott B.A. (Oxon) 1932, ICS (Usha Publications 1984, Daryaganj, Delhi.
79. Faiths, Fares and Festivals of India C.H. Buck - (398-38 IIC), Rupa Hoj.
80. Attitude assessment of male adolescents in Ratanpur and Laxmipur Blocks of Maharajganj district of Uttar Pradesh.
81. Maternal Death Investigations Purulia, West Bengal - 2005.
82. Sample Registration System - Maternal Mortality in India - 1997-2003, Trends, Causes and Risk factors.

83. Journal of Women's Health (An analysis of the Determinants of Maternal Mortality in Sub-Saharan Africa) Oct. 2004.
84. Challenges to Women's Reproductive Health - maternal mortality - Zoe Oxaal with Sally Baden (Sept. 1996 - revised Oct'. 1996).
85. Determinants of Maternal Care in a Region of South India - Jagdish C. Bhatia and John Cleland (Instt. of Management - Bangalore - Prof. of Medical Demography, Centre for Population Studies London School of Hygiene and Tropical Medicine, London, U.K.
86. Background paper to review current socio-economic factors affecting maternal mortality - Soc. Development Department - Overseas Development Administration UK. Zoe Oxaal & Veroniq Filippi.
87. Immediate and proximate causes of Maternal Mortality (Samce Maine 1992/Royston 89).
88. An analytical model of Maternal Mortality (Maine & McCarthy - Tinker & Koblinsky) 1993.
89. Statistical problems associated with the measurement of maternal mortality.
90. Relationship between socio-demographic factors and child survival: Evidences From Goa - India. T.S. Syamala, Instt. for Social & Economic Change - Nagarbhavl Bangalore.
91. Demographic study of Gujjars of Delhi-VI factors affecting fertility, Infant Mortality and use of BCM, Sweta Dabral - & S.L. Malik - Department of Anthropology (Univ. of Delhi - Delhi-7, India).
92. Development is not essential to reduce infant mortality rate in India - experience from the Ballabgarh Project, J. Epidemiol, Community Health 2000-54i, 247-253.
93. Millennium Development goals - 4 & 5 indicators (MDG). (Improving maternal, New Born & Child Health in the South East Asia Region.
94. Harvard Centre for Population and Development Studies, neonatal mortality in India - emerging Paradoxes - K.S. James - Ian Aitken, S.V. Subramanian (HCPDS - Working Paper Series Vol. 10 Number 13) Nov. 2000 K.S. James - Centre for Eco & Soc. Studies Nizamiah Observatory Campus, Begumpet, Hyderabad-500016/040-3312789, 3326808

95. The Australian National University Demography Program - Research School of Social Sciences. Determinants of Infant Mortality in a Backward Region of North India - Are Socio-eco. or Demography factors Damihant? Santosh Jatrana (Working papers in Demography No: 82-1999).
96. Infant mortality in a Backward region of North India. Does Ethnicity matter? Santosh Jakrana, Asian Meta Centre for Population and sustainable Development analysis, Hd. Qrts. at Asia Research Instt - National University of Singapore.
97. Reducing Child Mortality in India in the New Millennium Mariam Claeson, Eduard R. Bos, Tazim Mawji, and Indra Pathmanathan (World Bank Washington D.C. USA).
98. Ministry of Health and Family Welfare Govt. of India - Annual Report 2005-2006.
99. Compendium of Research Projects in RCH (Min. of Health Family Welfare, Govt. of India.)
100. National Rural Health Mission - Mission Document Min. of Health & Family Welfare - Govt. of India.
101. Janani Suraksha Yojana (Karyan Vayan Keliye Margadarshi Sidhant).
102. National Family Health Survey (1992-1993)
 - (i) Maharashtra (MCH & Family Planning, Gokhale Instt. of Pll. & Eco. Pune and International Instt. of Pop-sciences - Bombay Nov. 1994.
 - (ii) Haryana - NFHS. (1993).
 - (iii) Rajasthan - 1998-99. International Instt. of Population Sciences - Mumbai.
 - (iv) Andhra Pradesh.
 - (v) Tamil nadu
103. 11th Five year Plan approach Paper. Infant mortality rate in 1990 (2003) 80. Recent years 60. Best State 11 per 1000 livebirths Worst State in recent years 83, material mortality (Per 1000 livebirths) 4 (recent).
104. Search for a Vision Statement on Women Empowerment Vis-a-vis Legislation and Judicial Decisions. Sponsored by the National Commission for Women (Prepared by the Indian Trust for Innovation & Social Change. (ed: Padma Seth, 2004).

QUESTIONNAIRE

Socio-economic determinants of IMR (Infant Mortality and Maternal Mortality)

Infant Mortality and maternal mortality have not been eliminated in India

Reasons: Can be Medical system, infrastructure, lack of information, awareness, lack of Reproductive rights-no choice, no autonomy for women, poverty, illiteracy, faith in customary practices and beliefs superstition

Questionnaire:

WHAT ARE THE SOCIO-CULTURAL REASONS FOR INFANT AND CHILD MORTALITY AND MATERNAL MORTALITY.

I. Questionnaires

1. General information of the State/District/Tehsil/Block/Panchayat/Village.
2. Geography/Population/Sex-ratio (Male-Female)
3. How many PH centres/CHC (male-female)/Sub-centres are there.
4. How many VNMs are there.
5. Are there doctors posted in the PHC or health centre?
6. Are Pregnant women registered by the nurse and Counselling on ante-natal & Post natal Care?

II. Status of the Head of the family/or husband

- (a) Name-address etc. Employment.
- (b) Is the mother employed?
- (c) How many Children born - Survived?
- (d) What are the reasons are there infant deaths in the family?
- (e) How many maternal deaths in the Village?
- (f) Are deliveries conducted by untrained/traditional Dais?
- (g) Status of hygiene/environment?/delivery palce.

This annexure records quasi-empirical and quasi oral history sampling (as recorded on the spot. In the villages visited) hardly 8 or 10 gave articulate response out of 40 women.

In so far as Tamilnadu is concerned its official actions and policies are so positive that we have liberally recommended about the same in the main report.