

HEALTH AND NUTRITIONAL STATUS OF RURAL WOMEN - A COMPARATIVE STUDY OF ICDS AND NON-ICDS AREAS OF CHITTOOR DISTRICT (A.P)**

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"To awaken the people it is the woman who must be awakened. Once she is on the move the family moves, the village moves and the Nation moves".

Jawaharlal Nehru

Indian society accords the highest status to women and Indians are worshippers of "Shakti", the 'Universal Mother'. But women are yet to make progress to keep pace with their men counter-parts. Manu says "where women are honoured the gods dwell". This has been upheld for centuries as a part of social life and thinking. Women played important roles even in the formation of social policies and code of conduct.

Since the introduction of the planning era, general as well as special programmes have been taken up for the welfare of women and also to cater to their special requirements. The different Five Year Plans have consistently placed special emphasis providing welfare services for women in need, various welfare and development programmes have been initiated to ameliorate the living conditions of women and to increase their access to, and control over marital and social resources.

It is now well accepted that to understand the health status of women, health and health care systems must be viewed beyond the medical frame work.

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The neglect of Women's health is clearly linked with the lower status that has been accorded to Women in Indian Society. Malnutrition aggravates diseases and reduces resistance to various diseases yet, ironically women do not consider. More so, women have been the major targets of family planning programmes. It is unfortunate that Women's health issues have not emerged as a major focus of activity within women's movement. In India, higher mortality of women is a reflection of the role and status of women within the family and society at large. Low status in society leads to discriminatory feeding and health care for young girls and some times to overt infanticide. It also affects women's access to health information and other family resources such as food, education and Medicare, which showed through medical diagnosis that the maternal deaths were due to obstetric causes. Postmortem investigations reveal that women suffered from several health problems and pregnancy was only a precipitating cause (Seth etal 1985).

It is therefore urged that health and nutrition education may go a long way to raise the health and nutrition status of women especially rural women. Health education is a process that forms, motivates and helps people to adopt healthy practices and life-styles, advocates environmental changes and conducts training and research to the same end. The nutritional education aims at to create awareness about nutritional problems and dietary needs of pregnant women, nursing mothers, infants and adults performing different chores. Health and nutritional messages should be delivered through inter-personal communication methods synchronized with mass media approach and the programmes should be evaluated by measuring changes in knowledge, attitudes and practices, improvement in health and nutritional changes. The ICDS (Integrated Child Development Services Scheme) scheme today represents a major endeavor on the part of the Government of India in improving the nutritional and health status of vulnerable sections and forms the key elements of the human resources development strategy.

Objectives of the Study:

- To understand the traditional role and status of women
- To assess the sex-based division of labour in the families of rural women.
- To study the part played by rural women in the decision-making process in the family
- To examine the role of women in the family power structure.
- To assess the educational status of rural women
- To examine the economic status of rural women
- To study the health and nutritional status of rural women
- To analyse the attitudes and values of rural women.

Methodology:

In the development map of India, ICDS occupies an important place and can be seen as a significant activity on improving the status and empowerment of women. Keeping in view the growing trend of women in ICDS activity in Chittoor district which factor weighed largely with the researcher's mind specially in the matter of selection of the universe it was ultimately decided that the area of the research to be confined to Kalahasthi ICDS project. Having formulated the specific objectives of the study, the researcher preferred to adopt random sampling with the total number of 300 respondents. (150 from ICDS and 150 from non-ICDS areas) The information was collected from both the primary and secondary sources. The primary data was undertaken through interview schedule. The findings were given below:

Results and Discussions:

Feeding Pattern: Time of Dining:

Women's socio-economic status and her status in the family affect their own health and the health of the children. Low status in the society usually leads to discriminatory feeding patterns and health care for young girls. Women

have less access to health education and information. In India generally entire rural families never sits down together to enjoy a meal at the same time. Women are expected to cook and serve men first. Women and girls are usually last to eat, by which time many of the food items may run out.

The study amply shows that 94.7% in ICDS areas and 88.7% in non-ICDS areas were following the above pattern. A negligible percentage only sit and eat with male members of the family.

Spacing between children:

Age at marriage and spacing between pregnancies are very important factors that reflect the status of women. The study shows that a sizeable majority were married at a very early age. The data reflects that in all, they usually had their first child in about two years of their marriage. The mean spacing between the first child and the second child is almost the same as that between marriage and first child. Many women continue to have third child also in about two years after the second child. Over half of the respondents had a fourth child also within two years of the third child.

Care taken during pregnancy and lactation period:

The cause of deaths of the infants is mainly due to the poor health of the mothers, their low nutrition level and inadequate antenatal care. Malnutrition, under nutrition, repeated pregnancies, delaying medical treatment, overwork – all take their toll. The data shows that (37% in ICDS areas and 73% in non-ICDS areas) did not undergo any medical checkups during pregnancy because they did not realise its importance. Even though ICDS was introduced in 1975, the health status of children and pregnant and lactating mothers leaves lot to be desired. Health check up and immunization are some of the services in ICDS program, but only two-thirds of them availed it. About (39% in ICDS and 76% in non-ICDS areas) did not have any immunization during pregnancy. This is mainly because of the lack of awareness and non-availability of health personnel at the village level. Further, (43% in ICDS and 81% in non-ICDS areas) did not give first milk after the delivery ie cholestrum to the baby due to lack of awareness and

superstition. About (19% in ICDS and 41% in non-ICDS) areas had not immunized the children even though universal immunization program was in vogue since 1985. However, a small percentage (5%) of respondents monitored their children's growth in non-ICDS areas.

Place of delivery:

The data shows that 35% in ICDS and 24% in non-ICDS areas had their deliveries in hospitals at the parent's village. About 19% in ICDS and 10% in non-ICDS areas delivered at their husband's house. The aggregate analysis shows that in more than half the sample deliveries took place in parent's house only.

Delivery Attendant:

Health personnel usually give training to selected women in the villages to conduct deliveries. They are called Trained dai. The persons who have not undergone this training but conduct delivery are called untrained dai. Even though the trained dais are available in the village level, 46% of the sample in non-ICDS areas got the delivery done by untrained dais only.

Number of Abortions:

While the practice of infanticide was banned in 1870, modern science has provided society with tools to pre-empt it. A technique to identify genetic abnormalities at the pre-natal stage, amniocentesis, also discloses the sex of the fetus. However in India, amniocentesis has become almost synonymous with sex determination testing.

On the recommendations of the Shantilal committee, the Medical termination of pregnancy (MTP) Act was enacted in 1972. It liberalized the earlier grounds for abortion. The MTP Act was enacted for health and family reason and for raising the status of women (Lotika Sanikar, 1982). Consequently MTP services are made available free of cost to the needy even in primary Health Centres. This is to reduce the incidence of illegal abortions, which are very dangerous for the life of women.

The study tacitly reveals that about (65% of both ICDS and non-ICDS areas) had abortion once; 23% twice; and a meager percentage of (12%) had abortion thrice. The mean number of abortions in ICDS areas is 0.5 where as in non-ICDS areas it is 0.6.

Period of Breast feeding:

Studies conducted by Levinson (1974), MC Neil (1986) show that male babies were breastfed for longer period than female ones. The cultural factor that affected the duration of breast-feeding was the desire for male children rather than female ones. A field study in a village of western Uttar Pradesh found indication of indirect discrimination against baby girls in breast-feeding. In the distribution of more nutrition food like milk, butter and eggs, male babies were shown preference.

Our study accordingly shows that an average of 76.4% (i.e 73.4% in ICDS and 85.3% in non-ICDS areas) breast-fed the babies as long as the milk secretion lasts. Most of the respondents said that if the child is female they stopped breast-feeding till the next delivery or till the time milk secretion lasts. About 21% in ICDS and 15% in non-ICDS areas stopped breast-feeding before the baby completed one year because some of them were not having milk; some of them deliberately stopped the breast-feeding because of improper awareness. They felt that long periods of breast-feeding result in losing physique of the mother.

Common ailments of children:

Health status of children is reflected in infant mortality rate, child morbidity rate and incidence of morbidity, which may again depend on sex differences and rural-urban residence. In spite of an elaborate network of services, preventable diseases like gastro-enteritis and malaria have peak incidence during summer and rainy season. The expanded program of immunization has been making an attempt preventing diseases like anemia, diphtheria, tetanus, polio, typhoid, measles, small pox and the like Diarrhoeal disorders are often fatal among children (Cohen, 1987; Levinson 1974).

The data under study clearly shows that (39% families in ICDS and 6 percent in non-ICDS families) the children rarely suffered from diseases mainly in upper class families, 26% in ICDS and 35% in non-ICDS areas, the children frequently suffered from diseases mainly in lower castes in SC and STs. 21 percent in ICDS and 10% in non-ICDS areas sometimes suffered from diseases. Evidently, the frequency of diseases in ICDS areas is considerably less when compared to non-ICDS areas. The respondents felt that though they had health facilities, the health personnel were not available in time. If health personnel were to be readily available and educate the people it may go a long way in reducing the incidence of these diseases in these areas also.

Current contraceptive users

The success in family planning may be the first condition if women in our country have to attain full stature and status. The family planning movement should thus, primarily for the women, of the women and by the women. Family limitation, which controls the natural fertility of women, reflects the status enjoyed by them. Many of the rural women resort to sterilization after having had enough children. Even here discrimination is quite evident as tubectomy is thrust on women even though vasectomy is simple and easy. 44 percent of families had undergone tubectomy compared to 3 percent vasectomies as the study clearly indicates. About half the entire sample was not adopting any method of birth control for want of male children. A small percentage (4% on the whole) were following temporary methods of family planning such as Intra Uterine devices (IUD).

Reasons for not following family planning methods:

To a woman, family planning means not only a means, a solution of population problems for the nation, but also a much needed solution for the basic freedom to decide upon the number and spacing of children, she will remain in capable of availing herself of other types of freedom in society intended. Though this idea has permitted in all societies all over the world, still a greater number of women are not yet free to exercise the right to plan

their lives and their families because of their subsidiary position within their respective societies. They have to fight against the out-moded social traditions to achieve this basic freedom.

The study vividly presents that on an aggregate 23% of the respondents were not adopting any family planning methods owing to non-cooperation of their husbands; and 32% of the non-users had a strong desire for a male child. About 34% were not following any method because some of them were newly married couples and some not having children. Most of the non-users expressed their anguish with regard to possible side effects – eg: reaction to oral pills, pain and heavy bleeding owing to IUD etc. are the commonest complaints. Some of the women who went to tubectomy report to suffer from post-operative complication. They honestly felt that the health personnel were not doing proper follow-up and they were only concentrating on doing more and more sterilization (female) as it would help them to reach their targets and earn cash rewards.

The health and nutritional statuses are the major areas of the study where the disparity between the ICDS and non-ICDS areas were apparently pronounced.

Conclusion

In the ultimate analysis, it may be said that the respondents voiced forth that ICDS activity not only assured them empowerment but also infused self confidence and independence in abundant measure. This is significantly an eulogizing feature of the study. To achieve overall empowerment there should be a holistic approach in bringing attitudinal change to women in society at large.

Recommendations

Illiteracy, lack of knowledge and awareness, gender bias, societal values is the major stumbling blocks coming in the way of the status of women. ICDS is a good means of women's empowerment provided the following support services are augmented.

- Community based women workers can be effective and viable instruments of human resourced development, if these workers are supported with training guidance and the necessary material inputs.
- An integrated approach including a package of mutually supportive services is most cost and efficient than individual services delivered separately.
- Community ownership is fundamental to improve programme quality, impact and sustenance.
- The ICDS type of network makes it feasible to apply new, simple technology on a large scale.
- The flow of human and material inputs has to be planned and monitored carefully, with community participation.
- Collaboration of academic/research institutions is very useful in providing low cost objective feed back on the programme and continuing education to workers. The educational process in academic institutions is also enriched with the field experience of the programme.
- Field experience needs to be continuously reviewed and utilized for strengthening training.
- Need for continuous enrichment of training and development of standardized training modules with focus on core items.

Integrated Child Development Services Scheme (ICDS) has thus witnessed a universal coverage that is unprecedented and aims to reach every disadvantaged child and family in the new millennium – which has the potential of bringing about silent revolution – profound instrument of community and human resource development.

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