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Households, Kinship and Access to Reproductive Health Care among Rural Muslim Women in Jaipur

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Reproductive health [1] practices among Muslim women in India have been little researched perhaps because of the widespread notion regarding the tight Islamic control over sexual behaviour and the sanctions against contraceptive use. A study of the rural Nagori Sunni community in Jaipur districts[2]as described in this paper revealed that while it is generally true that Nagori men and women in Sanganer do not in principle entertain the idea of a control on conception, nevertheless at an individual level this study finds, they seek out health services for sterilisation is well as the medical termination of pregnancies. Most of their possibilities for seeking health care are not so much a function of general religious proscription as related to the organisation of Nagori household and kinship arrangements. The experiences of Nagori women in relation to the health care services were both similar to and different from other rural lower class and caste-women in the surrounding villages [3]. For most of these women, the decisions regarding the timing and physical and financial cost of health services sought are closely connected to work and production demands of the household, its assets and resources, the nature of health care services available and the perspectives of the causes of illness and perceived effectiveness of various cures sought.

Women carry more of the work burden of the household and therefore have less time to seek out health care services making them disadvantaged relative to men in their access and utilisation of health care services. Especially in their role as mother's women carry a grew health burden (as cares) as well as a greater health burden (as carers) as well as a greater reproductive burden than men in households. The recent gender inequity approach to health [Standing 1997] considers the gender skewed allocation of resources and power in the household as among the critical factors responsible for women's disadvantageous position within health care system. As feminist scholarship in the 1980's in anthropology and more recently in economics have shown, the household, far from being a 'natural' (biologically determined) unit of members with homogeneous interests, is in fact a site of Continuous negotiations, with decisions made through both consensus and conflict [Harris 1981] [Sen 1990] [Agarwal 1994]. As gender roles and relations within and between households vary from one material to another,

social and cultural and ideological context to another, decisions regarding matters of health Care, become at once both complex and challenging to understand.

A dominant issue to emerge from Nagori women's narratives of illness has been the negative experience of health care services related to the bearing, birthing and rearing of children. Recent studies have also shown that despite the vast network of health care provisioning in India, the outreach continues to be poor, especially for women [Jejeebhoy 1997] [Gittelsohn et al 1994] [Pachauri 1994] [Visaria and Ramchandran 1997]. The focus on women in health delivery Programmes has mainly been, with regard to reproduction with an emphasis on the control of fertility. At least until 1994 [4] reproduction has been narrowly defined by the characteristics considered demographically important see [Greenhalgh 1995]for a powerful critique on demographic approaches to fertility. Few studies on health delivery in India have moved beyond an orientation towards demographic statistics to actively engage with questions of gender, culture and power (the documentation to emerge from NGO activity in the area of health is, however, an important exception) [5]

This paper situates reproductive health care in the context of women's and experiences of illness in general, as well as in terms of the material idealogical and political dynamics of households, kin and gender relations. It focuses on menstruation and childbirth and local perceptions of the body, reproduction and ill-health. It describes the material ideological factors linked to the households, which facilitate Nagori women's use of health care services. The important role of kinship relationships in relation of health care financing is discussed. The conclusion considers which kinds of women in the household and community, are best positioned to play an active role in facilitating women's use of the health facilities provided.

I. Menstruation and Childbirth: Health Needs and Health Care Provisions

For most of the Nagori women in the study menarche commenced when they were between 15 to 18 years old and they had their first child when they were between 17 to 20 Years. On average, these women married when they were between 2 to 13 years, with the 'gauna' (or consummation) for those who were married below 9 to 10 years, taking place approximately three to four months to one year after menarche. Thus like other rural women in the area - meena, khateek. Raigar, rajput, brahmin for example - rural Muslim women are initiated into childbirth at a very young age and quite soon after their first menstrual period. Most of the women in their 30s had also been married in accordance with the local Rajasthani - custom when they were children with the consummation or gauna taking place after menarche.

Most of the reproductive problems of rural women in this area of Jaipur district were related to menstruation and white vaginal discharge. Information based on eight months observations of the patients at a voluntary health centre in the area indicates the menstrual disorders (mahawari/maheena ki pareshani) to be of four conditions: menorrhagia (excessive bleeding), dysmenorrhea (painful bleeding), amenorrhea (absence of bleeding), polymenorrhea (irregular bleeding), with the first and fourth being most common and hardly any instances where medicine is sought for painful bleeding [6]. Leucorrhoea or white vaginal discharge ('safed pani') usually refers to excessive discharge, leading to heavy soiling of clothes causing discomfort and accompanied by a bad smell. Other related problem were to do with conditions of pelvic inflammatory diseases referring to the infection of the fallopian tubes, ovaries and uterus including the cervix (often encompassed in the use of the local terms 'ghav', meaning wound or 'ganth' meaning lump in the 'nalli' or tubes and 'bachchadani' or uterus); prolapse of the uterus, cystocele (bladder prolapse), and rectocele (ractum prolapse) through the vagina, all referred to as 'shareer nikalna' by the women; anaemia and nutritional deficiency (indicated by the general term 'Kamzori', or weakness) with most of the women having a haemoglobin level of 8-10 grams per cent (under 8 gm per cent indicates sevre anaemia, over 12 indicates a good haemoglobin count) other such as a few cases of primary sterility (approximately five women in 2,000 who come to the health centre), few with suspected cervical cancer and a few relatively minor cases of breast abscess and mastitis.

While a few cases of maternal mortality came to the notice of the health centre, there was a high, incidence of maternal morbidity. This ties in with various statistics on women's health which show a high occurrence, of maternal morbidity and disease of women in their reproductive life span with a high correlation between poverty and maternal and infant mortality. [7]

As is well known infant mortality is crucially connected to maternal health. High infant mortality figures are recorded in Rajasthan in general. There was a very high figures of foetal and infant mortality across communities in the area with the highest number of children dying below one year. Twenty three of 48 Muslim women reported 43 infant deaths (25 girls, 18 boys). Twenty five deaths (58 per cent) were among children under the age of five with 21 of these deaths (84 per cent) occurring under the age of one year. There was an equally high incidence of foetal death (bachchadani mein bachcha kharab hona). Of 48 Muslim women 19 (40 per cent) reported one to three miscarriages ('safai' or 'grina') of foetuses between two to six months. The most common cited reasons for foetal and infant mortality alike were 'oonpar ki bimari' literally 'an illness of top', caused by an ill wind and tetanus. [8]

As women articulate their health problems in very general terms, it is important to consider women's reproductive health in the context of their wider complaints of illness. Nagori and indeed other caste women used descriptive terms such as 'dard/dukhana' (pain), 'kumzori' weakness) or 'pareshani' (discomfort) to convey their sense of ill-being. The most frequent general complaints of women, in order of highest occurrence are: (i) pain in the upper abdomen (epigastrium) related to hyperactivity, with nearly four to five out of every 10 women having this complaint. This problems is related to dietary habits and the fact that most women drink only a cup of tea till their midday meal; (ii) dizziness ('chukker) along with loss of appetite ('khana hajam nahi hota'), related to weakness and malnutrition; (iii) chronic cough (Khasi) a common ailment, which they share with men, (iv) fevers ('bukhar') and body aches (especially peeth mein dard / kamar dard'), the latter affecting older women more frequently; and (v) other, such as headaches and visual disturbances, seasonal diarrhoea, fungal skin infections and viral fevers. The use of more general words relating to pain, discomfort and weakness rather than specific disease related terms also points to the fact that women perceive their illness as related to causes lying outside the purely physiological domain. Often illness especially to do with fevers and sudden death or in cases when allopathic medicines are ineffective ('dawai nahi lagi'), is perceived to result from oonpar ki hawa' or an ill wind (related to jealousy and tense social relationships within the locality). Such references to the influence of soul and spirit upon a person's health indicates that in local (Muslim and Hindu caste) perceptions the health of the individual and the social body are connected [See Lock and Scheper-Hughes 1996] on three important notions of the body in medical anthropology, and on ethnomedical systems where illness cannot be situated in the mind or body alone precisely because no distinction is made between body, mind and self.

Almost 75 percent of the women I came across, resorted to spiritual healers for their ailments. Given the fact that the causes of poor health are regarded as lying as much in the social as physical domain, it makes cultural sense to also seek cures from healers other than from the medical profession. The high maternal morbidity among, rural Muslim and Hindu caste women was related to a combination of physiological, social, economic and psychological factors; wherein marital problems, the social consequences of aborted fertility, poverty and lack of nutrition, the inability to control infant mortality, the lack of information about diseases and effective recourse to cures were only some of the realities, which took their toll on women's lives. The government and formal private health services on offer are as yet ill-equipped to meet the health demands of this nature.

In Rajasthan as elsewhere in India, the provision of health care facilities from a development and macro-perspective lie on government's shoulder. It is the

government, which has the structure, albeit, a rambling one, to effect safe health practices among a wide and disparate population of health-seekers. In Jaipur district for the rural population, there are 17 primary health centres and family planning centres, 35 dispensaries and three hospitals. By contrast are 14 urban hospitals and 15 urban family planning centres. There are 15 mother and child welfare centres. Apart from alopathic services, there are 259 ayurvedic aushadhalay (dispensaries) and three ayurvedic hospitals [District Gazetteer 1987]. Each primary health centre has a number of sub-centres depending on the population with each sub-centre in Sanganer catering for between 2.500 to 5,000 persons which could include anywhere from two to 11 villages over a radius of one to eight km (personal communication, Sushma ANM).

Women in the Nagori village overwhelmingly tend to use the services of private, medical and traditional healers, rather than government institutions. This is not a surprising observation as [Bhat 1993]in his review of the private health care sector in India finds that both in terms of number of hospitals, dispensaries, clinics and number of physicians, the private sector far out-numbers the government sector. The small Muslim clinic in the smaller of the two Nagari populated villages is used for fevers, coughs, aches and pains but the doctor is not regular and the medicine is not effective. Apart from the private doctor in the village there are private clinics in three locations within a radius of 4-6 km. The first location, south-west of the Nagori village is in the railway town which has approximately 10 health centres (nine are private clinics which offer general services, of which one is ayurvedic and one is women-focused. The government also has a primary health centre here). Of these health facilities four including a government primary health centre have at least one doctor with the qualifications of MBBS or MD with four registered medical practitioners (RMP) [9]. One vaidya (ayurvedic qualification) and one 'doctor' with simply 'experience' (who has not passed his 10th class). Of the health services available within a radius of 1-6 km, none of the private doctors frequented by the Nagori Muslims offer reproductive health examinations or ante-natal check ups for women. Thus in seeking medical attention with regard to reproductive health related problems women have to traverse greater distances spending more on transportation costs and involving contact with fewer doctors who know their family contexts [10]

This may explain why women usually seek out reproductive health services only in very serious cases where infant or maternal life is at stake and not for what are regarded as routine matters of childbirth. [11]

For reproductive health services Nagori women go equally to private and government doctors but prefer to see government doctors in private where they are promised greater attention and care. They do try to have a good relationship

over a period of time with one or two doctors whose medicine is considered effective (jin ki dawai lagti hai'), irrespective of the cost of care and distance. Women travel from 8 to 20 km towards the city to seek out these private health services. There is usually a combined resort to allopathic, unani and spiritual remedies. The cures from appeasing afflicting spirits such as those of Sayyed Baba and Ramzani Baba who possess relatives or members of the community or even from men of the meena and bhangi caste who are possessed, are particularly effective for illness resulting from, 'oonpar Ki hawa' (literally wind from above or over the body). Usually these are illnesses, which have a sudden on-set such as fevers and may be accompanied by abnormal behaviour. There are also Hindu 'jhad phoonk wale' whose services are sought for ailments such as snake bites, body fever and aches and taken alone, with allopathic medicines. There are few 'jadi booti' or herbal home cures which are followed with any seriousness or in systematic way. Usually the jadi booti are those, prescribed and prepared by the unani doctors. When medicines are taken in such a combined fashion and the result is positive, i e, the patient gets better, the effectiveness ('phayda hona', 'dawai lagna') is seen to result from jhad phoonk rather than the allopathic medicine.

II Household Context of Health Needs: Work, Time, Food

The sexual division of household labour and further the division of labour among women of the household has implications for women's health at two levels. Firstly, in terms of the actual physical burden imposed by hard and continuous labour with little respite during weakness or illness. Secondly, the continuous daily demands made on women's time makes it very difficult for them to take 'time out.' To consult health specialists. This direct and indirect toll on women's health shifts with the development cycle of the household – being heaviest on newly married women, somewhat less burdensome when children become old enough to help (from seven to 10 years onwards) and signi9ficantly reduce with the arrival of daughters-in-law.

The desire of women to have children, daughters to help at home when they are young and sons to bring in their wives labour, works significantly towards achieving a reduction in their wives labour, works significantly towards achieving a reduction in their works burden. In this sense there is a conflation of the cultural notion of having more children (Where no active decisions may be taken) The cultural and economic factors are further modified according to the overall material situation of the household and the health of its members as I discuss below.

As other rural inhabitants in the area most of the married male residents of the Nagori village own small subsistence portions of land or have rights in crops

produced in the land of their kinsmen (brothers). On an average a household (conceptually members of one 'chullha' or hearth: although there may be more than one physical chulha) which has one main wage earner makes an earning of Rs 1,500 to Rs 2,000 - from outside wages (either from work with semi-precious stones or in the construction industry) and procures three quintals of wheat staple from within the village, which can last up to six months depending on the number of people who stay together ('shamil rahne wale'; of one chulha). I have found a maximum of two to three married brother who line together and one brother living separately, making for one separate household for every three joint households in the village. An average joint household would have a minimum of two to three goats and access to water for bathing, drinking, and washing cloths from a distance, of 0-1 Km

Women spend on an average between 10 to 15 minutes to half an hour in the early mornings sweeping inside and outside the house. This would include the collection of a couple of basket of animals. Following this, women spend half an hour to an hour filling approximately four to eight pots of water in the morning, a task which is repeated in the evening (each pot weights around eight to 10 Kg).

Women spend anywhere between one to two hours, preparing food and make eight-30 rotis for the day (the number varies according to the number of relatives, guests temporary, additional members of the household). Bathing small children and washing cloths take two hours to half a day but would be done once in two to days only. Washing dishes also takes half an hour to an hour twice a day. Then there is the work in the fields. Like all Muslim women Nagori women are proscribed from work 'outside' ('outside' I was told meant beyond the 'ilaka' or locality, which included the village as well as a certain portion of the surrounding area). Most middle and lower class Nagori women engage in some kind of agricultural activity, which is seasonaly determined. The heaviest of the agricultural work for women is the harvesting, of the wheat crop (including, jowar and gram) referred to as 'lavani' which takes place from mid March-April. There is another round of lavani of a smaller crop of bajra, moong, guarfali. cholai during October. Apart from lavani women also weed ('ninani'), water ('panat') and cut ('todna') the crop at other times of the Year. Men make bundles and sell the crop, which is not earmarked for household consumption. Women and men of the richer households who can afford to lease out their agricultural land do not work on their own fields. If the household is a poor one, i e, there is no steady income by an adult male member, then women also perform 'mazdoori' (wagelabour) or lavani for money (approxirnately Rs 40 to Rs 50 per day) on another Nagori or Pathan's fields in the village.

The division of household tasks works in favour of the age of women only if they have younger women to shoulder the heavier tasks (filling water pots, cooking,

cleaning, and cutting and weeding in the fields) or if the household is relatively well off. 'There are usually four categories of women who tend to live together, the mother-in-law ('sas'), younger sister-in-law ('devrani'), elder sister-in-law ('jethani'), and the husband's sister ('nanad') if she is unmarried. The task of preparing food, bringing water, cleaning utensils, sweeping and cleaning are, usually shared among the sisters-in-law. It is, common to find a rota of work anong the younger women so that when one cooks the other will sweep and fill the pots. There is no sharing in the raring of their respective children although occasionally small tasks such as dressing the children may be shared. The main work of the sas is to attend to the younger children nevertheless babies from six months upwards may be entrusted to the care of elder siblings (both boys and girls), while women complete domestic tasks and do errands or odd jobs in the village.

While some sas do indeed perform few household tasks, many because they live in joint households do a lot of household work especially when the younger women are sick or indisposed due to childbirth, both of which occur frequently. In fact most, younger women mentioned their mothers-in-law as co-workers rather than as shirking work.

One of the common work burden, related physical ailments which Nagori women suffer is of a prolapse of the uterus. Mehmuda, the Pathan 'dai' is 65 years. She has given birth to eight children. She said her uterus was protruding 1.5 inches at present but 25 years ago it projected about four inches outside her cervix. She said that when she was three months pregnant at the time of her third child she had lifted abundle of approximately 40 kg and immediately felt her uterus give way. At that time she consulted a private lady doctor in, the city who inserted a rubber ring but Mehrnuda discarded it as she felt uncomfortable "mein bechain ho gayi aur usko nikal ke phenk diya". Mehmuda also tried some herbal medicine (extract of the Bodjadi bush) but nothing worked and she just lived with it. In fact most women I talked to considered a prolapse of the uterus more as a condition to cope with and manage rather than treat. They also did not seek treatment due to 'sharam' (shame), the absence of knowledge about effective cures and the fear of termination of their fertility. While I was told that a lifting of heavy weights was not proper during pregnancy, yet all the women I saw in the last stages of their pregnancy both carried pots of water, bundles of weed and fodder as well as performed tasks such as lavani involving arduous labour in the fields. In reality women were careful with heavy weights for 10-30 days after childbirth. The number of days depending on (i) the presence of household help, (ii) the stage of the development cycle the household was in, especially the number of children to cook for and feed, and (iii) the seasonal work and food stocks of the household.

The weakness of mothers and infants is largely due to their under-nourishment and connected with little emphasis on the quantity and nature of the dietary intake of mothers during pregnancy and after childbirth. Nagori women ate no differently in quantity or type of food during their pregnancy compared to what they would eat under normal circumstances. This means they would have a cup of tea in the morning, approximately one to two rotis with one 'katori' (small bowl) of cooked vegetables or chutney or chilli; onions and one katori of buttermilk/dal or lentils at mid-day and the same at night. Most men were unaware that women needed any supplements to their food or even respite from work during their pregnancy. A few women mentioned that it was a good idea to eat 1/4 kg to 1 kg of 'khopre' (desiccated coconut), 0.5 kg urad lentils and up to 1.5 kg of sesame seed oil in the eighth month has these are chiknasi (lubricating) foods, which would help the foetus move easily with in the womb to ensure a smooth delivery. Almost all women reported having some special food after childbirth but the quantities were little and the duration was on an average up to 20 days after delivery [12]

Very few women mentioned the consumption of large amounts of fluid or eating greater quantities of food than in their regular diet. An important difference between food consumed following child-birth and regular food is that the former is freshly prepared each time (apart from the 'ladoo', see footnote above). As the new mother (jachha') is prohibited from touching the hearth and the water pots due to pollution ('gandagi - dirt) following childbirth (for a period of up to 40 days), she is dependant on other women to feed her. Either her mother-in-law looks after her or a 'sister-daughter' has to be called over. It is the availability of these other women, which determines the type, quantity and duration, a new mother gets fed. At the very least, I was told somebody looks after her for two to four days.

Thus it is not so much an equitable distribution of food in the household which is in question as the fact that women deny the food to themselves. This fact points to the important role of gender ideologies in the inequitable distribution of resources in the household and its implications for women and children's health. The notions of 'good' and 'bad' breast-milk are an, important example of the role of gender ideologies in determining access to nutrition or its denial. According to zahida there are women who can be differentiated according to the milk they produce and the evidence of this lies in the fatness of the baby relative to the mother. "Jab Mota bachcha aur dubli aurat hoti hai tho doodh acha/phulna hota hai. Jab patla bachcha aur moti aurat hai tho doodh katna hai." (Breast-milk is of good quality when the baby is fat and the mother thin and not in the opposite case). Such notions also pressurize women to be thin and consume less of food and especially fluids, so vital for milk production and general well-being. A generational factor could also be significant. Most older women claim to have

had enough breast-milk to raise all their infants. Zahida's mother for example, said she had plenty of breast-milk and fed her children exclusively on breast-milk.

Many of the older women also ascribe poverty to their inability to provide different it kinds of food (biscuit, milk) and therefore rely solely on breast-milk to feed the children.

Women themselves did not consider it important to change the type or quantity of foods during pregnancy or lactation. A number of women said they were incapable of ingesting much food under normal circumstances as well. This may very well be the case as in anaemic conditions, due to a reduced oxidation of the body, there tends to be a loss of appetite. But as one woman pointed out, this could have its roots in childhood eating habits. Also, women were afraid to become fat as this would invite comments from other women that they were not working enough. Compared to the women, men in the household ate the same food ('roti-subzi') but in greater quantities, with greater regularity and before rather than after physical labour.

III. Kinship and Finances in Access to Health Care

The inevitable preamble to any conversation on relatedness amongst the Nagori Sunni Muslims is, "all Muslims are one; we are all one". Caste type differences, however, emerged in discussions on marriage preferences. Most women were aware of four to five different groups, into which they could marry, including their own (father's) group. Most women in the Nagori dominated village fell into eight such groups and there were a further six groups whose names were mentioned. The common 'gotra', clan or sub-subcastes were sheikh, irawat (both upper), lalawat, khokhar (lower), raksha, samavat, ladawat and rav. There were a few pathan households in the village. Sunni Nagori women were quite clear that they married their father's sister's son (FZS: in the 'phhoophi' category), mother's sister's son (MZS) or a variant thereof (for example, Zahida is married to her father's sister's son). Married Sunni women were not only socially close to their natal kin ('piyar') but also physically close to them. In most cases women's married home ('sasural') was within a radius of one km to four km from their natal home. There were few women whose married home was further on (within A radius of 40-50 km). The social and physical proximity of natal kinsperson's has important implications for Nagori women's access to health care services in at least six ways, viz, (i) In the organization of money to pay for health costs, (ii) In arranging for women or men to accompany patients to health care centres, (iii) In the provision of help with child care for a sick mother, (iv) In the provision of help with domestic task while the woman is away, (v) As a means to reliable

information on health care facilities, costs, locations etc, and (vi) for emotional support as often medical experiences are traumatic and degrading for women.

On an average the expenditure over 10 months on the health of women alone is from Rs 1,000 to 10,000 which is very high considering that the average monthly cash income of the household is Rs 1.500 to 2,000. None of the households contacted had any specific sum set aside to cover illness expenditure of family members. All expenditure on health was crisis expenditure, and reached high sums because treatment was delayed till the problem was acute [13]. Money to cover health costs came from two main sources - kinspersons or unrelated money lenders (employer's, silver smiths, local people dealing in this business). The money is borrowed at a rate, which is currently between Rs.2 to Rs.5 per Rs.100 and used for all kinds of household expenditure with a larger portion being spent on health. Most households spend substantial sums of money on health care services from private sources compared to the income earned [14]. Most families who do not have more than one regular income earner are therefore permanently indebted, rising or falling in small cycles of debt. When the debt reaches a very large amount (in the region of Rs 40,000 and upwards) and a difficulty in repayment is envisaged, due to, for example, crop failure or further illness crises, then drastic measures such as the sale of a portion of land, highly priced in the area is resorted to. Being in debt of up to Rs 10,000 is such a normal condition that debtlessness does not seem to be actively desired perhaps because it is not achievable in practice. The role of kinspersons looms large in meeting health care costs.

Most Nagori women untilise the services of a private lady doctor for problems relating to menstruation, pregnancy, fertility and childbirth despite the large sums of money involved relative to the household cash income (very rarely are non-reproduction related problems of women given as much attention or financial outlay). If there is bleeding during pregnancy, usually the outcome is to get safai done by private women doctors who charge fees from Rs. 400 for foetuses of 2-2.5 months to Rs. 600 to Rs. 800 for foetuses of four to five months. Including transportation and medicine, women spend approximately form Rs. 500 to Rs. 1,500 for a medical termination of pregnancy (MTP). The facility for MTP as well as sterilization is provided free of cost in government hospitals yet there is less resort to these Services because (i) of the belief (and practice of at least one government hospital) that women be sterilized at the same time so government utilities are not wasted on continuously aborting the same woman's foetuses, (ii) of the practice of government gynaecologists who prefer to see patients in private as they claim they are able to give patients more attention at home. (iii) at government hospitals there is the expenditure on medicines which have to be bought from elsewhere for urine, blood and other tests patients are advised to go to private laboratories for speedy results and there is an

unauthorized charge made by hospital personnel (sweepers, washerwomen) for any services requested from them. The resort to safai proves far more effective than the prevailing contraceptive options presented to women which are neither culturally acceptable (like nirodh, only two young couples used nirodh) nor physically acceptable by weak bodied women (intra uterine devices such as the Copper-T and even hormonal pills can cause excessive bleeding in weak and anaemic women). Sterilisation (locally referred to as 'operation'), a possible but difficult to reverse process, is the most viable option for women but resorted to only when the desired mix of girl and boy children are attained (four to five children with two boys and two girls). For many women conceiving the desired number of girls and boys takes them up to their menopausal stage in the reproductive cycle [15]

On the subject of financing health care costs, Madari Khan assured me Muslims do not borrow from amongst each other but only take money on credit from moneylenders of other castes, especially, the meena in the area. Zahida, however, gives me a different picture of credit networks. She says the difference between borrowing from relatives ('riste wale') and non-kin is that there is no interest to be paid to one's relatives. Also, the amounts, which can be borrowed are smaller and range from a few hundred rupees to a thousand or two rupees. Her main source of credit is Maraim, her elder nanad (husband's eldest sister) who lives in the village. Maraim gives Zabida credit of up to Rs. 2,000 from whatever money she has. For greater amounts, such of up to Rs. 10,000 Marain gets money for Zahida from persons who can lead this amount ('paise dene wali' party. In case Zabida is unable to return the amount on time, she says Maraim will cover for her and give back the money borrowed. Women in the nanad category are thus important sources of funding. A woman's nanad also helps her during childbirth, with cleaning and washing, her important role is acknowledged in the Nagori custom whereby she offers the mother's breast to the newborn infant for its first breast-feed.

The relationships between children and elder women, which stem from ties, established through breast-feeding place kinship obligations (including to, meet financial requests) on the latter which are difficult to refuse. Although, not a very frequent practice there were several women who had breast-fed their younger sister or sister-in-law's children. Most women stressed that this was a practice only for the children of women you were close to kin in terms as there is the fear that if the child falls sick the blame would fall on the woman who had breast-fed it. There is a custom called 'doodh buksna' whereby boys pay money (Rs 21. 51 according to their means) to the women who have breast-fed them, when these women are nearing the end of their lives. The money is then distributed among the women's daughters. Mothers and daughter's have a strong tie in the Muslim community, which is also reflected in breast-feeding patterns. According to

Mehmuda, girls are breast-fed for six months longer than boys because they have a stronger right over the mother ('ladkiyon ka maa ke unpar zada haq hai') and girls always take from their natal kin ('ladki to piyar walon se hamesha leti hai'). Zahida says as a daughter she gets the goat's head (a delicacy) when a goat is sacrificed on Bakri-ld at her natal home. She told me how despite her negative experiences of childbirth (recounted below), she was pleased to finally get a daughter. Her story is also an account, which makes us consider the role women have in the decisions surrounding childbearing and birthing.

Zahida got her first period when she was 13 and in her natal home. She was married at 14. One year later she conceived her first child but was totally unaware of this. Her period stopped but she did not tell anyone about it. When she was in her ninth month she became very sick and could not walk-then her mother, father and father's sister came to see her. Her mother saw that her breast was leaking and told Zahida could have a child at any moment but she should not have her child in her married home as it would be dangerous for both mother and child. Zabida could not go to the bathroom, she could not see, could not hear, her body was swollen and she had little help or sympathy from her husband or in-laws. Her father said they would take her home. Her husband became angry and tore her father's 'kurta' (shirt) and dhoti. He said if she dies, she will die here. I am not sending her. Later her 'jeth' (husband's elder brother) intervened and said to his brother that you bring her to the city and I will show her to the doctor. Then her husband, and husband's sister tied her with a rope as she was too weak to sit up and put her on the cycle and took her to the government women's hospital. The doctor admitted her and asked her husband and his younger sister who they were. 'They said they were Zahida's neighbours, that she had no kin and that her parents were no longer alive and her husband stayed outside Jaipur. According to Zahida, they lied because they were scared and besides her husband's sister had been told by her in-laws not to say anything, to let her brother do the talking, otherwise she gets on well with her sister-in-law. Zahida was left alone in the hospital where she was treated for 15 days and she had a son of 1.5 pounds who "was like a rat" ('chuba jaisa'). Zahida stayed in the hospital for another 15 days and the child was kept in a machine (incubator). She also received two bottles of blood from a rickshaw walla'. Her jeth paid him she does not know how much. Her jeth did so much for her. No one came to collect her from her sasural not even her husband, not even after the child was born. Once her jethani came and others from her mother's house. When she was discharged a month later, she travelled home herself no one came to collect her. Her husband was ill. There was nothing to eat at home when she returned. Her mother sent 20 kg of wheat, her nanad (husband's younger sister) gave her some 'thooli' (broken wheat daliya).

This she roasted and boiled in water and ate she had no ghee, no milk.

Zahida did not conceive for another seven years. Her in-laws said she could not conceive and told their son to divorce her. Her husband kept her son, hit her sent her back to her 'piyar', where she stayed for two months. The meeting of elders called subsequently decided that because Zahida was a good women her husband must be forced to take her back.

Zahida then sought medical advice from a private infertility specialist. She became pregnant but the specialist said the foetus was not growing. Somebody in the village said it was because of 'oonpar ki hawa'.

Then she sought help from a man of the meena caste who became possessed by Bhairu (bhairu bhav), got a 'tabeez' (charm) made got jhadan done and wore a 'kada' (amulet) on bet right upper arm. She continued to take the specialist doctor's medicine and advice whenever she had some money. She also saw a 'bhangi' and got a thread to wear around the neck ('gale ka dora'). when she was five months pregnant she had a lot of white vaginal discharge ('safed pani'), and went back to the doctor specialist who recommended a sonography, gave medicines and then she became better. The baby (son) was born at home. A third son was also born at home as was her fourth son after a gap of a year. The fifth child (also a son) miscarried at five months as a cow hit Zahida and its bone ruptured the uterus. She bled for three days at home, without treatment- when the bleeding did not stop, she sent her son to call her mother. Her mother took her to the government women's hospital. The doctor said the baby in the womb was dead since 48 hours and refused to take up the case. Zahida was removed from the bed but she insisted on help and treatment. She was not attended to but stayed there for five days - "I was almost dead. I was completely blue. "Then her jeth came to talk to the doctor (her jeth had given her the phone number but she did not know how to phone and no one was with her) and insisted that she be treated. On the doctor's refusal, her jeth threatened to bring judicial proceedings against the doctor but to no avail. Then they contacted 'Neetu', a private doctor who had treated other women from the village. She said she would look at Zahida but took no responsibility if she died in her care. Zahida was admitted and an MTP was performed (safai) and she received blood. She said she felt dead and was unconcious most of the time. One of the doctors even proclaimed her dead. Her natal kin got things ready "kabr khod liya, kafan laa diya' (they dug her grave and brought the covering cloth). Her husband also started beating his chest in the hospital. Then Neetu came and saw a flicker in Zahida's eyes. She ordered for oxygen to be given. Zahida said she was put into 'machine'. The next day she became conscious and her jeth told the village people she was alive.

Some Rs. 7,000 was spent at the private hospital. The money was taken on credit and repayed at a rate of Rs 700 per month (totalling Rs 8,400). Two years later the

twins were born at Neetu's clinic at home. The bill came to Rs 15,700 of which Rs 3,700 were arranged from the household resources (the TV and a goat were sold) and Rs 12,000 was taken on credit from a brahmin, to be repaid within 14 Months. Zahida uses die copper-T since then

She has finally got a girl and wants no more children. The Copper-T is giving it for fear her pain but she cannot remove it for fear of pregnant again. She wants to get operated but does not know exactly when. She says her husband is useless because he does not work and somehow she has to feed the children. He also beats her. She says he is a good man because he lets her go where she wants.

IV Women's Agency and Health Care

In his study on the relationship between agency and fertility, [Carter, 1995] points to the small but growing body of evidence which suggests that even in pre-transition, high fertility and high mortality populations, which are considered to be characterized by natural rather than controlled fertility, certain strategies are operative, which effect a balance between household personnel and resources [16]. Control over the duration of breast-feeding and controlling intercourse are some of the examples cited by which couples schedule conceptions. Nagori women, I found also can directly control conception by opting for (i) foetus extermination (safai) rather than foetus saving techniques, ii) by resorting to sterilization and, (iii) indirectly by regulating the duration of breast-feeding. While Nagori women have greatest control over breast-feeding compared to safai and sterilization, they do not make a direct connection between reduced breast-feeding and the resumption of menstruation (or the ability to conceive). In fact they, believe the reverse occurs, in other words because they conceive, breast-milk production declines. Moreover, their control over breast-feeding is compromised by their weakness and malnutrition, as I discuss in the following lines.

With regard to breast-feeding, I have found that mothers' decisions made at two stages, one early on and one later, crucially influence the termination of post-partum amenorrhoea as well as the survival chances of the new born child. All Nagori mothers claim to breast-feed girls for 27 rnonths and boys for 21 months as stipulated in the Koran, yet there is a great deal of variation (on average the tendency is for girls and boys to be breast-fed till the age of 18 months or so). In the first six months, observations show that Nagori infants do not get exclusively breastfed. The infant is first put to the breast on an average of 24-48 hours alter delivery. As breast-feeding can commence only after the 'ajaan' or words of allah spoken in the ears of the new-born by a learned man, the infant's access to breast-milk depends on the availability of such a person and on the urgency with which he is sought. The NFHS also points to the delayed receipt of breast-milk and the

custom of removing colostrum as factors contributing to infant mortality. Although it is true that the Nagoris considered colostrum ('keeia' yellow straw-coloured first milk with essential antibodies for the infants 'immune system) to be 'bad milk' as it has been 'stored for a while and therefore it has to be removed, in reality only a few drops are squeezed out by the nanad (HZ) and so the baby does receive some of the benefits of ingesting colostrum even if in reduced amounts. But perhaps what is more debilitating to the infant's health and to the mother's health is the practice of bottle-feeding with a mixture of goat's milk and water, from as early as four to five days onwards. In these instances the mother is either working in the fields or more often says she does not produce enough milk. 'While generally suckling the breasts should stimulate milk production, in weak and malnourished mothers this may not be the case (Banerjee, personal communication). Here the line of difference between taking an active decision (where the mother continues to breast-feed even though there is less milk) and the decision not to breast-feed because of the absence of milk is a thin one. Then there are also the Nagori notions of 'good' and bad' breast-milk which come into play.

Given the patriarchial, Muslim setting in which child birthing takes place, it is difficult, especially for young women, to exercise reproductive choice [17]. Shakila has a daughter of four years and a son of two years. A week or so after she missed her period she sought out the lady doctor at the voluntary centre to know if she was pregnant. She said she did not want a child so soon. A couple of weeks latter when pregnancy was confirmed she began enquiring about safai. Her "tai" (her father's elder brother's wife) who accompanied her said it would be alright provided she asked her husband. Shakila did ask him but said her husband wants her to have the child. He is a great 'namazi' (scholar of the Quran) and would not hear of safai.

He did not even allow her to take any 'takat ki dawai' (medicine for strength). Shakila says she will now go ahead with the pregnancy but she comes regularly for takat ki dawai and has her TT injections.

Women were quite open in talking about the 'operation' (sterilization), both as something they wanted done or as having undergone it. When I recounted a story I had heard to a group of Nagori women, that women who underwent sterilization before conceiving all the children written in their destiny would be troubled in their coffins by these unborn children, the women laughed. Jabunnisa scoffed and said, 'who is there to check on what happens in the coffin!" The decision to undergo sterilization is one of the couples rather than the women alone and thus depends on men's attitudes as well. Several Nagori men. unlike Shakila's husband have had a positive attitude to sterilization either having undergone it themselves or have encouraged their wives to be 'operated'. When I

point out the proscription of the Koran on the subject to the men, they point out the problems related to their wives' illhealth or their poverty as forcing them to take such decisions. Nagori women's agency must also be seen in terms of the different attitudes and social hierarchies (especially of poverty and Quranic education) which exist between men. It was often the case that men who were well versed in the Koran and read it daily placed greater strictures on their women as a means of differentiating themselves from other men in the community.

Much of the recent demographic literature has been on the impact of schooling and employment on women's powers to take autonomous decisions regarding their fertility. Yet as [Jeffrey and Jeffrey's 1997]study of Muslim Sheikh women in Bijnor, UP suggests, that while there is a correlation between lowered fertility and women's schooling experience, and work outside the home, it is not always so (1997: 121)[18]. Eight women from approximately 200 Nagori households have had formal non-religious education of up to at least the fifth class. On the one hand, there is Shahnaz who along with her husband is one of the two young couples who use nirodh. On the other hand, in the same set of young women, there is Shakila who would like to have an abortion to space her children but who cannot do so because of her husband's wishes against it. Then there is Zahida who has had neither a Quranic nor any other education, is relatively poor and uses the Copper-T.

This would suggest that schooling and employment are only two among a number of individual household specific factors, which have to be taken into account in understanding reproductive health seeking behaviour.

The material on Nagori women emphasises the fact that the extent to, which they can be active agents in health care matters depends, apart from their own motivation, on their physical condition (with weakness acting as a constraint, upon their activities), their vulnerability to cultural notions (which especially young and first time mothers are prone to), their age, household relationships especially with the husband and the women in his family and the inter-household (piyar-sasural) connections. Thus any discussion of agency, however, nuanced, can only be partial.

V Conclusions for Policy: Enhancing Access and Responding to Health Demands

The task of enhancing reproductive health service outreach in the villages around Jaipur lies at many levels which address not only the question of access to existing services but also the provision of facilities which take into account the context specific, gender and age health needs of the local populations. With

regard to the rural Muslim community in north-east Sanganer, it requires that preconceived notions among health service personnel regarding beliefs such as the uncontrolled fertility of Muslims and a consequent low demand for reproductive services be surmounted. Religious and cultural differences between the Nagori Muslims and caste groups in the area while they are significant as markers of identity are less important as far as their reproductive health perspectives and needs are concerned. The main cultural difference, which lies in the pattern of Nagori marriage and residence of adult women works mostly in favour of facilitating women's contact with health care functionaries. And, Nagori women, as mothers, mothers-in-law and elder sisters-in-law are more able to support younger women, in material, emotional and work terms when they are ill. The only other custom, which sets the Muslims apart from other communities in the area, is to do with their practice of male circumcision, which can make infants doubly vulnerable to dangers of tetanus following the cutting of the umbilical cord). Nagori Muslims have neither more wives nor more children than other groups in the area, nor have significantly different notions as to the causes and effective cures for illnesses. All groups seem to share an approach to health and reproductive health in particular wherein mind, self and the social body are combined rather than separate, and where sickness is as Lock and Scheper-Hughes (1996; 53) put it, "a form of communication through which, nature, society and culture speak simultaneously". There is thus a common tendency to first seek out health services which are organically connected to the social body (such as 'family' doctors, those who have treated other members of the family, or those who heal through spirit possession, both Hindu and muslim). Medical approaches are generally regarded as important but alien precisely because the treatment is clinical, separating social cause from physiological consequence. Tubectomy, which is dominant in the medical discourse on women in Rajasthan and elsewhere in India points to the extremes to which there is a medicalisation of women's bodies.

Most villagers in the area tend to seek private rather than public health services with a significant amount of household income being, spent on treatment. Because of the large sums on money which, may be involved, treatment cannot be sustained for long periods and is discontinued the moment there are any signs of the patient getting better. Women's reproductive ailments, particularly if they are in their child bearing years, tend to receive more immediate attention than reproductive problems among adolescents or in elder women. This is because men as husbands also give greater importance and value to the reproductive capacity of women. In general, there is great reticence in talking about reproductive ailments between men and women as well as among men. Usually reference to sexual and reproductive processes between members of a household is made indirectly. Similarly, reproductive illnesses are resented indirectly which is why problems considered shameful, such as vaginal discharge, or 'natural',

such as related to breast-milk production or those which women are meant to cope with such as a prolapse of the uterus, tend to remain 'invisible'. It is only when women and men are listened to, and encouraged to talk rather than being talked at, that any delivery of health care can be effective, sustained and meaningful. A large number of health problems in the area stem from the lack of adequate water supplies and a preponderance of sand and dust in the environment. As one woman said "humara mitti ka kaam jyada hai" (our work and lives are dominated by sand) programmes need to be broad-based, so that they help tackle the wider sources in the environment from which diseases stem.

Improving women's access to existing health care services in Sanganer requires both general and specific measures. There are many recommendations pertaining to health sector reforms in developing countries and in India which are equally applicable here [Singh and Gupta 1997] [Bhat 1993] [Kothari 1989] [Pachauri 1994] [Jejeebhoy 1997] [Ramachandran and Visaria 1997] [Standing 1997], to name but a few). At the risk of repetition, I will outline a few points, which emerge forcefully from the specific observations made in the paper. As health care is sought from a number of sources, even for a single illness access can be improved by encouraging all types of health delivery activity, private, government and NGO, in a manner which recognises their specific strengths and weaknesses. So for example private health services while they are efficient and attentive to patients problems, need to be made accountable in terms of the doctor's qualifications and with regard to the safety and ethical nature of the services offered. The government medical services, on the other hand, have to be made more sympathetic and more efficient. According to Jejeebhoy (1997), two masons for the insensitivity of the services to women's needs and situations are because the services are designed centrally and based on demographic targets. Moreover maternal health activities are unbalanced, focusing on immunisation and the provision of iron and folic acid rather than on sustained care of women or the detection and referral of high risk cases. Jejeebhoy emphasises the need for a greater client focus in a health and family planning programme which responds to women's requirements. Such a perspective could provide more and better services at home and involve a sympathetic and culturally sensitive probing of health problems.

In order to establish an effective referral network. I would suggest that as is the case with the government 'anganwadi' (childcare) schemes more emphasis should be given to locating and resourcing women and men within each village who are not just informed about matters of hygiene and basic medication such as the ANM or Jan Mangal couple but also about local health services (facilities, distance, cost, qualifications of doctor), health rights and statistics and the politics of health matters in, general. Health workers such as ANMs should be committed women and men from among the local population and resourced in

such a manner that their job gives them status in the area. This would enhance communication with the and men from among the local population and resourced in such a manner that their, job gives them status in the this would enhance communication the local elite as well as with men as husbands and kinspersons. Local health centres (at the primary and sub-centre level) to compile basic health data pertaining to their area in order to be appropriately responsive to the household nature of health demands, an area where NG0s are particularly successful, precisely because of their local relationships built upon trust and their household knowledge, which enables them to assess and react speedily to local situations [Ghosh 1994]. Government medical services need to be more transparent about the costs involved in meeting patients health needs, and be more efficient through a 'trimming' of resources. One area where the input of resources compared to output in terms of patient utilisation is imbalanced is strikingly evident in the disproportionately large number of ayurvedic dispensaries. In this case trimming could allow that funds be transferred to use in providing other health care services within the hospital. Government health care in the 'zenana' (women's) hospitals could be more effective if attention is paid to the customer friendly side of their services with perhaps the appointment of a welfare/liaison officer who is available to inform answer queries, and present cases to the doctor.

There is no doubt that the villagers in Sanganer want and need access to good health care services as is reflected in the high costs they incur as well as the distances they travel to seek out effective health cures. At the same time most of their experiences with the health services on offer have been negative, and given the exacting nature of their lives, women especially have a tendency towards inaction as far as seeking treatment for illness is concerned. At the same time, given reliable information about effective cures and doctors, women are quickly willing to explore the possibilities of seeking treatment from these sources, provided they have some support from their kinspersons to do so.

Notes

[A somewhat different and longer version of this paper was presented at the VIIIth National Conference of Women's Studies, Pune, June 1998 in the subtheme on 'Women's Autonomy and Reproduction'. This appears as IDS, Jaipur working paper no 103, September 1998. The fieldwork on which the findings of the paper are based was made possible by funding from the Wellcome Trust, UK and encouragement from Hilary Standing, Ursula Sharma and David Robinson. I would like to thank IDS, till September 1998. Special thanks to A.K.Banerjee and staff at Khejri Sarvodaya Health Centre. Gerda and Narayan Unnithan, Vipula Joshi, Mohan Singh, Zahida bano, Kamlesh Gogaram, Kavita Srivastava, Shail Maryaram, Surjit Singh and K R Vasanthan for their help and support.]

1. The termreproductive health is used, following the definition used in Gittelsohn et al (1994) to mean that people have the ability to reproduce as well as to regulate their fertility safely and effectively; pregnancy and the outcome of pregnancy are successful in terms of maternal and infant well-being, including the child's development to its full potential; and couples we able to understand and enjoy their sexuality, free of the fear of unwanted pregnancies and of conuwting disease (8. 1994).

2. Jaipur district has a rural population of 2.8 million persons (of a total of 4.7 million people) living in a little over its 3,000 villages (1991 Census figures). The work was carried out in Sanganer tehsil which has a population of 8,404 Muslim out of the 3,81,214 Muslims in the district as a whole (1991 Census figures on religion). The material presented in the paper is based on two Sunni, Nagori Muslim dominated villages in the northeastern part of the tehsil, which together have a population, roughly estimated by me to be around 5,000 muslims. As a researcher I was based at the Khejri Saryoday Voluntary Health Centre in the area.

3. The material presented in the paper is part of a wider project which is concerned with women and men's access to health care services in three villages and one urban slum in Sanganer/Jaipur. All the villages mentioned in the paper have recently (since 1994) become part of the urban municipality; however, there has been no perceived change in the villagers lifestyles and for all purposes they regard themselves as rural in contrast to urban people 'of the city'.

4. The international conference on Population and Development held in Cairo in 1994 is significant for its orientation towards sexual and reproductive health rather than population growth, which in turn has been responsible for a shift in international and national policies, away from a narrow focus on fertility control.

5. See forexample, newsletter and material produced by Chetna, Ahmedabad or the Anubbay case studies [compiled in Pachauri 1994] or the self-help training manual Na Shariram Nadhi supported by Asmita [Sabala and Krand 1995] women's resource centre as also [Pal 1997] for empowerment work in slums in Jaipur.

6. The assistanceof A K Banerjee, director of the voluntary health centre, with technical, medical information presented here is gratefully acknowledged.

7. South asiais thought to have the highest maternal activity rates in the world [NFHS-India] with 27 per cent of all maternal deaths occuring in India

(Unicef 1991). The Indian average maternal mortality rate is estimated at 437 deaths per hundred thousand live births, occuring in India (Unicef 1998). The India average maternal mortality rate is estimated at 437 deaths per hundred thousand live births (NFHS-India: 1992-93) for two years preceding the NFHS survey. Due to large sampling errors, no figures could be made avilable for individual states or population subgroups (1995, 226). In India maternal deaths amount for 10 per cent of all deaths among women in the reproductive age and 13.2 percent of all deaths among rural women were maternal deaths in 1987, Unicef 1991). The main causes of death have been indentified as due to haemorrhage (16-22 per cent), toxaemia (10-12 per cent), sepsis(8-13 per cent), abortion complications (10 Per Cent), anaemia (17-25 per cent) [Registrar General 1987, as quoted in Jejeebhoy 1997). There is an equally high presence of reproductive morbidity, obstetric and gynaecological, especially to do with reproductive tract infections [for example, Bang and Bang 1989).

8. Informationon male circumcision ('musulmani', 'Khatna, sunnat banani') revealed that only in very few cases did an infection develop which was then contained. Although if one considers the periods of high infant mortality with the preferred periods when circumcision takes place, a correlation does seem to arise. Circumcision is done preferably in the first to third month after birth or in the second or fifth year. Moreover, there is an added risk of tetanus infection as the foreskin which is held in place by a bamboo shaft, is cut by a blade or scissor. However, the deaths due to tetanus reported by the women were all believed to result from the cutting of the umbilical cord ('olnaal ki nalli' tube of the placenta) rather than due to circumcision.

9. The RMPqualification is available to anyone who fills in an application for a small sum. No attested documents are required to be sent and there is no check on the actual establishment or quality of the practice.

10. Sincethe last three years, with the opening of a voluntary health center close to the Nagori village women have also the option of using the services of the gynaecologist at the centre. Three times as many women use the centre compared to men (the men are mostly older men). Women tend to come together and bring sick children, girls and boys, with them. On an average 450 patients visit the centre each month.

11. Accordingto NFHS findings, in Rajasthan infant mortality rates fall from 76 per 1,000 births with no care, to 71 per 1,000 for births with either antenatal or delivery and to 45 per 1,000 for births with both antenatal and delivery care (1995:137).

12. For thefirst few days after delivery, mothers drink milk (1-2 glasses to half a Kilo each day) and once a day eat a small proportion of 'healthy' milk enhancing ('doodh badhane') foods such as coconut or khopra (upto 1/2 kilo), asafoetida(1/4-1/2 Kilo), thuli (broken wheat flour porridge), halwa (wheat flour sweat-meat) or a mixture of these ingredients in the form of a ladoo (sweat-meat ball). Some women also mentioned sonth (1/4 Kilo) and almonds (1/4 Kilo). Only a couple of women ate an egg for 2-4 days and one or two muslim women mentioned eating meat, especially goat's head believed to strengthen the infants neck through the breast-feed. At approximately two weeks after child-birth, the foods ingested were 'thuli', 'Khichdi', 'halwa', with roti-dal for at least one meal and 20-30 days afterwards regular food was resumed.

13. For a numberof cases where problems were long-standing, usually non-reproduction related, treatment was sought in intermittant periods and stopped the moment the patient was better for a while.

14. This observationis similar to Bhat's findings that the spending on health care as a proportion of total consumption is quite significant with a larger proportion of the expenditure borne by the household sector rather then the government (1993:48). Furthermore as Bhat observes, there is no indication that the high costs have discouraged the use of private facilities in favour of public facilities.

15. One of 47 Nagori women currently uses the Copper-T or any IUD, five of the 47 women were sterilised (two had husbands who had undergone vasectomies); each has four to seven children of the desired mix and are aged between 30-40 years. Two other women have consulted a doctor about an 'operation'.

16. For a discussion on agency see [Dissanayake 1996], [Carter 1995], [Agarwal 1994], [Unnithan and Srivastava 1997], Carter is critical of the use, of the notion of agency as divorced from culture.

17. Lingam (1995)argues that the focus on reproductive rights to the exclusion of women's social, economic and political rights, is a limited one. Powered by western consumerism and north-south inequalities such a perspective is in danger of reinforcing the view of women mainly as biological agents.

18. Unlikesheikh women in Jeffrey and Jeffrey's study, Nagori Sheikh women were neither hostile to sterilisation nor generally open to any other methods of fertility control.

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