Having developed the framework on the basis of the reviewed literature and findings of our previous study that was conducted during 1991-1992 in the same rural block, we now focus on the methodology. The main components of it are discussed below.

1. CONCEPTUALISATION OF THE PROBLEM

Women’s health is shaped by certain factors which are rooted within the internal dynamics of the family as well as in the wider socio-economic structure within which families are located. We do not consider these two domains as independent. Rather, these are conceptualised as inter-dependent and constantly interacting. Therefore, the dynamics of family located within specific social categories cannot be separated from the social dynamics of stratification, as the two are constantly influencing each other. To understand one, the influence of the other has to be taken into account. For the purposes of elaboration, the conceptual format is being desegregated into the following:

A. Social Aspects

Stratification

A uniform access of the people to larger interventions for change (such as health services, education etc.) and an ensuing increase of awareness among the people, cannot simply be assumed. Stratification of the population under study on the basis of their socio-economic capacities and relations becomes critical. This is so because it influences access to health, information about services, occurrence of disease and treatment, nutritional status and environmental conditions, which in turn, influences the state of health within a given stratum. It also influences their links with social and political institutions such as the panchayats, non-governmental organisations, voluntary groups etc. which often intervene in health related activities.
Even at the subjective level, the commonly prevalent perceptions and attitudes in the different socio-economic categories may differ as well as influence each other. Understanding stratification thus, was necessary to grasp the social processes at work. In the villages, the basis of economic stratification could no longer be agriculture alone. Therefore, it was decided to use criteria of land ownership, services and business together, on the basis of which economic categories were developed. In addition, it was also decided to divide the population into different religious or caste categories and locate their distribution over economic classes to develop socio-economic strata for comparative analysis.

**Welfare activities**

These included health services, health information, education and the role of Panchayat. Given the stratified nature of society, our assumption was that both access to these services as well as awareness created through them would vary across socio-economic categories. It would therefore be necessary to examine the nature and quality of the services provided and their differential access.

**Health services**

The available services for women's ill-health are provided by the maternal and general health services at the primary level of the health care delivery system. The purpose was to find out, in a stratified society, to what extent the above services provide health care to the women and generate awareness. For this it was necessary to examine the nature and quality of the services provided and its differential access. Another key input into illness management of women is through local village practitioners. Their views and practices regarding women's illness therefore, also need to be covered.
Health Information

Information regarding the prevention and cure of diseases are available through various sources. Welfare institutions and mass media play an important role in determining actions regarding women’s health. The utility of these sources of information in improving the understanding of men and women and their changing behaviour towards women’s health across different socio-economic strata was an important aspect of our study. The roles played by health personnel, television, radio and panchayat in health education were seen as one of the societal inputs into changing people’s perceptions of and behaviour regarding women’s health.

Education

Education as a major factor of welfare intervention is assumed to produce beneficial effects in a population including women. We explored its impacts on women in different socio-economic categories as well as generations.

Politics of the Panchayat

Panchayats provide economic support to women through welfare programmes, they also mobilize them at political level and attempt to generate awareness. Therefore, it is relevant to examine what role these activities play in the life of women and how they influence their health.

The social processes penetrate the family at various levels by influencing the material basis, through diffusion of norms and values of life and also through the welfare strategies targeted at the women. This interface gives rise to changes in the lives of women at the family level.
B. Intra-Familial Aspects

For this study, the intra-familial aspects within any socio-economic category have been considered as a composite of objective and subjective factors which influence women’s health and their illness. Inter-familial differences between both these types of factors are the basis of the variations within socio-economic classes. These familial factors are the following:

Material basis of existence

The occupational structure of a family, availability of resources, total numbers of members in the family, form of the family and the extent to which the family functions as a production unit, create the material basis of existence of a family. Intra-familial interactions such as women’s relationship with her in-laws, husband, sons and other women in the family develop around two dimensions of life.

Relationships within families

The material dimension of the family creates certain expectations and demands on the women. Besides, the intellectual and emotional dimensions of relationships also shape their life within the family. These latter dimensions are influenced by the traditional norms and values existing in families (both parental and in-laws). Interplay of all these factors give rise to certain patterns of relationships in the family. The relationships thus formed also influence women’s own access to family resources, health services and information.

Men’s sickness

Given the status of women in society, and the norms and values around it, men’s illness is yet another factor in determining women’s illness in the family. This in turn, influences possible actions for cure.
Women's Image

Women's self-image as well as the perception of other male and female members of the family regarding them are a very critical aspect of intra-familial dynamics. These subjective factors influence women's own perception of their illness. These perceptions and self-image of women are born out of their experiences of securities and insecurities in life.

Women's Roles

The criticality of women's labour within the family and also their reproductive and caring roles act as important factors in shaping the internal dynamics of the family. Different combinations of these three roles, in turn, determine the degree of demands on women in terms of emotional and physical inputs. In other words, production, reproduction and caring for others get intimately linked to women's health.

Traditional Norms and Values

The traditional norms and values with regard to women's role and position within the family have an important function. They provide a degree of stability to the family while retaining its patriarchal bias at the cost of women. They do so by acting as a shield against the forces of change. For instance, such norms prevent women from taking advantage of external realities. Women's vulnerability thus becomes a tool for status quo. They are socially more appreciated by the kin when they accept total dependence and hence, acceptance of tradition is a form of security that is offered to women. These traditional norms and values regarding women's role, which actually shroud the control over her labour, have persisted in varying degrees despite socio-economic transformation of the society over time. The persistence of these traditional family norms and values can be explained by the following social reasons:
a. The patrilineal laws of inheritance and control of property have only marginally changed the reality of power relations.

b. The women in the family have continued to play a very critical role in production, survival and reproduction, without being socially acknowledged for it. This too ultimately reinforces status quo.

c. There has been little change in the organizations of the employment sectors where women are involved, as these sectors largely remained technologically backward.

The persisting traditional norms and values make women dependent and powerless and therefore insecure. Its implications for their health therefore, is self-evident. To understand the dynamics of women's health therefore, it is important to understand the intra-familial norms and values and their traditional content, for they are not only rooted in the objective conditions of the family, but are also perpetuators of those conditions which are responsible for women's poor health.

Transformation in the larger socio-economic organisation brings about changes in the three main roles that women perform within families. Changes in the social forces such as health services and information, work, education, participation in the Panchayat run programmes or in voluntary group activities and the socially accepted gender norms, shape women's roles in the family. These changes at the social level also influence the intra-familial relations which are embedded in the material conditions as well as traditional values prevailing in the family. The relationships thus influenced exert new demands on women's roles and labour. Their physical health is an outcome of the balance of these two forces at the family level.

According to the understanding developed through the conceptualisation then, though socio-economic stratification is critical in determining women's health, it alone does not explain the state of health
of women. Other social factors including the prevailing social norms are also important as they add to women's burden of ill-health in various degrees across the class categories. These largely permeate through the porous boundaries of the family and reflect on its internal dynamics. In the prevailing norms and traditions of the family units, these factors are either unquestioningly accepted or challenged by both men and women.

What are the trends of socio-economic change and do these changes give women a different set of intra-familial norms and values, a better health, or do they further lower their status and therefore, health? These are the questions that we have attempted to explore along with the exploration of differential illness among women and men and social dynamics of health across socio-economic strata.

2. OBJECTIVES

Given the above framework of understanding, it was proposed to study the social dynamics of women's health in the changing socio-economic context of rural Bengal, emphasising the family and social dynamics and their interface. The sub-objectives of the study therefore, were:

a. To quantify reported illness among women and men across socio-economic categories and compare them.

b. To assess the influence of socio-economic stratification upon women's health.

c. To understand the relationship between the social and intra-familial determinants of women's health through a detailed study of women's labour within the families.

d. To explore the changing intra-familial norms, values, relationships and attitudes regarding women's health by studying women across occupational groups in the socio-economic categories as well as across generations.
f. To assess whether the breaking of these barriers of traditions or shift in work participation and other socio-economic organisation actually improve or further increase illness among women.

3. DATA COLLECTED

It was necessary to collect both quantitative as well as qualitative information to fulfill the objectives of the study. It was also necessary to be able to articulate people's perceptions and expressions of major events at different points in their life; similarly, understanding the local expressions of the symptoms associated with various illnesses was equally important to assess the nature of illnesses people were suffering from. For this, a local calendar of major events over the past decades and one of annual events observed by the local communities were prepared in the primary phase of the study (Appendix-I).

A. Quantitative Information on the socio-economic status and health

Information was collected through a baseline survey to quantify certain aspects of people's life including their health. They were,

a. The socio-economic background of the families* (synonymous to the term 'household') on the basis of its structure, land ownership, occupation, caste and religion.

b. Chronic and Acute illnesses** during the previous year and month respectively, perceived by women and men of 15 years and above age group.

* A family was defined as a collection of people sharing food, prepared in the same hearth.

** A chronic illness was defined as any illness persisting for more than one month. Illnesses which led to being bed ridden for three days or more were defined as acute illness.
c. Preferences for health care available at various sources.

d. Place and type of attendance at birthing in the previous year.

e. Practice of various family planning methods by the eligible couples.

The socio-economic data collected from the baseline survey were used to develop the picture of social stratification. This helped in understanding the qualitative data collected in the later phase of the study.

B. Qualitative Information

Qualitative exploration was conducted both at the village level as well as the family level. At village level, information was collected on the following aspects:

a. The material basis of women's lives was studied by considering the nature of occupation such as agriculture, services, business, or a combination of them and their distribution over the economic categories, terms and conditions of the work women do, and their participation in the power structure, and the help women get from existing institutions.

b. Interactions between the socio-economic categories were studied in terms of existing material and power relationships. How such interactions influenced the understanding of health and health actions of women across economic categories were also probed into.

c. The role and status of women were primarily assessed through their work status. For this, various kinds of economic and other activities performed by them, kinds of jobs allotted to them and the wages paid were looked into. In addition, we also explored the ways in which women's economic, reproductive and caring
roles were combined together in different socio-economic categories. Their relationships within and outside the family, participation in decision making processes in the family and also at the panchayat level were studied.

d. Assessment of Welfare Services was done through people’s understanding of the available services such as education, health, information and their impact on the life of women and men. Along with it, opinions of personnel delivering the services was also taken into account.

e. Health and specific illnesses of women were understood in terms of people's understanding of these, both in women as well as men. Cultural traditions, norms and values regarding chronic and acute illnesses and the existing practices were also explored. Views of the health practitioners and other personnel were also considered in this matter.

f. Health actions of the people and sources of health care were studied on the basis of the actions commonly taken by families at various stages of illnesses, preferences of various source of treatment and reasons behind, and experiences that lead to change the source from one to another. Opinion of the local health workers, healers were considered to have a comprehensive understanding into these.

At Family Level: Information on women were also collected at family level in each economic category. The processes of illness among women were elaborately studied on the lines described in the conceptualisation part of this section. The roles and influences of the members of the family, neighbours and welfare personnel through services in the specific process of illness and women’s own views on the same were explored. Also, deeper insights into women’s understanding of their own health problems
(perception of illness, how illness was handled, how experience of one event led to change in their understanding of health and how women recognised the role of associated factors in this process) were also studied through detailed case reports. Men's lives and illnesses in corresponding strata were also explored on similar lines for the purpose of exploratory comparison between the health behaviour of women and men.

4. DESIGN OF THE STUDY

A. The Area

Given the objectives of the study, Bolpur block in the district of Birbhum in West Bengal (Map 1) was chosen for the study. It was also in this block where our exploratory study was conducted earlier, during the years of 1991-1992. The block has one hundred and fifty seven villages and a municipal town - Bolpur. Through the previous study in a cluster of one of these villages, some qualitative insights into social dynamics of women's health had already been developed. The present study intended to further explore this dynamics in a changing social situation.

The overall socio-economic and political developments (such as land reforms, communication etc.) which have taken place in the district over time had considerable influence on the development of the rural block. Development of Bolpur has also been associated with the establishment of the educational institution, Visva Bharati, in the 1920s. Communication with the villages and other towns improved with construction of good roads including the highway. Later, during the 1980s however, Bolpur got the status of a sub-divisional town in the district. All these developments have not only intensified the trade, employment and welfare opportunities in the town, but they have also moulded the occupational structure of the nearby
Location of Birbhum District in West Bengal
villages and the life of the people there. It is this changing situation of Bolpur block within which we explored the social dynamics of women's health.

B. The population

The population under this study was located in the households of a cluster of three census villages, chosen on the basis of certain criteria. One, it was proposed to focus on the villages within a radius of seven kilometers around Bolpur town. Second, the villages had to be located in the closest proximity to the town, the highway and Visva-Bharati, and were to be under the collective influences of these modernising influences. These villages were Surul (JL.No.104), Ballabhpur (JL.No. 63) and Binuria (JL.No. 54), which share different sub-centres of the Primary Health Care network of the block (MAP 2). These villages had 2225 households and an estimated population of 11,000. The 15 years and above age group constituted the study population to explore the influences of growing opportunities in various fields specially upon women and their health problems.

For eliciting information from the population the study used a three pronged strategy. It consisted of,

a. A baseline survey in sample households, drawn from the villages under study; and collected socio-economic and health information.

b. Qualitative exploration in the largest selected village, using intensive study tools and techniques to focus on social processes, peoples' perception and views.

c. Quantitative probing into the specific findings of qualitative exploration, using the traditional as well as the largest cluster of intensive study village, to quantify specific trends and indicators.
STUDY VILLAGES IN BOLPUR BLOCK

STUDY VILLAGES
A. SURUL
B. BALLABHPUR
C. BINURIA
■ ADITYAPUR (EXPLORATORY VILLAGE)

GOVERNMENT HEALTH INSTITUTIONS
• SUB CENTRE
• SUBSIDIARY NEW PRIMARY HEALTH CENTRE
• BLOCK PRIMARY HEALTH CENTRE
• SUB DIVISIONAL HOSPITAL
+ VISVA BHARATI DISPENSARY HOSPITAL

■■■■ MUNICIPALITY
--- HIGHWAY
----- RAILWAY

MAP-2
The details of each of these are discussed below.

C. Making Rapport with People

Knowledge about people's life and life processes being a critical component at all levels of the study, various strategies were developed to ensure enough rapport with various social groups and individuals. First, help was sought from the local administration and Visva-Bharati to find an accommodation in the largest study village to ensure the extensive interaction with the local organisations and people. The governmental as well as non-governmental organisations were approached for a preliminary introduction to the community leaders. Soon the village level organisations as well as their members, in their own spontaneous way started contributing to the fieldwork. All these contacts at organisational and community levels were further developed to strengthen the qualitative and quantitative components of the field work.

In qualitative exploration rapport at both the above levels was necessary to understand the overall socio-economic, cultural and political organisations in the villages and people's perception of their overall way of life including health and health actions. Special care had to be taken to communicate with the women folk with openness and on equal basis before exploring their life processes, their perception of their own lives and various roles in the family. Besides these, making rapport with the local welfare workers in the field, the young girls and boys of the village communities, the youth club members and the village level panchayat members was an essential part of the study. It helped in evolving an understanding of the physical territories of the villages, for making a list of households, locating these and also for cross-checking information collected through the household survey. This initial qualitative study formed the base for quantitative estimation.
For making rapport with the organisations, groups and individuals, certain measures were adopted. To achieve cooperation from various organisations it was necessary to explain to them the purpose, theme and relevance of the research. Rapport was made through repeated visits, sharing one's own organisational skills and experience with them, participation in their various activities and developing a mutual link for coordination. Once convinced of the research, these organisations extended their support in various ways. They not only introduced the investigator to groups in the villages but also acted as facilitators by giving contacts to other relevant sources of information. Thus, the political and welfare organisations like panchayat, Primary health care net work, voluntary health clinics, Integrated Child Development Services scheme, the private household production units and various training units including Visva-Bharati and other governmental or non-governmental organisations shared their own understanding of the way of life of the communities at large and co-operated in the field work.

Small groups of women and men including the village level workers of the panchayat and other welfare organisations residing in the village, the qualified or self-trained healers, the youth club members and skilled or unskilled workers were contacted at various social, cultural and political gatherings in the village. Rapport was also established with their families by accepting invitations to family celebrations, which often removed the barrier in communications and became a strength for the study. Besides, these were also visited at the places of work which enhanced the access to information that came up through the interactions of multiple views.

Thus, the social groups and institutions having varied perceptions of the research project became an asset for the study as their differential understanding of the realities in their social environment critically contributed to the explorations of the dynamics of women's health. While some found the research as
merely an academic activity to obtain a degree, there were some who considered it as a force to strengthen the movements at the grassroot level. It was interesting to note how, even the young illiterate tillers of agricultural land or an aged poultry raiser, at times narrated the principles of 'class relationship', 'surplus of production' or social divisions and hierarchies between the various caste, class, religious or cultural groups in the context of their life.

Most valuable, however, were the women across all social groups. Besides the common places of meetings as mentioned above, they were also contacted at other places where they felt comfortable in talking, often away from the restrictions and inhibitions of the family. While giving special sessions for teaching 'Kantha embroidery' to the investigator they poured out their hearts. Besides, they had their own preferences regarding timings when they could be comparatively free from their routine roles in the family. Thus they chose to talk while washing vessels in the pond or taking a somewhat relaxed dip. Or at times they preferred the afternoons for such purpose. Women in general felt 'honoured' or 'valued' to share their experiences and views about life. Moreover, once rapport was established they did not hesitate to stop in the local market, on their way to the place of work or even while returning tired in evenings from work, with load of collected twigs on head and small purchases in hand. Women were also met in the temples.

While there was a common thread in the understanding of women about their 'degrading' existence, the expressions varied widely. Thus a woman with a doctorate degree from the better-off household narrated her oppressed life as 'an inanimate piece of almirah at home, ... meant for the daily use of the family'. There was a just literate woman in the poor resettlement cluster, who realised throughout her life that 'woman's life is shaped largely by the need of family for money, ... money is everything in life'. Despite such feelings of oppression at home, women continued to remain vibrant in the little space that they could
call their own. They also agreed that ‘women as a category had many problems in common’. These women also showed enormous interest in information that helped them to link the work they do within or outside home to the rest of the world. They longed for information, may it be about their work or hike in the prices of medicines or the implications of modern contraceptive technologies in their life. There were women who could not read a clock yet were punctual in their daily activities, only because they knew how the time moves along with the sun and shade in their courtyard. Once they shed their inhibitions, these women had no hesitation to articulate their anger against the prevailing social system within which the price of the common drugs have been increasing. This wide ranged potential and versatility of the people became an inspiration for the study. They provided valuable insights into the social as well as family dynamics in the context of women's health.

D. Research Methods and Tools

The main research methods used for the studies were as follows:

Qualitative exploration

Listening to women and men about their perceptions of life as well as close observation of realities in the socio-economic, cultural and political setting within the family and beyond were considered the basic criterion for the qualitative explorations. Reporting by people was a prerequisite to structuring further qualitative or quantitative enquiry.

Qualitative explorations were also conducted through general group discussions, followed by Focus Group Discussions on particular issues that came up through the former. Besides interviews of the pre-identified key informants in the community, the key personnel such as members of the panchayat,
the healers, practising social workers, school teachers and welfare workers of the government and non-
government organisations were also contacted to elicit necessary information. Simultaneously direct
observations were also recorded to note the validity of the findings of the discussions and interviews. In
addition, incident analysis was also used as a technique to analyse and interpret social events and their
associations. For this, however, in-depth interviews was used as a method, substantiated by direct
observations.

The study also incorporated certain measures to capture the information on illnesses effectively.
Chronic illnesses during preceding one year and acute illnesses over the previous one month, were
recorded on the basis of reporting by the people. Recording was done of spontaneous reporting followed
by those on a systematic probing. Subjective perceptions were cross-checked with prescriptions or with the
medical practitioners wherever possible, and also with the perceptions of the local healers who provided
medical care. It is worthwhile mentioning here that there was a large proportion of population who was
never provided with a diagnosis on the prescription. There were some who had lost the prescriptions if the
illness did not seem to be something serious to them as compared to other problems in life, and there were
some who, despite consulting a healer, did not have any prescription as the practitioners were not qualified
for curative practice. There was yet another group who reported symptoms but kept quiet about it or very
few of them sought some symptomatic relief. For example, women repeatedly reported of "back ache,
giddiness with or without dimness of vision and blackouts", preventing them from work. Few of them
were already diagnosed as cases of "Bloodlessness" (Anaemia) at some point in time, while some of
them as "Low pressure" (Hypotension) mostly by the community level self-trained practitioner.
In order to get an idea of the proportions of reporting on or without probing, specially in case of reproductive problems of women, a method was later built into the survey in the largest cluster of Surul.

The Baseline survey

This had three major components in it - formulating a schedule, sampling and conducting the interviews to elicit baseline information.

An unstructured open ended schedule was formulated on the basis of the qualitative information (Appendix-II). It was formulated to capture information at three major levels. At the family level it focussed on occupational and caste structures, religion and access to drinking water facilities as well as on fuel resources. It was also to collect demographic information on individuals within families. In the following part, information was elicited on presence or absence of illness, history of illness and associated health actions. Along with these, care at birthing and use of family planning methods by the eligible couples were also the focus of inquiry. The schedule provided scope and space for recording the qualitative bits of information on illness and family planning practices that were provided by the respondents at the time of the survey. Once formulated, the schedule was pretested and standardised in randomly chosen eighty households.

Sampling Procedure

Though the villages were picked up purposively, it was ensured that, for the purposes of the survey of reported illness, an adequate and representative sample was covered. For this it was necessary to have a rough estimation of current illness by referring to either existing literature or a pilot survey (Sundaram,
Two sources were available for the purpose. One was the document of the twenty-eighth round National Sample Survey of 1974 (GOI, 1980), which provides morbidity rates per annum for all ages, for all the states including West Bengal. The other was the findings of the previous exploratory research in Adityapur village of Bolpur block expressing average annual rate of illnesses reported by people above fourteen years of age.

According to the first objective of this study, wherein the attempt is to explore the relative position of women's illnesses compared to that of men, it was proposed to calculate adequate sample size on the basis of the second reference for the following reasons:

a. It provides morbidity estimate for an age group (15 years and above) that is similar to the one that this study has chosen.

b. Women's Health was conceptualised within a similar framework. The basic purpose of both, the previous and the proposed studies, were very similar.

c. As the source of data in the referred study, is a population living within around ten kilometers distance from the villages covered under the present study, chances of variation remain low.

d. Compared to the NSS data, it provides us information on a larger variety of health problems of women (e.g. still birth, pregnancy related problems, perceived weaknesses etc.).
e. Methodology of data collection was based on adequate rapport building, detailed questioning and cross checking with available prescriptions and meeting the health practitioners wherever possible.

The average rate of illness reported in the previous study was 6.8 percent per year and on an average there were three persons above fourteen years in a household.

The estimated population of villages included in this study, by adding 21.96 percent growth rate of the district (1991 Census) to the total population of these villages recorded in 1981 census came to be 11,000. Since the unit of the present study was to be households, considering the national average of family size (five persons per household), the number of estimated households under the study was calculated to be 2,200.

Calculated on the basis of permissible error of 15 percent, the minimum population required for estimation of illness to be reported by the people of 15 years and above was 2340. On the basis of the previous exploratory study where there were an average of three persons in the above age group, a total sample of 780 households was required. The formula used for estimating the minimum sample size is appended (Appendix -III).

Like our previous exploratory study, actual number of households in the survey villages were not exactly similar to that reported even by the Census. While for Binuria the census reported 410 households in the 1991 census, while conducting this survey it was found to be 441. Similarly, for Ballabhpur it was found to be 301 instead of 273, and for Surul it was 1484 instead of 1764 as reported by the census, of 1991. The difference was +7.3% percent for Binuria and +10.2 percent for Ballabhpur, whereas for Surul it
was - 18.1 percent. Thus, the universe under the study was 2225 households instead of 2447, as recorded by the Census of 1991. Thus, though our estimate of minimum sample size was 780, in reality when we covered proportionately one third of the total households, it came down to 742. This, however, did not affect the findings of the survey as the overall prevalence of reported illness was much higher (33.88% per year). Finally the level of standard error turned out to be 12%, while the earlier estimate was 15%.

Thus, the baseline information was collected from 742 households out of the total 2225 households. The distribution of the sample households in the three villages were in proportion to the size of the village. Systematic random sampling method was used for selection of the sample. Thus, every third household was included into the survey. And the sample households covered 2320 women and men under the study. A map of the area that was to be covered under the survey and household lists were already prepared with the help of various social groups before the sample was picked and the survey was begun.

Women were the prime and major source of information in the baseline survey. While for the socio-economic information they provided the general and qualitative information, the occupational details were also substantiated by the men who were directly controlling such activities. However, for information regarding illness, the woman who was actively in charge of the family kitchen was chosen as the prime respondent. This was done with the understanding that it was the food preparation and its distribution system which were first to be adjusted if any member in the family were ill. However, these information were always cross-checked within and outside the family.

While the schedule served as a tool for the baseline survey, the method used for collecting information was mainly personal interviews and, at times, through brief discussions in groups. Questions
were asked directly followed by certain degree of probing. For instance, the question "Did you or anybody else in this family have any illness or injury during past one year, which lasted for more than a month?" was followed by, "Were you or anybody else in your family bedridden due to illness or injury, for more than three days during the past one month?" These questions were followed by probing for specific individuals in the family and also by mentioning the popularly classified parts of the body. Timings for such interactions, however, was chosen according to the convenience of the respondents.

**Case Reports**

Repeated visits were made to the families of the women who were of interest to the objectives of the study. Case reports were developed on thirty such women who represented various socio-economic, generation and illness categories. They provided detailed insights into various social dimensions of the dynamics of women's health and their changing life situations. They were studied in-depth. Apart from visiting these women and listening to them carefully, other family members were also talked to. When required, neighbours and health practitioners were also interviewed.

**Quantitative Probing**

Though it was proposed to quantify some of the critical findings of the qualitative exploration, there were few dimensions of women's life which could meaningfully be clinched upon by a quantitative probing in limited time. However, on the basis of certain key information regarding women's life which were thrown up by the qualitative exploration, a survey was conducted in the households of the traditional village cluster of Surul census village during the last phase of the study. The survey included one woman from every household who was willing to give her time. Their experiences of life were considered to be most relevant to the issues that were thrown up by the qualitative explorations. Two hundred and sixty one women in 291
households were covered by the quantitative probing. Specific information on women's access to family resources, their freedom of spending cash for themselves, burden of their economic and domestic activities, of their physical labour and nutrition were some of the key aspects of women's life that were focused in this probing. Women bearing the maximum burden of the socially defined roles in the family were chosen for this survey. A largely structured schedule was formulated on the basis of the findings of qualitative explorations (Appendix - IV). The schedule was pre-tested in a population of 30 women before it was finalised for the survey. The women were contacted at their convenient time. Interviews were conducted in order to get the information from women's life in the inner courtyard of the household.

Cross-checking

Maximum efforts were put to cross-check information at all possible levels. Moreover, there was a built-in mechanism in the study for cross-checking information as the qualitative exploration proceeded from the institutional and socio-economic to the family and individual level.

5. TIME SCHEDULE OF FIELD WORK

The field work for the study was spread over a period of one year and ten months starting from September 1993, with two breaks of a total of two months duration, which were actually used for articulation of some of the qualitative observations. Broadly, first three months of the field work were utilised for introducing the research proposal and associated ideas to various institutions including the local administration. This period was also used for settling down in one of the villages which was covered under the study, for developing contacts and making rapport with the local people and also for collecting the history of these villages from the locally available secondary literature as well as substantiating them by the popular
knowledge. A total period of six months was taken for qualitative exploration, of which around four months went into the general exploration of the institutional structure and dynamics of the villages and the rest for following up specific cases. Between these two phases of qualitative exploration, the baseline survey was conducted over a complete year. Quantitative probing into specific aspects of women’s life was conducted over the last two months of the field work. While this was the broad schedule of the field work, at times there were overlapping activities due to demands of adjustments which came in the way as a part of community based research.

6. DEFINITIONS USED

Household: A household was defined as the collection of people sharing the food prepared in the same hearth. In this study, the term family has often been used synonymously with the term household.

Reported Illness: People’s reporting of any deviation from normal activities caused due to physical discomforts. The reporting was in response to a simple query and also on probing.

Chronic and Acute illnesses: A chronic illness was defined as any illness persisting for more than three months. An acute illness was defined as the one which interfered in the daily routine activities of the individual sometimes leading to being bed-ridden over a shorter period of time, with or without medical intervention. Health problems of women during pregnancy and at delivery were also included in the study.

Prevalence and Rates: Considering the objectives of our study and the constraint of human resources, we have conducted the survey of reported illness assessment over an year. For chronic illness,
the year preceding the survey was considered as the reference period. Thus prevalence is defined as reported illness over the previous year per hundred population. For acute illness however, the reference period was four weeks to ensure maximum accuracy. The annual rate was calculated by multiplying monthly prevalence by twelve.

**Episodes**: An episode was defined as an attack of illness. The symptom complexes arising simultaneously were considered as a single episode of illness. Whereas different symptoms which appeared at different points in time were considered as multiple episodes. However, for chronic illness, when similar symptoms appeared repeatedly over the year, frequency of which people often found difficult to recall they were considered as a single episode.

7. **ANALYSIS OF THE DATA**

Taking an account of the transformation of the social and economic organisations in the study area over the past century was a prime requisite to explain various aspects of the socio-economic realities that prevailed in the villages at the time of the study. Once such qualitative understanding was developed, stratification of the population under the study became a basic necessity in order to locate women's health in the social dynamics of the transforming villages.

On the basis of the baseline survey, the surveyed households were stratified into different economic categories. According to the levels of land holding and other occupations, families were categorised into the Well-off, Middle and Poor. Collected data were analysed with reference to these categories which are defined explicitly in the table (Table - 2). The criteria for such stratification were
<table>
<thead>
<tr>
<th>ECONOMIC CATEGORIES</th>
<th>UNITS</th>
<th>STUDY VILLAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALL</td>
<td>SURUL</td>
</tr>
<tr>
<td>POOR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Any form of labor alone or supported by agriculture in less than 1 acre of land with/without petty business or employment in household industry or Petty job alone (equivalent to monthly wage or less) or in any combination of others</td>
<td>N</td>
<td>334</td>
</tr>
<tr>
<td></td>
<td>Per Cent</td>
<td>45.01</td>
</tr>
<tr>
<td>2) Petty business alone or supported by any form of labour or employment in household industry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIDDLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Government Service (Class II, III &amp; IV) alone or supported by agriculture upto 2.5 Acres of land with/without petty business or petty job or employment in household Industry or supported by only small private job (Rs 3000/month) or petty job/petty business/ in any combination of these.</td>
<td>N</td>
<td>316</td>
</tr>
<tr>
<td></td>
<td>Per Cent</td>
<td>43.59</td>
</tr>
<tr>
<td>2) Agriculture in 1.5 Acre &lt; 5 Acres of land or supported by wage labour/petty business/employment in household industry or household industry alone/in combination of these.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WELL-OFF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Agriculture in &gt; 5 Acres of land (2) Big business or Government Service (Class I) alone or supported by other government or private services or petty business alone or in combination with agriculture in &gt; 2.5 Acres of land or supported by agriculture alone between 2.5 &lt; 5 acres of land,</td>
<td>N</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Per Cent</td>
<td>12.40</td>
</tr>
<tr>
<td>ALL</td>
<td>N</td>
<td>742</td>
</tr>
<tr>
<td></td>
<td>Per Cent</td>
<td>100</td>
</tr>
</tbody>
</table>
developed from our earlier exploratory study in Adityapur village located in the same rural block. Compared to Adityapur, however, there were more variations in the sources of occupation in the present study villages which were located closer to the town, the highway as well as the central university - Visva-Bharati. The occupational structures of the study villages were influenced by the development of these and urbanisation and related migration into the area, as compared to that in Adityapur, and this made our study population suitable for the study of change and continuity in peri-urban villages and its implications for women's health.

Social groupings of the population on the basis of other social criteria were also looked into. In addition to the traditional caste structure of the dominant Hindu community, the groups were also classified on the basis of their overall way of life. Within the Hindu caste structure there were two major components - the scheduled and the non-scheduled castes. The latter was dominated by the occupational castes followed by the Brahmins and then by the Kayasthas. The scheduled group comprised of largely Bagdi, Bauri, Dom and Suri sub-castes. There was yet another small group who had migrated from Bihar in search of livelihood. They were locally known as 'Bihari' irrespective of their specific caste position.

There were three other social groups which were located outside the traditional caste structure. These were the Muslims and the Tribals who were represented as a whole and their intra-community social divisions did not reflect on the overall social groupings in the area. Besides, there were others who, in connection with employment at Visva-Bharati, had migrated into this area from other Indian states or countries. They were known more as cosmopolitan group with reference to the place of their origin, economic and educational levels and strong urban influences in the way of life, and not by caste.
In the analysis, the social groupings were first matched against the economic classifications; and then the sample households were located in the socio-economic structure. Within the economic categories, the population were divided according to their sex. This helped us in focusing our analysis on the concept of 'gender' within 'economic classification'. The proportions and trends in the relationship between the economic and the sex components were observed across all economic strata. Such analysis was critical to the understanding of the dynamics of both the state and status of women's health in the study villages. Further, the differences between the economic as well as sex related data on the prevalence of reported illness in the study population was statistically verified by applying 'Chi Square' test of significance.

8. LIMITATIONS OF THE STUDY

Time and person power were two major constraints which very often restricted the depth as well as the duration of the follow up which would have generated more details. The study being restricted to only three revenue villages in the particular block of Bolpur, also does not allow to explore the variability of health problems, perceptions and actions in rural Bengal.

In-depth exploration was conducted within limited number of cases, selected purposively. Cross-checking of such explorations was done only to the extent that the time had permitted. It was not possible to cross-check queries at a deep emotional level of women. In addition, the study would also have been strengthened by an epidemiological survey of the population (to see how women's perceptions match actual illness process), but time and resources did not permit this.
The current popular perceptions of the social divisions also involve some religion specific cultural practices and the economic position, in addition to the criteria of traditional caste system. Explanations of this, however, needs a historical analysis of the caste and other social hierarchies in the state as well as in the specific region, which was not possible within the scope of this study.