CHAPTER-I
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One of the burning issues in third world countries in the last phase of 20th century was the concern about individual health and also the facilities available to get good health. World Health Organization's motto is to provide good health to all humans across the world. As a result, most of the countries in general and the third world countries in particular have launched several programmes to provide good health facilities to its citizens without any discrimination of caste, creed, race and gender as well.

Health is a common theme in every society and has its own beliefs and practices regarding healing diseases and its treatment. Since time immemorial, man has been trying hard to control diseases. The medicine man, the priest, the herbalist and the magician all undertook various ways and means to cure man's diseases and thereby to bring relief to the sick. In the past health and illness were interpreted in a Cosmological as well as Anthropological perspective. Medicine in the past was dominated by magico-religious beliefs, which were an integral part of society itself. Dubos (2002) opines that, "ancient medicine" was the mother of every Culture. All of these practices are keenly interrelated with environment. During the past few decades the concept of health has emerged as a fundamental human right and a worldwide social goal. In 1977, the 30th World Health Assembly decided that the main social target of the
government and World Health organization in the coming decades should be “the attainment by all citizens of his world by the year 2000 of a level of health that will permit them to lead a social and economically productive life.” For brevity, called “Health for All”, with the adoption of health as an integral part of Socio-economic development by the United Nations in 1979, health while being an end in itself has also become a major instrument of overall Socio-economic development and the creation of a new social order.

India, the second most populous country on the globe having more than one hundred crore of population. Almost half of the population constitute women folk. More than 70% of the women live in rural areas working either as housewives or agricultural labourers. Added to this these women folk are from suppressed, oppressed and depressed sections and they are a neglected lot. As a result, they find it very difficult to lead a problem free and a meaningful life. Basically India is known as an agrarian economy. Our men folk along with women busily engaged themselves in the cultivation of land and there by produced sufficient food stuffs and became responsible for Green Revolution and made the country totally self sufficient in the field of food grains. Since time immemorial women also have contributed their might in various ways according to their capacity with regard to the development of the society. And at the same time, women were exploited, neglected, rejected, abused and most inhumanly treated over the centuries, by feudal Lords, Zamindars and the Rich upper strata of the society. India being a
patriarchal society wherein only men enjoyed all status including the right to inherit the property and women were deprived in several ways and became a mere burden to the society. Among such several fields of sheer negligence, their health in general and reproductive health in particular suffered a setback. The health disorders of the women folk were badly neglected or not attended due to gender discrimination which is prevailing in society since a very long time. As a result, the sufferings, sorrows and feelings were swallowed incessantly by these women folk without being told to others openly.

Health plays an important role in the life of an individual. This is because of the fact that since inception man had faced several health hazards and to overcome this, tried through several mechanisms including Ayurveda, Homeopathy, Siddha, Unani, Tibet and Chinese. Before the recognition of medical systems our primitive ancestors had used and tried several means and ends to combat their health hazards by trial and error methods, with the indigenously available medical plants. Due to this mortality rates were decreased considerably. At present mortality rates were slowly and steadily reduced to the minimum. Health may be classified in to two types, General health and Reproductive health. General health and condition of general health are more are less visible and openly shared and discussed in public. But the reproductive health is neither visible nor publicly discussed. It is purely private and individualistic in character.
India, in the initial stages dominated by poverty, illiteracy, superstition, and blind beliefs. These things were very common in the beginning due to their unquestioned faith in the existence of supernatural beliefs. Many reproductive disorders were not discussed properly and openly by these women because of their shyness. They hesitated a lot in convening them to their nearer and dearer ones. Due to this many Sevier problems were not attended properly and got the expected relief. As a result of this people did not pay much attention to their health in general and reproductive health in particular. Added to this India was known for Agrarian economy. Agriculture was not only an occupation but a way of life. Hence people irrespective of their gender involved in this. Women constitute almost 50% of the total population. They too contributed their might in the overall development of the economy and agricultural sector. These women folk were illiterate, highly conservative and also the victims of child marriage. As a result they knew nothing about reproductive health hazards like, miscarriages, pregnancy, abortion, and such other things. If at all these things happen they felt that it was due to the wrath of the dead ancestors or Gods and Goddesses.

World Health Organization (W.H.O) has defined Health as a “state of complete physical, mental and social well being and not merely an absence of disease or infirmity” (W.H.O. 1948). The Webster dictionary defines health as “the condition of being sound in body, mind or spirit especially freedom from physical disease or pain”. Health to all is the prime motto of W.H.O.
WHO (2008) defines 'Reproductive health, or sexual health/hygiene, addresses the reproductive processes, functions and system at all stages of life. Reproductive health implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so'.

Definitions of Reproductive Health:

Reproductive health occupies a central position in the identity of the health as well as the development of a given population. However, the events of reproductive health are usually found in women who due to their biological function invariably bear the greater burden of the shortcomings of reproductive health such as unsafe motherhood or unsafe abortion. In developing countries especially in rural, there is need to improve maternal and child health care services as most deaths of women during pregnancy or delivery are preventable.

Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods
of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

**Significance of Reproductive Health**

The current focus on reproductive health marks a global recognition that reproductive health needs have been largely abandoned and that the consequences of this neglect have been profound, particularly for women. According to World Health Organization (WHO) health is one of the fundamental human rights. Unfortunately health cannot be given or distributed, but has to be actively acquired and won. Health is a very broad concept and reproductive health is a fundamental component of general health. A very simple indication of the level of wellbeing enjoyed by women in India is that, in large parts of the country, their levels of education are amongst the lowest in the world, and the levels of maternal mortality are amongst the highest in the world. Indian women, by and large, have poor reproductive health status. One of the reasons why women succumb to reproduction-related complications is lack of timely transportation to the nearest hospital. Experts estimate that 70% of the maternal-related deaths are preventable. Tetanus and anemia claim a large number of women because mothers get very little or no care in the postnatal period. Anemia can be overcome with proper nutrition and supplements. But cultural, social and economic barriers delay or prevent women from seeking reproductive health care at any stage antenatal
delivery or postnatal. Safe maternity is a vital social indicator which requires immediate attention.

Reproductive health in India is largely influenced by poverty related and socio-cultural factors on one the hand and program interventions on the other. Socio-cultural factors which impinge on reproductive health include women’s lack of awareness of health practices, strong seclusion norms which inhibit health-seeking, adolescent marriage, large family size norms which encourage frequent and closely spaced pregnancies, and a general devaluation of women which makes them the last to obtain food or health care and which requires them long periods of physical activity. Interventions directed towards reproductive health include maternal and child health, integrated child development services and family planning programmers. The present chapter considers each of these underlying sets of factors and the ways in which they affect reproductive health at various stages of the life cycle.

Reproductive health encompasses a range of health concerns, as indicated in the consensus definition emerging from the 1994 International Conference on Population and Development (ICPD) at Cairo. Specifically, reproductive health is defined as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes’ (United Nations, 1994). A reproductive
health orientation, drawn from this and other sources, more specifically implies:

- A satisfying and safe sex life free from the fear of disease and free from coercion and violence.

- The capability to reproduce, and the freedom to decide if, when and how often to do so; that is, that women and men have the right to be informed, and have access to, effective, affordable and acceptable methods of family planning of their choice on the one hand, and access to infertility services on the other.

- The ability to go safely through pregnancy and childbirth and have the best chance of having a healthy infant, and the right of access to appropriate health care services.

- Access to safe and affordable abortion facilities

- Access to services for the prevention and care of sexual and reproductive health problems, both gynecological and obstetric, in a culturally sensitive manner.

- The right of all, including women, men, married, and unmarried adolescents, to information and services (including counseling), whether on contraception, pregnancy, disease or the implications of coerced sex, and the freedom to make decisions on the basis of this information.

This implies that although reproductive health problems, per se, are rooted in the biomedical sphere, their origin often lies in human behavior.
that is embedded in socially and culturally constructed patterns of gender relations.

The concept further recognizes that women’s needs are different from those of men because biologically and socially women’s bodies and social realities are different from those of men. To that extent, women’s health risks and their health seeking behavior may also be expected to be different. And since women are generally more disadvantaged than men, their vulnerability to common health risks may be expected to be much greater, with additional implications for their reproductive health. But precisely because unequal gender relations disadvantage women, i.e., man’s culturally conditioned behaviors and roles sustain women’s vulnerability to health risks, the challenge is to investigate how women may be empowered on the one hand and on the other, how men may be drawn into the process of responding to women’s reproductive health needs.

Reproductive ill health represents an important part of the overall burden of disease, especially for women. From infancy through old age, problems such as female genital mutilation, malnutrition and anemia, unwanted pregnancies, reproductive tract infection including socially transmitted diseases, HIV/ AIDS, infertility, sexual and gender violence, unregulated fertility, maternal mortality and morbidity, breast and cervix cancers, osteoporosis and prolapsed of uterus in later years take a toll on women and her healthy life.
• The health consequences of violence against women – rape, sexual abuse and forced prostitution - have been contributing substantially to the burden of disease in women.

• The rapid spread of HIV/AIDS, particularly among young women demonstrates their vulnerability and the need for sensitive and responsive educational messages, technologies and services. It also demonstrates the need to address gender inequalities.

• Women’s desperate burden is a result of the social, economic and political disadvantages that have a detrimental impact on their reproductive health.

Reproductive health is relatively a new field of research; most studies focused on fertility and family planning until recently. Women are the prominent focus of research in the area of reproductive health. Reproductive health is seen in the program of action as linked to reproductive rights, which in turns are a part of basic human rights (UN, 1995). Women bear most of the responsibility in sexuality and reproduction through contraceptive use, pregnancy, child birth and breast-feeding. They also bear the greatest burden of reproductive ill health. Their burden starts even at birth. Having a son is like having two eyes, having a daughter is like having only one eye; says an old proverb.

Keeping in view the concept of reproductive health the present study entitled ‘Women Farm Labourers and their reproductive health’ been undertaken. This study has been conducted in two multi caste
villages of North Karnataka which are numerically bigger in size. Women Farm Labourers were selected at random giving appropriate attention for their caste/community, marital status and their groups. These people were briefed specifically about the importance of the study and how one can take care about one’s Reproductive Health. First of all the informants were informed about some ticklish issues such as Miscarriage, Pregnancy, Abortion, Child and a number of other issues involved in it. Sizeable respondents were selected at random who are sexually active and were totally unaware of the reproductive health and its disorders / hazards. This is true that the rural women folk are by and large illiterate and hails from agrarian families. Added to this before something is learnt or known about marriage, husband and children their marriages were celebrated. A series of issues regarding reproductive health has been taken up seriously and meticulously dealt with. Issues such as, Miscarriages, Pregnancy, Abortion, Problems in Child delivery and Menopause were studied carefully. Attempts were made to understand these issues by using both emic and etic perspectives.

Anthropology occupied a notable position in the basic medical sciences which correspond to those subjects commonly known as pre-clinical. However, medical education started to be restricted to the confines of the hospital as a consequence of the development of the clinical gaze and the confinement of patients in observational infirmaries. The relationship between medical practice and anthropology is well
documented. Some of the characters share clinical and anthropological roles. Whereas a large number of contributors to 20th Century medical anthropology had their primary training in medicine, nursing, psychology or psychiatry, including W.H.R. Rivers, Abram Kardiner, Robert I. Levy, Jean Benoist, Gonzalo Aguirre Beltran and Arthur Kleinman. Others came from anthropology or social sciences, like George Foster, William Caudill, Byron Good, Tullio Seppilli, Gilles Bibeau, Lluis Mallart, András Zempleni, Gilbert Lewis, Ronald Frankenberg, and Eduardo Menéndez. A recent book by Saillant & Genest describes a large international panorama of the development of medical anthropology, and some of the main theoretical and intellectual actual debates. The hegemony of hospital clinical education and of experimental methodologies suggested by Claude Bernard relegate the value of the practitioners' everyday experience who was previously seen as a source of knowledge represented by the reports called medical geographies and medical topographies both based on ethnographic, demographic, statistical and sometimes epidemiological data. After the development of hospital clinical training the basic source of knowledge in medicine was experimental medicine in the hospital and laboratory, and these factors together meant that over time mostly doctors abandoned ethnography as a tool of knowledge. Most, not all because ethnography remained during a large part of the 20th century as a tool of knowledge in primary health care, rural medicine, and in international public health. The abandonment of ethnography by medicine happened when social anthropology adopted
ethnography as one of the markers of its professional identity and started to depart from the initial project of general anthropology. The divergence of professional anthropology from medicine was never a complete split.

Since the mid-1960s, medical anthropology has developed three major orientations. Medical ecology views populations as biological as well as cultural units and studies interactions among ecological systems, health, and human evolution. Ethnomedical analysis focuses on cultural systems of healing and the cognitive parameters of illness. Applied medical anthropology deals with intervention, prevention and policy issues and analyses the socioeconomic forces and power differentials that influence access to care. In this triad, cultural anthropology is most closely allied with ethnomedicine. In the formative years, some anthropologists favoured identifying the field as "ethnomedicine," while others preferred "anthropology of health." The term "medical anthropology" prevailed, however, coming to represent a diversified range of orientations.

The term "medical anthropology" has been used since 1963 as a label for empirical research and theoretical production by anthropologists into the social processes and cultural representations of health, illness and the nursing/care practices associated with these. Furthermore, in Europe the terms "anthropology of medicine", "anthropology of health" and "anthropology of illness" have also been used, and "medical anthropology", was also a translation of the 19th century Dutch term
"medische anthropologie". This term was chosen by some authors during the 1940s to refer to philosophical studies on health and illness.

**Medical Anthropology:**

Medical Anthropology is an interdisciplinary field which studies "human health and disease, health care systems and bicultural adaptation". It views humans from multidimensional and ecological perspectives. It is one of the most highly developed areas of anthropology and applied anthropology, and is a subfield of social and cultural anthropology that examines the ways in which culture and society are organized around or influenced by issues of health, health care and related issues. Medical anthropology is the study of human health and disease, health care systems, and bicultural adaptation. The discipline draws upon the four fields of anthropology to analyse and compare the health of regional populations and of ethnic and cultural enclaves, both prehistoric and contemporary. Collaboration among paleopathologists, human biologists, ethnologists, and linguists has created a field that is autonomous from any single subdiscipline, with strong potential for integration of physical and Cultural anthropology. The field is also highly interdisciplinary, linking anthropology to sociology, economics, and geography, as well as to medicine, nursing, public health, and other health professions.
Doctors, anthropologists and medical anthropologists used these terms to describe the resources, other than the help of health professionals. The term was also used to describe the health practices of aborigines in different parts of the world, with particular emphasis on their ethno-botanical knowledge. This knowledge is fundamental for isolating alkaloids and active pharmacological principles. Furthermore, studying the rituals surrounding popular therapies served to challenge Western psychopathological categories, as well as the relationship in the West between science and religion. Doctors were not trying to turn popular medicine into an anthropological concept; rather they wanted to construct a scientifically based medical concept which they could use to establish the cultural limits of biomedicine.

The concept of folk medicine was taken up by professional anthropologists in the first half of the twentieth century to demarcate between magical practices, medicine and religion and to explore the role and the significance of popular healers and their self-medicating practices. For them, popular medicine was a specific cultural feature of some groups of humans which was distinct from the universal practices of biomedicine. If every culture had its own specific popular medicine based on its general cultural features, it would be possible to propose the existence of as many medical systems as there were cultures and, therefore, develop the comparative study of these systems. Those medical systems which showed none of the syncretism features of European
popular medicine were called primitive or pre-technical medicine according to whether they referred to contemporary aboriginal cultures or to cultures predating Classical Greece. Those cultures with a documentary corpus, such as the Tibetan, traditional Chinese or Ayurvedic cultures, were sometimes called systematic medicines. The comparative study of medical systems is known as ethno-medicine or, if psychopathology is the object of study, ethno-psychiatry or transcultural psychiatry.

Under this concept, medical systems would be seen as the specific product of each ethnic group's cultural history. Scientific biomedicine would become another medical system and therefore a cultural form which could be studied as such. This position, which originated in the cultural relativism maintained by cultural anthropology, allowed the debate with medicine and psychiatry to revolve around some fundamental questions:

1. The relative influence of genotypical and phenotypical factors in relation to personality and certain forms of pathology, especially psychiatric and psychosomatic pathologies.
2. The influence of culture on what a society considers tube normal, pathological or abnormal.
3. The verification in different cultures of the universality of the nosological categories of biomedicine and psychiatry.
4. The identification and description of diseases belonging to specific cultures which have not been previously described by clinical

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medicine. These are known as ethnic disorders and, more recently, as culture bound syndromes, and include the evil eye and tarantism among European peasants, being possessed or in a state of trance in many cultures, and nervous anorexia, nerves and premenstrual syndrome in Western societies.

Since the end of the 20th century, medical anthropologists have had a much more sophisticated understanding of the problem of cultural representations and social practices related to health, disease and medical care and attention. These have been understood as being universal with very diverse local forms articulated in transactional processes. The link at the end of this page is included to offer a wide panorama of current positions in medical anthropology.

In the western countries collaboration between anthropology and medicine was initially concerned with implementing community health programs among ethnic and cultural minorities and with the qualitative and ethnographic evaluation of health institutions (hospitals and mental hospitals) and primary care services. Regarding the community health programs, the intention was to resolve the problems of establishing these services for a complex mosaic of ethnic groups. The ethnographic evaluation involved analyzing the interclass conflicts within the institutions which had an undesirable effect on their administrative reorganization and their institutional objectives, particularly those conflicts among doctors, nurses, auxiliary staff and administrative staff.
The ethnographic reports show that interclass crises directly affected therapeutic criteria and care of the ill. They also contributed new methodological criteria for evaluating the new institutions resulting from the reforms as well as experimental care techniques such as therapeutic communities. The ethnographic evidence supported criticisms of institutional custodialism and contributed decisively to policies of deinstitutionalizing psychiatric and social care in general and led to, in some countries such as Italy, a rethink of the guidelines on education and promoting health.

The empirical answers to these questions led to anthropologists being involved in many areas. These included: developing international and community health programs in developing countries; evaluating the influence of social and cultural variables in the epidemiology of certain forms of psychiatric pathology (transcultural psychiatry); studying cultural resistance to innovation in therapeutic and care practices; analyzing healing practices toward immigrants; and studying traditional healers, folk healers and empirical midwives who may be reinvented as health workers (the so-called barefoot doctors).

Since the 1960s, biomedicine in developed countries has been faced by a series of problems which demand that we inspect the (unfortunately-named) predisposing social or cultural factors, which have been reduced to mere variables in quantitative protocols and subordinated to causal
biological or genetic interpretations. Among these the following are of particular note:

a. The transition between a dominant system designed for acute infectious pathology to a system designed for chronic degenerative pathology without any specific etiological therapy.

b. The emergence of the need to develop long term treatment mechanisms and strategies, as opposed to incisive therapeutic treatments.

c. The influence of concepts such as quality of life in relation to classic biomedical therapeutic criteria.

Added to these are the problems associated with implementing community health mechanisms. These problems are perceived initially as tools for fighting against unequal access to health services. However, once a comprehensive service is available to the public, new problems emerge out of ethnic, cultural or religious differences, or from differences between age groups, genders or social classes. If implementing community care mechanisms gives rise to one set of problems, then a whole new set of problems also arises when these same mechanisms are dismantled and the responsibilities which they once assumed are placed back on the shoulders of individual members of society.

In all these fields, local and qualitative ethnographic research is indispensable for understanding the way patients and their social
networks incorporate knowledge on health and illness when their experience is nuanced by complex cultural influences. These influences result from the nature of social relations in advanced societies and from the influence of social communication media, especially audiovisual media and advertising.

Currently, research in medical anthropology is one of the main growth areas in the field of anthropology as a whole and important processes of internal specialization are taking place. For this reason, any agenda is always debatable. In general, we may consider the following six basic fields:

- the development of systems of medical knowledge and medical care
- the patient-physician relationship
- the integration of alternative medical systems in culturally diverse environments
- the interaction of social, environmental and biological factors which influence health and illness both in the individual and the community as a whole
- the critical analysis of interaction between psychiatric services and migrant populations ("critical ethno-psychiatry": Beneduce 2004, 2007)
- the impact of biomedicine and biomedical technologies in non-Western settings
Other subjects that have become central to medical anthropology worldwide are violence and social suffering as well as other issues that involve physical and psychological harm and suffering that are not a result of illness. On the other hand, there are fields that intersect with medical anthropology in terms of research methodology and theoretical production, such as cultural psychiatry and transcultural psychiatry or ethno psychiatry.

Theories of the cultural patterning of health behavior can be applied in any arena. Following the pioneering examples set by Margaret Clark, George Foster, and Pertti Pelto, anthropologists work, for example, in clinics serving multicultural populations, in maternal and child health programs, on surveys of community responses to environmental hazards, on program planning and evaluation in psychiatric hospitals, on AIDS prevention projects, and on the reintegration of people with traumatic brain injury to community life. The populations served are often people on the margins of mainstream society—refugees, native peoples, rural elderly, drug addicts, people with disabilities, ethnic minorities. The difference between basic and applied research is that applied medical anthropologists deliberately become advocates for the community and attempt to do research that is useful and ethical.

While some applied research is a theoretical, others employ explicit theoretical frameworks. One notable framework is the political economy of health, also called critical medical anthropology. Influenced by Marxist
theory and dependency theory, this approach analyses the impact of global economic systems, particularly capitalism, on local and national health. Political economists such as Soheir Morsy, Hans Baer, Lynn Morgan, and Merrill Singer argue that change programs should not be attempted unless one also studies the social production of illness and poverty within the larger dynamics of class interactions, colonialism, or world economic systems.

Critical clinical medical anthropology is an adjunct of political economy. This approach analyses biomedical practice and the differentials in power and authoritative knowledge of practitioner and patient. Clinical anthropology has been influenced by Michel Foucault's writings on the historical production of medical knowledge and the notion that the body can become an arena in which social control issues are played out. Usually focused on medical communication, the approach has been used particularly in relation to women's reproductive health and has developed a controversial literature on the lexicalization of women's bodies through the work of Brigitte Jordan, Emily Martin, Rayna Rapp, and others.

Applied anthropology methods are eclectic, ranging from qualitative to highly quantitative. Ethnographers have developed rapid assessment techniques to document community health needs during brief field trips. Others trained in public health, epidemiology, nursing, or medicine may do clinical or laboratory procedures or work with vital
statistics. In quantitative approaches, rigorous attention is paid to sampling issues and sophisticated statistical analysis, and informed consent procedures are followed. As Carole E. Hill (1991) points out, many medical anthropologists are now working outside academia and combining standard anthropological skills with technical planning and evaluation skills.

Medical Anthropology addresses the biological, cultural, and political-economic dimensions of health, illness, and healing historically and at present. Research includes attention to the body as a site of symbols and evolutionary processes, suffering and healing as interpretive processes, and the multiple facets of affliction at individual and collective levels.

Biomedicine and a range of other healing systems come under scrutiny as social phenomena shaped by the impact of history, social organization, and dynamic relations of power. Thus, health issues are considered in relation to broader, intersecting systems of environment and ecology, gender, sexuality, race/ethnicity, nation, and class subjectivities. A central contribution of medical anthropology is the critical analysis of how knowledge about health is constructed, deployed, and contested in various social arenas and for various purposes.
Place and People

The present study has been carried out in Soundatti Taluka of Belgaum district. Two multi-caste villages are selected which are numerically big in size has been selected at random and studied in detail.

Women farm labourers from this village has been selected at random from all castes and that too in the age group of ‘18-45’. Sufficient care has been taken to keep the informant’s information confidentially.

Somapur and Irapur are the two multi-caste village selected to undertake this study. This village has been dominated by agriculture. As a result of this in this village one could find lot of women folk who work as landless agricultural labourers. These farm women labourers are studied for their reproductive health disorders. In the beginning a pilot study was conducted to study these women folk to understand their overall socio-economic and cultural background. Added to this these women folk were classified on the basis of age and caste. 400 (Four hundred) samples were selected at random for this study. For a clear understanding of the health disorders, I restricted the sample size of the women for study from 18 to 45 age group only. On an average in a rural scenario, a girl will be given in marriage at the age of 16 to 18 years. As a result of this, at this age, it is very difficult for her to know about the reproductive hazards as well. This is due to the non awareness of health aspects in general and reproductive health in particular. Out of the four hundred respondents, 55
women are in the age group of 18 - 25, 93 are in the age group of 26 - 37, 108 are in the age group of 38- 45 and remaining 144 are in the age group of 45 and above. Women in the age group of 18-25 suffering from an innumerable reproductive health disorders which have affected their reproductive life badly. The major problems like, recurrence of frequent white discharge, urinary tract infections, miscarriages, and giving birth to the babies which are not normal in nature and so on, are commonly found among them. Soundatti and its adjacent places are known for dry land cultivation. It requires lot of manual work from morning till evening. Both men and women involve in cultivation of land. Due to the Constant work in the fields, without proper hygienic conditions made these women folk to develop a series of health disordres. Especially the carrying ones who work continuously without break and rest are prone to loose their pregnancy. As a result miscarriages are more in number. To find the exact solution to these problems the researcher met Ayurvedic, Homeopathy and Allopathic doctors in the area to whom these women labourers often visit for medical checkup. For many having sexual intercourse itself is a major problem due to several constraints due to multiple infections. As a result most of these women folk by and large avoid sexual intercourse to avoid problems. 93 respondents fell under the category of 26- 37. They are sexually active. The common problems are also confronted them. Yet they are managing the same, with indigenously available
medicine. It is also true that the male life partners often visit to different womenfolk outside the family fold for sex. Hence they may be infected by several Sexually Transmitted Diseases (STDs). 108 respondents are the age group of 38 to 45. 40 out of 70 respondents are totally frustrated regarding sexual life. They are the chronic patients of reproductive health disorders, like frequent abortions, multiple miscarriages and constant white discharges. Out of remaining 30 have got tubectomy operation to get space rid of these multiple health disorders. 25 respondents are in the age group of 45 and above. They are totally free from reproductive health disorders of whatsoever. This is due to the awareness they got through education and other Medias. In simple one can say, several problems have come in the way of having safe sexual life to these women. Malnutrition, Anemic, Low level of hemoglobin level, Low immunity has made them totally helpless and burdensome.

Socio-Economic Background of Farm Women Labourers:

India is a country wherein one finds both vertical and horizontal divisions. Unless we know the social structure which is caste based one it becomes very difficult to arrive at a definite conclusion. The most striking point is that the women agricultural labourer hails from the so called downtrodden sections only. Due to the utter poverty, the women folk from these sections were forced to go out of the family to work as agricultural labourers. When they go like this there is every possibility that, in their working place they may not get good drinking water or good
Some times even the women who are carrying ones are compelled to work heavily from morning till evening without rest. The most unhygienic conditions and also the environment which is prevailed there is a not conducive to their work. As a result whenever and wherever they get water both hygienic and unhygienic drink and get infected. Due to their resistance they may not get the infection quickly but in due course of time they pay for it. Most of the downtrodden sections do not own agricultural lands. They are landless agricultural labourers hence they go out to work without any alternative to earn a living for them and to their dependants.

**Social Composition**

The field work has been carried out in two villages of Sounadtti taluk of Belgaum district, which are multi caste ones and having population of 16500 and 9200 respectively. As many as eight castes are inhabited. The subject for this study has been selected at random from different castes and religious groups from both the villages giving sufficient attention on age, caste, marital status and gender. Parameters like education, economic status, marital status and their social status in the village have used in collecting the overall socio-cultural background of these subjects.
Social Composition of Farm Women Labourers
(Caste wise and Age wise)

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<td>010</td>
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</tr>
<tr>
<td>6</td>
<td>Muslim</td>
<td>09</td>
<td>14</td>
<td>18</td>
<td>27</td>
<td>068</td>
<td>17</td>
</tr>
<tr>
<td>7</td>
<td>Jain</td>
<td>00</td>
<td>01</td>
<td>02</td>
<td>01</td>
<td>004</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Harijan</td>
<td>08</td>
<td>13</td>
<td>20</td>
<td>24</td>
<td>065</td>
<td>16.25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>55</strong></td>
<td><strong>93</strong></td>
<td><strong>108</strong></td>
<td><strong>144</strong></td>
<td><strong>400</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table No-1

Graph-1

The above table shows that caste wise and age wise distribution of the samples. Out of 400 respondents 135 are from Lingayat Community which comprising the age group of between 18 and 25 there are 21 subjects, between 26 and 37 there are 37 samples, 33 subjects were fall
under the age group of 38 and 45 and remaining 44 respondents are in the age of 45 and above.

Next to Muslim Community, out of 68 subjects 9 are in the age group of 18-25, in the 26-37 age group there are 14 respondents, 18 samples are fall under the age group of 38-45 and remaining 27 are in the group of 45 and above.

Then coming to Harijan Community, out of 65 samples 8,13 are in the age of 18-25 and 26-37 respectively. 20 subjects are falling under 38-45 and remaining 24 respondents are in the age group of 45 and above.

Subsequently to Kuruba Community out of 58 population of Kuruba, 8 subjects are fall under the age group of 18-25. 10 subjects are in 26-37, 18 respondents are in 38-45 and left over 22 respondents are fall under the age group of 45 and above.

Then coming to the Talwar community, out of 45 subjects 5 are in 18-25 age group, 9 are in 26-37, 13 are in 38-45 and remaining 18 subjects are in the age group of 45 and above.

Next to Madiwala community out of 400 respondents 15 are from the same community, which comprising the age group of between 18 and 25 there are 03 subjects, between 26 and 37 there are 06 samples, 02 subjects were fall under the age group of 38 and 45 and remaining 04 respondents are in the age of 45 and above.

Then among the Jadar and Jain community there are 10 and 04 subjects respectively. In the age group of 18-25 only one Jadar subject is there, 3,1 subjects are fall under the age group of 26-37 respectively. 2
Jadar, 2 Jain community respondents are in the age group of 38-45. Remaining 4 Jadar, one Jain Community subjects are in the age group of 45 and above.

Regarding the economic status of the farm woman labourers is concerned, majority of them are living below the poverty line. As a result of this they don’t find any alternative other than working as agriculture labourers.

Few reproductive issues such as pregnancy, miscarriages, abortion and Menopause have been tackled with them.

1. **Pregnancy**: Indigenously known as माता / ಮಾತಾರು. It indicates a woman who has growing fetus inside her.

2. **Miscarriages**: Locally known as ಹೋಗಕುಂಬಿ / ಹೋಗಕುಂಬಿ. It is a spontaneous abortion which takes place unknowingly. A number of causes are responsible for miscarriages. Due to chromosomal or genetic problems, pregnancies failed. Added to this constant work, that too hard work without rest also lead to such miscarriages.

3. **Abortion**: Indigenously known by the term, (ಮುಂಚೆಯು) (Medical Termination of Pregnancy-MTP). This is an intentional termination of pregnancy. Unwanted pregnancies can be terminated through various means by using both Ayurvedic and Allopathic methods.

4. **Menopause**: Locally known as ವಾಸ್ತು / ವಾಸ್ತು. This is nothing but the cessation of menstrual period. The age at which
this occurs differs from woman to woman. A number of cultural factors are also responsible for this. This is also determined by environmental and food habits. Menopause means a woman ceases to give birth to a child.

Out of 400 respondents to whom I have interviewed, 104 women were pregnant. 24 women had lost their pregnancy spontaneously due to constant and hard work and without rest. 11 have got abortion on their own to avoid unwanted pregnancy, 75 women have given birth to babies and the remaining 186 women have attained menopause. On an average the respondents to whom I have studied deprived of good health in general and reproductive health in particular.

**Research Methodology:**

Doing research in Anthropology has a unique feature of its own. This is because of the fact that a researcher in anthropology does her/his research work keeping in view the holism of the discipline, learning native language and staying with people for months together to explore the necessary and relevant data needed for her/his research work. By staying with people he/she establishes his/her first hand rapport with them and at the same time he/she uses key informants to cross check the data which he/she gets in the field. By staying with them the researcher, creates conducive atmosphere to make the group to feel this researcher is one of the members of the group which he studies. By doing so both the researcher and the community feel happy about each other's temperament and at the same time both of them will be able to understand the nature of
the work and also about the information sought for the research work. This is what Malinowski advocated the importance of participant observation in Anthropological research.

The important tools of Anthropological research have been used to complete this work such as Observation, Interview and Case Study method. Through these tools it was possible to gather the sufficient information which was needed for my study. Since doing research in anthropology involves intensive, in-depth and qualitative field work to collect information for the research work. Much of the data has been collected through participant observation. The researcher involved intensively among the informants who too involved in the preparation of reproductive health. Most of the information collected through in-depth interviewing the case studies regarding women’s reproductive hazards have added additional strength to this work. As a result of this, the information collected has been cross checked with the information available through key informants.

Observation is one of the important tools of anthropological research. Any amount of information can be gathered or collected by the virtue of this participant observation. Researcher observes all the spontaneous activity and situations which take place around him. P.V.Young (1961) opines that “observation means what all the spontaneous things that occur before him”. Participant observation is the foundation of cultural anthropology. It involves getting close to people to
make them to feel and educate about his research work. The technique also helped the researcher to know the depth and dimensions

Anthropology is the holistic study of man. It has been defined in different authors depending upon its understanding to them. Among them the definition of Herskovits (1940) appears as if it is very comprehensive one and it runs like this “Anthropology is the study of man and his work”. Whatever human beings do, come under the purview of anthropology. It has several branches of its own. Studying in a specie both biological and cultural aspects might be the specialty of anthropology. Side by side with other branches of anthropology, Anthropology of women also gained much popularity, wherein the study on women, their problems and prospectus were highlighted as and when the specialist attempted to study them over the years. Anthropology of women is solely devoted for the study of women from several attributes by using both Emic and Etic perspectives.

Apart from participant observation, the researcher also relied upon interview which is also treated as one of the very important tools of acquiring information. In this the researcher interviews the informants about his topic of research by maintaining a cent percent confidentiality and so on. Depending upon the quality of the people he frames questions to ask. In simple majority of the amount of information which he collects will be crosschecked whenever occasion demands from both the key informant and others. In doing so the researcher maintains his confidentiality so that nothing untoward incident happens. Being close to
the people the researcher without spoiling the time and without distorting the informants collects information.

This study has following objectives:

1. To know the perception of reproductive health amongst women farm labourers.

2. To understand the various mechanisms adopted to overcome the reproductive health problems indigenously.

3. To make them aware of reproductive health hazards.

4. To understand what they understand by reproductive health management.

Two Villages have been selected to do field work for my research work. These two villages are located in Belgaum district, Karnataka, where I am working. These two villages are multi-caste ones. The total populations of the villages as per village panchayat census are 16,500 comprising of 9374 males, 7126 females and 9200 of which 5566 are males while 3634 are females respectively. The social composition of the villages consists of Lingayats, Kuruba, Talwar, Madiwala, Jadar, Muslim, Jaina and Harijans.

Lingayats are the dominant ones both in terms of numerical number as well as economically. Educationally also these two villages are doing better in educating their children. In these villages Eight Government
Schools, one high school, two convents and one Pre-University College is there. One Veterinary Hospital, one Government Hospital, and more than 10 doctors are doing practice in these two villages.

In these two villages there are 18 temples and more than 8 Musjids are found. One bank (Karnataka Vikasa Grameena Bank), more than five co-op societies, post office, on telephone exchange office, one electricity grid and many Self Help Groups (SHG’s) are working in villages. 26 water tanks, 9 bore wells, two post offices and one BSNL (Bharat Sanchar Nigam Limited) office are found in these two villages.
Women Labourers separating veed in ground nut field

Women Labourers after the work going back to the village
Family Types

Families in India may be viewed from different view-points and the classifications obtained thereby are indeed varied in nature. Till recently these two villages had very good number of joint families which in tum is an indication of physical solidarity and oneness.

Iravati Karve defines joint family as “a group of people who generally live under one roof, who eat food cooked at one hearth, who hold property in common and who participate in common family worship and are related to each other as some particular type of kindred.

Flora

Somapur village is surrounded by a number of trees. Every village irrespective of its other differences has some common trees having its impact on agriculture, animal husbandry and human beings. The trees, which are traceable here are Neem trees, Tamarind and Mango trees. We can find several plants of fruits and bushes along with the main trees. All together the flora is appeared as green and looks attractive by the virtue of irrigation facility.

Fauna

Every village in India is in need of several animals for their settlement. As Indian agriculture is yet to be machanised fully, the people of somapur greatly depend on animals for various agricultural activities like tilling of the land, the Buffaloes and Bulls are used for transportation (bullock carts). Cows, Sheeps, Goats Buffaloes mainly used for milk. Among them cows gained religious status and worshiped by Hindu
people. Due to the scientific methods of cultivation specially the cultivation of land by tractors, the importance given to the bullocks are reduced to the minimum. Very rarely people use animals for the cultivation of land.

Soil

The soil of the taluk is red loam, black deep and excessively drained, gravely clay type of gently sloping area in alluvial plains with moderate erosion. The land is suitable for cultivation of sugar cane, maize, cotton, tobacco, paddy, ragi, jowar, pulses, fruits and vegetables.

Temperature & Rain Fall

The temperature is minimum 15°C to 38 °C. The average rain fall in the taluk has been 629.1 mm. However, during 2005 the rainfall has been less than the average rainfall i.e. 548.7 mm. The temperature of the village is very fluctuating one. Humidity ranges from 38-40 degree in summer.

Occupation

This subsection will present a glimpse of the local economy that constitutes agricultural and non-agricultural activities, goods and services. The economy of these villages based on two major domains agriculture and non agriculture. Main occupation in these villages is agriculture activity. 71,656 hectares area is cultivated. Some of the peoples are engaged in different kinds of occupation such as business and some in both government and non-governmental sectors.
Roads

The taluk has average road facilities. As per district note from dept. of Statistics 2004-05, a total length of road in the taluk is 1264 Kms. of which 271 Km is State highway, 148 Km is major district roads, 304 Kms other district roads, 126 Km village roads and 151 Kms is TDB roads, 52 Kms municipality roads, 145 Kms Irrigation dept. Roads and 67 Kms forest roads.

Village Administrative System

This subsection will briefly touched upon the administrative system of the village. In the beginning district administrative structure which consist basically of three layers were talukdar or collector at district level, tahsildar at taluk (or sub-district), and village officer (After Independence, Panchayat Raj system was introduced in 1959). Entire
administration of the village is looked after by two wings, one is, Village Panchayat system which is taken care of the village in terms of its development. To do this the panchayat seeks financial aid for the government, under Panchayat Raj schemes. The other one is also known as village panchayat consists of members from different caste group. The main purpose of this body maintain peace and order in the village by setting small and pretty cases which arises among its members from time to time with and the interferences of police department. Which consists of a three-tier administrative structure in this area (Robinson 1988:51). What follows is the introduction to the Panchayat Raj, the current system of administration in the village.