Coming Back to Thaiyur - Health and Medicine in a Twenty-five Years Perspective

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Introduction

The Volume

The theme of this volume can be narrowly interpreted to refer exclusively to work which involves revisiting particular villages already studied earlier. In a sense, this would reflect one of the motivations underlying the project from which the volume emerged, namely, to consider in depth the findings, and even more the methodologies, of these restudies of specific villages. However, the theme can, and indeed needs to, be read in its broader possibility, where the focus is on a return to the theme of the village as such, where what is sought is a reconsideration, or return to the study, of the Asian village.

This more general concern, equally valid and as important, would place in the foreground a somewhat wider agenda of investigation and would embrace such questions as the location and interface of the Asian village with larger global and societal processes. The narrow and the wider interpretations are clearly complementary in the attempt to identify and explain patterns of rural social and economic change over the past decades. The essays in the volume relate variously to either of these themes and, as such, stimulate reflection over issues ranging from specific questions concerning alternative methodologies of restudies of the 'same' village, to queries over the changing nature of the village in general in response to either exogenous pressures or endogenous transformations and metamorphoses. The common strand running through both lines of approach is the comprehension and analysis of rural change.

The broader focus provides a timely emphasis to contemporary agrarian questions. Arguably, the peasantry remains the unsung hero in most renditions of the legend of the East Asian miracle. Some of the Southeast Asian economies might optimistically harbour hopes of letting rapid non-agricultural growth,

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Coming Back to Thaiyur

Health and Medicine in a Twenty-five Years Perspective

Göran Djurfeldt, Staffan Lindberg and A. Rajagopal

In 1969-70 two of us, Djurfeldt and Lindberg, studied the village of Thaiyur in Chingleput District, Tamil Nadu, and we published *Pills Against Poverty: The Introduction of Western Medicine in a Tamil Village* in 1975. This chapter is about our return to Thaiyur 25 years later, together with A. Rajagopal, and about our assessment of the general health situation and the division of labour between Western and indigenous traditions of medicine.[1]

In this age of social constructivism, it needs to be pointed out that this work is not constructivist. The previous study was informed by what in today's parlance would be called a 'realist' perspective (see, for example, Bhaskar 1989, especially Chapter 5, and Djurfeldt, forthcoming). Such an approach entails certain assumptions, in this case about the nature of the bio-medical reality setting the conditions for illness and for health behaviour. Health and illness are here viewed as being determined by the environment in a broad sense, and the chances of staying healthy or falling ill are viewed as being

[1] Mr G. Kasturi, consultant, accompanied us in the field, and we are deeply indebted to him for his enthusiasm, perseverance and friendship, and also to our friends in Thaiyur. The Swedish Council for Research in the Humanities and Social Sciences assisted in funding the research.

set by the relations which individuals have to that environment. A very important component of these relations are living conditions, in the broad sense of the term. In this vein, *Pills Against Poverty* attempted to explain the 'social production' of disease, by relating the disease panorama to the living conditions assumed to produce illness. A similar attempt will be made here to assess the changes in living conditions and their effect, primarily on the medical system.[2]

While the earlier study was based on a one-year fieldwork, the present one draws on a short re-visit to the village. In 1969–70 we lived on what could be called neutral ground, having our own household in an old temple choultry in one of the smaller hamlets with a mixed caste composition. This time we rented a room in one of the old Vellala landlord houses in the main Thaiyur hamlet. Here we could meet people of all castes including Paraiyans, which was a sign of the pervasive changes in caste relations that had taken place during the past twenty-five years. Visiting most of the hamlets of the village we met old respondents from 1969–70 as well as some younger people and immigrants who had settled after our departure. In this way we could get a balanced view of the changes that had taken place. Time constraints made it possible only to work with qualitative methods, although quantitative data, for example on morbidity patterns, are needed for a full assessment.

We will start by introducing the setting, and then give an overview of the general changes that have occurred in the village. Next, we will deal with changes in living conditions, and the way they form people's 'life chances'. The term is used here more in a down-to-earth sense than in the ordinary sociological terminology. How have the overall processes of social change affected people's chances to stay healthy, to fall ill, or perhaps to die? After having thus laid the ground we look at changes in medical behaviour and try to connect them to changes in living conditions and other factors. In the concluding part we

[2] Working with a realist perspective does not mean that we deny the importance of cultural or normative definitions of health and illness. On the contrary, 'a sound definition of disease must recognize the dual character of health as a natural reality that is socially defined'. Not only that, it is also a socially defined natural reality that is socially produced (Cf. Djurfeldt and Lindberg 1975a:26).

focus on the role of the State in the transformation of the medical system in Thaiyur.

Twenty-five years is more than half the working lifetime of a researcher, and it is not only the village and villagers that have changed, but so have we. Our perspective on the sociological study of health and illness has remained basically the same over the years, seeing, for example, traditional medicine as an indigenous way of coping with disease and illness that should not be thrown overboard by a wholesale adoption of Western traditions.[3] However, we have probably changed in another respect — we are not so categorical about the negative effects of a capitalist development as we were at that time, schooled as we were in a dependency perspective.

New Thaiyur?

The revenue village and *panchayat* of Thaiyur is situated 35 km south of Madras, close to the small town of Kelambakkam. It is a big village with a population of 7305 (1991), and is completely dominated by Paraiyans, a Scheduled Caste (SC). The upper-caste settlement, i.e. Thaiyur main hamlet, no longer dominates the surrounding *cheris* (SC colonies) which, increasingly, are villages in their own right. Closest to Kelambakkam and the main road is Periapilleri, and further south is Chinnapilleri. Between the two *pilleris* and Thaiyur main hamlet, lies Periamanagar, which has a Harijan welfare school, Medical Sub-centre and other facilities. South of Thaiyur proper, and farthest away from the main road and the town, are the two colonies of Palamanagar and Komancheri, of which the latter is 7–8 km from Kelambakkam. In addition to these big colonies, there are a number of smaller settlements.

Returning to Thaiyur after a long interval, we had speculated about the changes that might have taken place, especially about the effect of the metropolis of Madras expanding towards the village. Would the whole village have become a suburb?

One surprise was the Vellala street. It used to be town-like with its rows of two-storied houses. Now the prosopis jungle is spreading over the ruins of several houses, and only nine houses

[3] It is very satisfying to note that traditional midwives now are trained by the medical authorities and are able to work in a new context (see below).

remain. Ten to fifteen families have sold their land and left the village. Vellalas presumably suffer the same fate that has befallen other landlord castes in India. Kannumuthu calls it the 'labour problem'. In economic terms it means that these landlords cannot offer the wages needed to attract a regular and reliable labour force. The competition from the factories along the road from Madras is too stiff. As a farmer said:

> Formerly the labourers would come at dawn and knock on our doors with their sickles and ask: 'Are we not going harvesting?' Nowadays, we must offer them wages plus full meals, fish curry and booze in the evening to tempt them to come.

The Vellala landlords who remain just about manage, waiting, like Natarajan, for a good moment to sell their land. Their children are already settled in the city or in non-agricultural occupations. So in that respect the 'Software park' that has come up on the main road is certainly a symbol of how the city is encroaching on this 'conurban' village. A mile from this hi-tech island the old Vellala village is slowly dying, clinging as best as it can to its traditions.

But even that is difficult. Not only have several Vellala families left Thaiyur but others too have deserted the village. All the barbers, for instance, have left. The Vellala have been forced to learn to shave their own chins. 'Did the barbers leave after you purchased the razor, or did you have to buy the razor because the barbers left?' we asked Kannumuthu. 'They left the village first', he said. There was a government order which conferred ownership of the land that the service castes held as remuneration for their services to the village. After they got that land they sold it and left for the city. Probably they are running barbershops in some middle-class suburb now.

But the barbers were also upset because the landlords had stopped giving them food twice a day as was the traditional custom. When the Vellalas stopped cooking rice in the evenings and began to have tiffin, they could no longer give rice to the servants, and they were too miserly to give them their tiffin. 'There was a lot of argument about that, which contributed to their leaving the village', said Kannumuthu. We should therefore not exaggerate the traditional mentality of the Vellalas. They are far from immune to 'modernization', as changing food habits reveal.

It would be wrong to speculate on the effects of the Vellala exodus on land distribution. It is possible that the same process that has occurred elsewhere, i.e. of cultivating castes buying the land, may apply to some extent here. In the local context this could mean that 'the colony people', as the Vellala call them, or the 'Scheduled Castes', as they call themselves, have bought much of the land. Old tenants, and other landlord favourites could have been given the opportunity to buy land. In such cases the net effect may have been a certain evening-out of the skewed land distribution in the village.

But what about the gentlemen farmers, the moneyed people from the metropolis? Have they not bought land? It may perturb the Vellalas that urban demand for land in interior Thaiyur has, so far, been less than the demand for land along the road. They own the best land below the big tank and, paradoxically, the urban demand for that land is much less than for the poorer land along the road. Ease of communication is the reason for this. Thaiyur is still not connected to the main road by an all-weather motorable road. Therefore some Vellalas prefer, like Natarajan, to hold out for better prices and perhaps rent out the land to 'colony people'.

The 'rich people' prefer to lay their hands on the roadside land. Here are located the big fenced estates growing coconuts or mangoes, though, in all probability, they are not as profitable as the poor *cheri* people like to think. Between the estates are the factories and the software park. These are more welcome, because they provide employment and create upward pressure on wages, which the Vellalas are unable to match and hence a cause of their 'labour problem'.

Changing Life Chances

The processes summarized above imply changes in the conditions of health. But change is not all that pervasive. Take sanitation, for example. Our first impression was that nothing seemed to have happened. Even in the most prosperous part of the village, there is not a single house with a latrine. One would have expected that the situation would be the same for the *cheris*. In Chinnapilleri, we found a pump-house standing at the entrance to the village, signalling the installation of a

piping system for drinking water. The Mariyamman temple was newly painted, an evident index of prosperity. People were dressed up for the *Pongal* harvest festival. No one wore the rags that we have learnt to associate with the poverty of the *cheris*. There were no pot-bellied children, no reddish lustreless hair, and few running noses showed that the children perhaps were better fed and healthier than they have ever been. The mud hut with palmyra roofing is still a common sight, but most of them seem to have electricity, and many houses are made of concrete with *pucca* tiled roofs rather than straw ones – and most of them have been built on private initiative, even if some have been built with support from the government or from NGOs.

They have toilets too in Chinnapilleri, and in that sense the *cheri* is more advanced than the upper-caste hamlet. But little inspection was needed to find out that they were not used. Deeper probing showed that ten latrines had been built by a local NGO, based in neighbouring Kelambakkam town. These were without counter-prestation and, worst of all, were wrongly constructed, at least according to the residents. They alleged that the soakage pit had no capacity and that, consequently, the latrines quickly overflowed. Thus, the environment was made worse and the readiness to adopt latrines was diminished.

But we also found other attempts to extend sanitation in the *cheris*. In Periamanagar hamlet, yet another NGO had constructed six latrines with septic tanks, i.e. not a low-cost solution like the one attempted in Chinnapilleri. This NGO is led by a former health worker from the Swedish NGO, 'The Swallows', which formerly had a clinic in Thaiyur. The toilets have been given to the office-bearers of the two women's organizations in different parts of the hamlet. We asked members of the household of one of the fortunate toilet-owners if they used the toilet:

'No, we don't use it, we go to the open fields instead.'
'Why don't you use it?', they replied.
'First of all there is no roof, and secondly there is no door', we asked.
'But in the open field can't everybody see you?'
'We can hide behind bushes. The most important thing is that there is no door to the toilet.'
'But couldn't you easily build a door with some branches and leaves?'

'We don't have any money. We don't even have money to repair the house, and we spent Rs 30,000 for my brother's marriage. A door will cost Rs 500. When we have money we will build one and start using the toilet. It will be convenient for the women', they said.

This family could easily have afforded the door. Under the thatched roof there was both electricity and a television set. Clearly sanitation was not their priority, at least not for those wielding economic power, i.e. the men.

Evidently the new policy of avoiding *giving away* latrines to people, to avoid subsidies and strive for full cost-recovery has not reached Thaiyur. Had it done so, some of these failures could possibly have been avoided. The only example we found of latrines that were functioning does not contradict this conclusion.

In Palamanagar where we found traces of several NGOs, one of them, incidentally the one which had failed in Chinnapilleri, had managed to convince people not only to accept a latrine free of cost, but also to use it. Perhaps frightened by what they had heard of Chinnapilleri's experience, people used them only in an emergency.

According to a survey result (Government of Tamil Nadu 1993:103), 9 per cent of the rural population of Tamil Nadu have access to latrines. Thaiyur clearly contributes to the lowering of the average, even if a slight dent into the practice of open defecation has been made. Obviously, sub-urbanization is not synonymous with sanitation, and having seen sanitary conditions in the cities it is perhaps foolish to expect otherwise.

Starting with sanitation may be misleading, however. Take for example, drinking water. It is true that the piped water-supply in Chinnapilleri is not working, that the water is alkaline and non-potable and that the overhead-tank is hazardously shaky and may collapse without warning. On the other hand, the same type of system is functioning for parts of Palamanagar. Two streets are without water connection, however, and they are apprehensive about the bribes they say they will have to pay to government officials to get it installed.

We also saw many hand pumps. The one in the fish market, at the entry to Kelambakkam, had been sunk at the lowest spot in the whole neighbourhood and the drainage had been led upwards from the pump, with the risk of the pump getting drained along the raiser pipe, thus polluting the source. Some

other pumps also had poor drainage, but the rest were okayed by this amateur team. A number of new wells have also been constructed. The supply of water has thus gone up and its potability should also have improved somewhat. Tourists passing Thaiyur on their way to Mahabalipuram may thus miss the photogenic sight of long rows of women walking kilometres with brass pots on their heads to fill them at the river on the southern border of the village. But they may be the only ones not to benefit from the improvement in water supply.

Water-borne diseases are difficult to cope with and an addition to the supply of drinking water and an improvement in its quality is not going to do the job. It is not surprising that diarrhoea and other water-related diseases figure in the lists of common ailments mentioned by medical practitioners. One does not need to be an epidemiologist to understand why. In the rainy season, when large parts of the village are prone to flooding, diarrhoea may reach epidemic proportions.

That diarrhoea is connected to deficient sanitation and that effective protection can only be attained by environmental sanitation, better water and food hygiene, is a message which, if it has been broadcast or televised, has not yet reached a wide audience. 'We shut off the television during the news,' they said in Chinnapilleri, 'we are only interested in the films.'

Old Dhanapal Irula talked with enthusiasm about the importance of keeping the environment clean. He had learnt it from Muthu Irulandi, the social reformer who gave the Villies their present name 'Irula', and managed to make them a Scheduled Tribe. Dhanapal does not practise what he preaches, however, but is prisoner of the very same circumstances as the fieldworkers who go sight-seeing at the tank bed every morning.

When we asked our friends in Chinnapilleri how life is now compared to twenty-five years ago, true to their self-image and identification as poor, they first denied that they are better off now than then. One indication of their misery, they said, is the recent flood, when the colony stood in a metre of water and they had to flee to Kelambakkam, camp in a school for three days, and be fed by the government. But counter-indications are many and obvious and our friends soon agreed with us on some indices, like their clothing, housing, and nutritional status. The issue is perhaps settled by comparing the daily wage

levels then and now. In 1969–70 the daily coolie rate was Rs 2.50 plus meals and, like today, the rate for women was half of that. The market price of rice was Rs 1.10, and a daily wage thus sufficed to buy just about 2 kilos of rice. No wonder people were underfed in those days! The going rate today is Rs 30, and the price of rice is Rs 9. With a day's wage you can thus buy about 3½ kilos of rice. Rice is the staple food, and although it will hardly make up as great a share of the household budget as it did twenty-five years ago, we can use the coolie rate and rice price as a crude index of the real value of wages. By this index, the real wage level has increased by 81 per cent. This implies a 2.5 per cent increase per year over the period. In addition, ration shops are now to be found in all hamlets. Since the demand for labour has increased rather than decreased, especially in view of all the factories along the road, there is hardly any doubt that the level of living of the working class in Thaiyur has gone up considerably.

This observation does not hold for all parts and sections of the population, however. There are a few pockets that do not share the general progress that Thaiyur has undergone. In the 'good old days', as a member of the declining Vellala caste might have put it, the Scheduled Caste subsisted on *kanji* (gruel) and rarely got luxuries like vegetables and milk products. They may not be swimming in *ghee* like the rice-bellied gentlemen of the Vellala street, but for much of the year the SC get enough food, although a nutritionist will find several faults with their diet, as with that of the upper castes. They eat little pulses, but on the other hand they consume a great deal of fish. Their intake of vegetables, especially green leafy vegetables, and fruits is too low. Milk continues to be a scarcity in Thaiyur just as it was twenty-five years ago. Yet the milk intake has increased considerably, especially for adult men, with the proliferation of tea shops. Women and children consume much less tea than the men, however. Enough food is therefore not the same as a well-balanced diet and, as we shall see, nutrition-related diseases are still prominent in the disease panorama.

It is also the case that all children, both pre-school and others, get the (in)famous 'midday meals', the allegedly populist innovation of the late Chief Minister and legendary film hero, M.G. Ramachandran, and a pet policy also of his successor, Jayalalitha.

Whatever you can prove about its effect on the fiscal crisis of the state government, it will be difficult to deny the beneficial impact of this scheme on child health and nutrition.

Another successful government intervention is immunization. Through its network of Primary Health Centres and Sub-centres and the grassroots 'Maternity Workers' and 'Midwives', expectant mothers and infants are monitored by the Medical Department and by the Integrated Child Development Scheme (ICDS). One part of the scheme is supplemental feeding, already dealt with, and another is immunization, both of mothers and babies. We ran into only one child which had not been immunized during our fieldwork and it seems that the efforts to control polio, measles, pertussis, tetanus and tuberculosis are quite successful in Thaiyur.

Summing up, there is no doubt about how the balance sheet reads. Ordinary people in Thaiyur are much better off than perhaps ever before. Weak and vulnerable groups still persist, like old people without descendants, or those who have encroached on common lands and lack a *patta* (title deed) which can serve as a ticket to government doles, like water supply, subsidized housing, etc. The real wage level is higher and the food standard is better, although the diet is far from the balanced ideal. Preventive medical care has made great progress and almost all children are immunized. Water supply has improved both in quality and quantity. The ugly blot in the whole picture is environmental sanitation. The occasional smell of faeces that you encounter when entering and leaving a hamlet is more than just a whiff: it should alert us about a sanitary situation which can lead to water-borne and other diseases, breeds epidemics of diarrhoea, typhoid and other killers and endemic infestations of hookworm and roundworm.

Changing Disease Panorama

Life was hazardous back in the 1970s. Given the low income levels, it is but natural that nutrition-related diseases were dominant in the disease panorama, closely followed by diseases related to deficient hygiene and sanitation. Keeping in view the palpable improvement in living standards and the enhanced social services now available, it is possible to foresee certain

changes in the disease panorama. People eat better now and the children get midday meals to complement their mothers' cooking. Although there are still instances of nutrition-related diseases, these have changed character and probably also incidence. Previously general under- and malnutrition caused susceptibility to infections. Nutritional deficiencies are not as broad-ranged today, but local medical personnel reported that lack of Vitamin A and B-Complex are common, and that many people, especially children, still get inadequate or poor diets. Part of the reason is worm-infestation which decreases the nutritional effect of the food intake.

Hygienic and sanitary conditions are almost as deplorable as they used to be and it is therefore not surprising that they continue to cause disease. Although many people in Thaiyur, and probably more than a generation ago, lay great stress on personal cleanliness, bathe, and change clothes every day, consciousness about environmental sanitation and hygiene is low. Scabies continues to be common, especially among children.

We estimated infant mortality at 290 per thousand live births in 1970. We did not have current data for Thaiyur, but the figure for the area covered by the Kelambakkam PHC should be a pointer. At 34.8 per thousand it is appreciably lower than the state-wide figure which is 48 per thousand (Government of Tamil Nadu 1993:17). Expecting mothers are now better nourished and this ought to be reflected in vital statistics. The immunization now provided against neo-natal tetanus should also be mentioned as an important cause of lower infant mortality.

What has been dubbed 'developo-genic' diseases (Hughes and Hunter 1970) could be expected to increase, although the absence of morbidity data makes it difficult to substantiate. Doctors say that cancer is increasing and the indiscriminate use of pesticides and other chemical agents, as well as the exposure of many Thaiyureans to industrial work, could contribute to such a trend. Tourism to nearby Mahabalipuram also implies some trafficking involving local people. Doctors report that venereal diseases are on the increase, although no AIDS case has so far been detected. Heavy drinking was a problem already in the early 1970s and it has deteriorated since then. There are now illicit breweries in most *cheris*. It has led some of the many local women's associations to plan huge demonstrations to put a stop to it.

This is more or less what can be said without precise morbidity data which are not available locally. A more penetrating analysis would demand other data of the kind that cannot be collected during a fieldwork as brief as this one.

Allopathy on the March

In *Pills Against Poverty*, Djurfeldt and Lindberg documented an elaborate division of labour between the allopathic system and the various indigenous systems of medicine and tried to demonstrate its reproductive stability. They foresaw that with shifting world views, induced by education, media exposure etc, allegiance would gradually shift from the indigenous traditions to the allopathic system. They did not foresee, however, the rapid improvement of living conditions described above. On the contrary, in the sister publication *Behind Poverty* (Djurfeldt and Lindberg 1975b), they were very pessimistic about possibilities to better the life of rural poor. This pessimism has proved unfounded and the question, therefore, is how the division of labour between the medical systems has been affected, on the one hand by changed living conditions, and on the other by shifting allegiances. When we drove into Kelambakkam, the small commercial town serving surrounding villages, we noticed the manifold increase in the supply of allopathic medicine. While it used to have only one private doctor, besides the Primary Health Centre, there are now four allopathic doctors running private practices in Kelambakkam. Twenty-five years ago there was no pharmacy in the town, now there are three. The same is true of Thiruporur, a small town some 9 km south of Thaiyur. Its once very poor hospital has been upgraded to a Primary Health Centre, serving seven sub-centres, among them one in Thaiyur.

Kelambakkam also has two 'Registered Indian Medical Practitioners', who are supposed to be trained in ayurveda[4] and homeopathy. But available data indicates that they are in fact practising some kind of amateur allopathy which may render credible Dr Govindan's characterization of them as 'quacks'.

When making our rounds of the hamlets in Thaiyur to locate

[4] Ayurveda is an Indian academic tradition of medicine with ancient roots.

practitioners of indigenous medicine, we noticed that there were few left. The number of midwives has gone down drastically, and there are now only four more or less well-known practitioners of *natu marundu* (indigenous herbal medicine) .

People say that an *uusi* (injection) in Kelambakkam costs only Rs 10 to 15, or half a day's wages. Formerly, a *natu vaittiyan* (literally a country doctor) would demand a day's wage or even more for treatment. If, for example, he had to spend a day collecting herbs and preparing medicines and one more day in administering the treatment, he could demand even more. Seen in this perspective, a crude assessment of the cost effectiveness of the two systems indicates that allopathy has become cheaper. Indeed, in the Primary Health Centre you can even get it free, but most respondents shun this alternative since the PHC is considered inferior to private practitioners. But again, this is not the whole truth. Allopathic medicine can become very expensive if, for example, you are referred to a medical institution in Madras where you cannot get free treatment. Likewise, many practitioners of indigenous medicine do not demand payment at delivery, as it were, and if their treatment does not succeed, the patient can often successfully dodge the payment. Thus, it is difficult to generalize about cost effectiveness, since costs vary from nil and upwards within both systems. Routine allopathic treatment is not expensive, however, and its cost is not a barrier to most patients. All government-supplied service is free of cost. An increased supply at comparatively low cost is thus presumably one reason for allopathy being 'on the march', and it should be added to the factors discussed in the introduction, namely changing living conditions and shifting allegiances.

We can examine the current role of allopathy in the medical system by first discussing childbirth. Practically all children were born at home twenty-five years ago. The expectant mother would be attended to by a traditional midwife from the same village who was skilled in arranging the delivery, and also in detecting difficult cases which she would refer to the hospital. The most dangerous moment was the cutting of the umbilical cord with a rusty knife or a pair of scissors, often leading to *karuppu*, the black death, as people used to call neonatal tetanus. Today all that has changed and tetanus has become rare.

Most births take place in clinics or hospitals or under the

supervision of traditional midwives trained by personnel at the Primary Health Centre in Thiruporur. Shanbagavalli, who runs the sub-centre in Thaiyur, handles eight to nine deliveries per month, supervises the midwives and regularly visits all hamlets in Thaiyur for immunization and the prenatal care of expecting mothers. She is known by all villagers and highly appreciated.

Kamala, in her 60s, has received midwife training. Although she claims she has not received the delivery kit promised by the sub-centre, she says she uses a new blade to cut the umbilical cord. She takes care of many of the deliveries in her hamlet which, like other outlying villages, does not to the same extent follow the trend towards hospitalization.

When Veliamma was to deliver her first child five months ago, she went to her mother's village, as is the practice. They had planned to go to the nearest clinic for the delivery, but when the pains started she realized that there would not be time enough. So she asked her mother to call the local midwife, and the whole thing went without complications. After coming back home she had her child vaccinated in the sub-centre. But Veliamma's delivery is not typical today.

Delivery practice is but an example of the general trend. To put it as local people do, 'we only go to MBBS doctors, not to *natu vaittiyan* (country doctors)'. In almost all our interviews people said that they nowadays use only 'English medicine' when they get ill. They answered in the negative when we asked if there were not occasions when they preferred to use the services of a traditional *vaittiyan* or *manthiravathi* (shaman who works mainly by reciting *manthirams*, that is, sacred hymns).

This shifting of allegiance is illustrated by the case of Kandan whose father is Dhanapal, a traditional masseur, bone-setter and specialist in various insect and snake bites. For three or four years Kandan has suffered from cough and fever during the rainy season, and is also generally weak. When we asked him what treatment he was getting, he said that he did not want to take the medicine prepared by his father because it tasted awful. Instead he goes to the Primary Health Centre in Kelambakkam where he gets capsules, which give temporary relief.

Kandan, who is now fifteen years old, sits at home without any employment, since nobody wants to employ such a weak person. His father thinks that he can cure his son, but has not much say in the matter. 'People now prefer English medicine only, since my herbal tonics are bitter in taste and my massage is painful to many. The doctors just give them some pills', as he scornfully put it.

If not even the members of a *vaittiyan's* own household withstand the trend away from *natu marundu*, there is little wonder that sick people flock to doctors, clinics and hospitals. Those who live near the sub-centre in Periamanagar have easy access for their most common ailments, stomach-ache, diarrhoea, wounds, etc., even if, for example, the upper-caste people of Thaiyur only use the centre in an emergency, since they avoid mixing with the SC people in the colony.

The presence of allopathy is not confined to the popular but already run-down and under-staffed sub-centre. The brand new Jubilee Hospital built by the Catholics is just about to open its gates a few hundred yards away. Presumably, the church has not consulted the authorities about the location of the new hospital, because the present location makes for an unnecessary duplication of services. The mobile team of a Catholic organization has already been working for some years in Thaiyur. Their doctor visits the hamlets twice a week for medical check-ups. Villagers interested in their services have to pay a membership fee of Rs 10 and can then freely avail themselves of their services, including qualified treatment at the RC main hospital at Perungudi, not far from Thaiyur.

So the loss of the Swallow's clinic, which opened in Thaiyur main hamlet in 1968 but closed down in 1991, has been richly compensated for by other agents. The Swallows once intended to develop child and maternity care and look after medical problems in the village. As we showed in *Pills Against Poverty*, this was an impossible ambition. As is the case with many NGOs, the Swallows could not sustain the initiative, and withdrew some years ago, handing over the clinic and the 'demonstration farm' to the local community.

The centrality of the towns of Kelambakkam and Thiruporur with their clinics and doctors came out clearly in our interviews. Many people pass on their way to work in the industries and salt fields. There is always somebody in the house or the neighbourhood with an errand to the fish market who can drop into one of the pharmacies for some pills. But for the more

outlying hamlets, these centres are less accessible. Among poorer households it may still be that the nearest help is sought rather than the more qualified one available in the clinics. Since the bus connecting the interior of Thaiyur *panchayat* to the main road has stopped running because of bad road maintenance, the cost of transport may bar quite a few households from going, and may also delay badly needed treatment. There are also allegations that many people neglect their children: alcoholics in particular are accused by their neighbours of doing so.

The story could end here with the conclusion that apparently the earlier division of labour has shifted dramatically in favour of modern medicine. But this would be premature. Careful probing and the recording of actual cases of illness threw up other dimensions of the medical system.

Vaittiyan Beating the Retreat?

Many avoid it, because of the dominance and prestige of 'English medicine', but *natu marundu* is still used for quite a few ailments. Take, for example, jaundice, which seems especially common among the alcoholics of Thaiyur. It is seldom referred to allopaths, but instead treated by indigenous practitioners of various sorts. Dr Masilamani is the most famous of these. He is a traditional doctor in Chromepet, a Madras suburb 20 to 25 kilometres from the village. He applies a medicated bandage and advises the patient to restrict his diet. Similar treatment is given by a *vaittiyan* in Kelambakkam. People we met claimed the treatment is effective.

The same goes for child diarrhoea, of which apparently some cases are still taken either to a *vaittiyan* who administers some tonic, or to the *manthiravathi* who performs his magical rites. However, the recent death of a child in one of the *cheris*, after being treated orally with oil by a *vaittiyan*, has made many neighbours think that it is perhaps better to go to the doctor.

People generally do not regard diarrhoea as a single phenomenon but distinguish between, on the hand, *dosham* or green motion, which often is treated with religious medicine by a priest or a *manthiravathi*, and on the other hand loose or white motion. The latter is seldom taken seriously, but seems to be treated as being more or less natural. More serious cases of

diarrhoea are taken to the doctor, although there are many exceptions, which may endanger the life chances of the suffering infant. Despite the recent emphasis on Oral Rehydration Therapy (ORT), it seems that very few villagers have heard about it, except in those *cheris* in the southern part, where the RC seminary students have tried their best to inform people about it. Some people in close contact with the sub-centre also knew about it and had used it. The folk definitions of 'diarrhoea' differ from that of the allopaths and that may be one reason for the difficulties met in trying to extend ORT.

Bites from snakes, scorpions, dogs and insects are still treated by a local specialist, Arumugam Irular in Thaiyur, Dhanapal in Periapilleri, Chetty in Chinnapilleri, etc. We met Dhanapal, the masseur and 'bite specialist', who in 1969 successfully treated one of the authors for his back pain. He is still continuing his practice, but as before he earns his main income from wage labour in agriculture and the salt pans.

Dhanapal uses a medicinal plant with a bitter taste which he calls *sirurengan yelai*. It will help against bites from cobra and krait, but for the snake we take to be Russell's viper (*Karivelam pambu*) he has no cure. 'For that you have to go to the Irulars in Thaiyur, who have anti-venom which they get from Thirukalikundram. The hospitals cannot manage this', he says. Snake bites are not that frequent though, so most of his practice is massage of muscle contractions and bone-setting, which he attends to every now and then. He says that he does not face any competition in his field, but as he puts it, 'people generally prefer English medicine'.

Again, old people are more prone to consult a *vaittiyan*, a traditional specialist or a *manthiravathi* than the middle-aged and young, who are impressed by the efficiency of allopathic drugs and injections and identify allopathy with the urban culture, propagated by education, TV, films and the whole modern consumption culture displayed in nearby urban centres. But there are also groups, mostly landless agricultural coolies and poor peasants in outlying parts of the village who have no access to the new employment opportunities and have not shared in the general material progress of the village, who cannot afford allopathic treatment and transport costs and are perhaps also less influenced by 'modern' culture. For such

people a local practitioner, or no treatment at all, may be the only alternative.

So traditional herbal medicine is alive, even if on the retreat, and continues to cater to some diseases that modern medicine cannot cope with, as well as cases where it offers an apparently efficient cure or relief. But there is a risk of decline of *sitta marundu*, because when faced with a shrinking demand, many *vaittiyan* seem tempted to start quacking in allopathy. This also goes for the Registered Indian Medical Practitioners, who generally have a short training only, and may not always be devoted to the tradition in which they are trained.

We also think that another role for traditional medicine is becoming more important. As in the west, folk and other non-allopathic traditions of medicine treat cases of illness where modern medicine tries its best but still fails. When patients leave the hospital or the clinic of the private doctor without having been cured, the *vaittiyan* is waiting outside to offer his/her services.

Religious Treatment Holds the Bastion

If indigenous secular medicine is on the retreat the same cannot be said about religious medicine. We had thought that with the eradication of smallpox and measles the Mariyamman cult would have lost some of its centrality in the local religious order, but this is far from the case.

When we asked people in one hamlet about *amman*, that is, the disease complex referring to smallpox, chickenpox, measles and mumps, we were told that *Periayamma* (smallpox) may be gone but *Mariyattai* remains a threat:

'*Amman* is still with us', they said.
'How come, now that you are getting immunized against measles and when smallpox is no more?', we asked.
'*Mariyattai* is still with us. The immunization is not always effective.'
'How do you treat it?'
'As we always have done. We apply a paste made from turmeric and *neem* leaves and pray to *Amman*. The patient should not eat anything for three days. Then Mariyamma will come down and the patient will recover. If the sick person is not cured after three days we will take him to the Primary Health Centre at Kelambakkam', they replied.

More medically informed people call chickenpox *Umaiammai* or *Chinnammai*, measles *Thattammai*, and mumps *Puttalammai* or *thavadi veenghi*.[5] But not everybody can differentiate among the three and it appears that many people take these various forms of Mariyattai as one and the same. In other words, measles, chickenpox and mumps are thought to have the same cause, and must be treated accordingly. This may be the reason for saying that immunization against measles is not always effective. Or can it be that the immunization programme fails to give 100 per cent protection?

Anyway, people reported that chickenpox was quite frequent, spreading quickly when it came, and that there were occasional cases of mumps. This is presumably the main reason for the perseverance of Mariyamma. Moreover, nowadays nobody dies from *Amman*, it seems, so there are reasons for concluding that the worship is paying dividends.

The importance of Mariyamma and her sister goodesses is also seen in the great interest people take in the celebration of the yearly Adi Kappu festival in her honour. Many of the various *Amman* temples of the villages which were rather unimpressive buildings twenty-five years ago have been rebuilt and painted in bright colours. They are the pride of the local community. The temple and the cult continues to symbolize the unity of the community, bridging class cleavage and factional tension.

Apparently the centrality of the Mariyamma cult is appreciated also by some outsiders buying land in Thaiyur. When a rich *Chettiar* from Madras bought a large piece of dry land just outside the biggest *cheri* in Thaiyur, he donated Rs 10,000 for the construction of a Mariyamman temple there. When we visited our old friend Jeyaraman, he told us that he was a member of the temple committee, and that the temple already had become the centre of the community in that part of the *cheri*.

Exorcism is another form of religious treatment which does not appear to be retreating. Twenty-five years ago 'evil spirits' were common in Thaiyur. Cases of illness with no immediate cure and diffuse symptoms, which were considered untreatable by allopathy or *vaittiyans*, were often attributed to the designs

[5] These terms are the same as reported from North Arcot by Matthews, 1979, pp. 437ff.

of evil spirits. With the greater popularity of allopathy, the incidence of such cases has perhaps gone down, even if we occasionally came across stories of vomiting babies with fever that could not be cured by the 'English doctor'. Yet people claim that possession by evil spirits is very common.

We talked to Egambaram, living in the southern-most *cheri* of the village, a big settlement and a village in its own right, where there are many cases of evil spirit possession. The women are most afflicted. 'They start throwing things around them, hitting their husband and children, and they quarrel loudly', some people said. An evil spirit driver from the village will then be called and the patient brought to the local temple for the usual ceremony involving the Guru, the local *manthiravathi* and the *poosari* (priest) of the temple. The whole ceremony may take a week and may cost up to Rs 1000 in cash and kind for the ceremonial expenses and the officiants, but it is presumably worth the expense since the patient is allegedly always cured.

A typical victim of 'evil spirit' intrusion, today as well as a generation ago, is a young or middle-aged housewife who develops what a psychiatrist would classify as some sort of hysterical reaction. The students at the RC seminary in the same *cheri* had their own explanation: 'People are very promiscuous in this village. It may very well be that the wife discovers that her husband has an affair with another woman'. If we add what we already know, that many women suffer unduly because of the mother-in-law or because of childlessness, as documented in our earlier study and by many others, the list of frequent causes may be more or less complete.

It is also quite clear that the religious treatment with its dramatic exorcism of the evil spirit is seen by the villagers as an efficient way of dealing with the problem. The woman is brought to her 'senses', and order is also restored in those cases when she leaves the house and returns to her parent's home, or even when, in rare cases, she attempts suicide.

An Indian Welfare State?

In this concluding section, we will shortly summarize our findings and then try to relate them to the overall theme of this book, i.e. the effects of state intervention. To summarize, then,

we started this chapter by outlining a realist analytical strategy where bio-medical reality is viewed as determining the life chances of individuals. In this perspective we first outlined the processes of change that have swept into this increasingly sub-urban village. Industrialization and various types of state intervention have increased real standards of living and, thus, the chances for individuals to stay healthy have improved. Deficiencies in sanitation, drinking water supply and other environmental hygiene to a certain extent prevent these chances from being realized.

Changes in health behaviour have been almost as dramatic as those noted in living conditions, and in the supply of curative and preventive allopathic medicine, but at an uneven pace and with some important exceptions. The division of labour between the traditional and the modern systems has clearly shifted strongly in favour of allopathic medicine. There is a discernible difference not only between different sections of the population but also between the generations when it comes to health practices. For obvious reasons the poor in distant hamlets consume less allopathic medicine.

Allopathy has successfully marched into the hearts and minds of many Thaiyur residents. Their shifting allegiance is thus one major reason for the changing division of labour. Another reason is the cost effectiveness of allopathic medicine. Many shun free treatment at the Primary Health Centre but go for the services of private practitioners which are relatively cheap. Consequently, there has been a shrinking demand for indigenous medicine (*natu marundu*), and the number of practitioners has gone down, while some *natu vaittiyan* have started quacking in allopathy rather than keeping alive their traditional skills.

Religious traditions of medicine seem largely to withstand the competition from allopathy. The Mariyamma cult remains a focal point of the religious order of the Scheduled Caste Paraiyan. Although the diseases named after her (smallpox, chickenpox, measles and mumps) have changed character with the eradication of smallpox and the near-control of measles, people continue to interpret chickenpox and mumps as afflictions of the Mother Goddess. Similarly shamanism and exorcism continue to be important, partly because of what in bio-medical parlance would be defined as psychiatric problems.

Now what is the role and function of the Indian state in these processes of change, both in life chances and in health behaviour? To gain a perspective on this question, we will discuss the concept of an 'Indian Welfare State'. While this concept may be offensive to some, and ridiculous to others, it merits discussion.

The welfare which the Indian State provides is certainly unpretentious, but nevertheless important. Midday meals schemes for both school and pre-school children, nearly 100 per cent immunization, free hospital treatment (even if of low quality), access to at least part of the basic necessities of life through fair price shops, access to an improved water supply through hand pumps and *pucca* wells, access to subsidized housing, are but some of the 'welfarist' programmes operating with a reasonable level of efficiency in Tamil Nadu. This enumeration illustrates one basic feature of contemporary Indian society, namely the extent to which the Indian poor have become dependent upon the State for the modicum of welfare which they enjoy. Formerly, one can say that the poor were dependent on the munificence of the landlords, today they depend on the generosity of the state. Their ability to build themselves a decent house, or to get support to do it from the state, is dependent on their having a title deed issued by the same state. Their basic food security is dependent on their having a ration card, and the well-being of their children is dependent on their getting the noon-day meals, their injections against communicable disease etc. Where the state fails, as in improving sanitation and hygiene or in preventing floods, it is the poor who suffer the consequences most.

At the same time, we should beware of attributing the evident improvement in Thaiyur only to the interventions of a 'welfarist' state. Much of the improvement is clearly due to suburbanization rather than to the poverty alleviation programmes. Wherever you go in the *cheris*, you run into people working in the factories along the main road, either as coolies on a daily basis or as permanent employees with, by village standards, decent wages. In other words, the rural proletariat is becoming urban and in the process their living standards are going up.

In that respect Thaiyur is obviously not indicative of rural Tamil Nadu as a whole. We are convinced, however, that economic development in the state has meant improvement not only for the rich and the middle classes, but that trickles of 'welfare' have dripped down to the lowest strata of the rural population, thanks largely to the poverty alleviation programmes. In other words, it is a mixture of two processes that we witness in Thaiyur, i.e. 'welfarist' interventions and 'sub-urbanization'.

In terms of health this implies that residents of Thaiyur are likely to have better life chances than rural Tamils in general. Likewise, they enjoy higher levels of 'welfarist' services, and a better supply of allopathic medicine. The retreat of the *vaittiyan* that we have observed in Thaiyur is therefore likely to have gone further here than in less sub-urbanized villages. Religious medicine, finally, which apparently holds its ground, does not seem to be similarly affected by this process. Since fundamental social transformations, like the one going on in rural Tamil Nadu, lead to strains on identity formation, shattered world views and upset social relations, it may be expected that religion will not weaken, but rather strengthen its hold over people, including their medical behaviour. Shamanism and exorcism and new forms of religious healing are therefore likely to remain important.

List of Tamil and Indian English Terms

Amman	honorific term for the Goddess Mariyamman or Mariyattai, also referring to smallpox, chickenpox, measles and mumps
cheri	Scheduled Caste (SC) Colony
Chettiar	merchant caste
dosham	evil foreboding or evil cause, also refers to diarrhoea with green motion
manthiravathi	shaman who works mainly by reciting sacred hymns (*manthiram*)
Mudaliar	members of the Vellala caste in Thaiyur often call themselves Mudaliar. The name can also refer to other castes. It can also mean just a rich person
natu marundu	indigenous herbal medicine
neem	leaves of *melia azidirachta indica*, often used for medicinal purposes
Paraiyan	a scheduled caste (SC)
pucca	solid, permanent or regular
poosari	non-Brahmin priest

sitta marundu	the classical Tamil system of medicine
vaittiyan	doctor
Vellala	the dominant caste in Thaiyur who owned most of the land

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Change and Resilience in Producer Strategies in Uttar Pradesh Agriculture

Ravi Srivastava

In 1985, wishing to study a few villages in Uttar Pradesh (UP) at varying levels of development/accumulation, I examined a list of villages for which benchmark studies were also available. The final selection included two villages which met this criteria. These were Alipurjeeta, a village in the *doab* region of Allahabad district, and Chaukra, a village in Muzaffarnagar district of Western Uttar Pradesh.

Alipurjeeta was among six villages studied earlier in 1964 by the Agro-Economic Research Centre, Allahabad, in its village study series. The village study was one of the first such studies carried out by this Centre and was mainly based on a small sample of 10 per cent of the households. One of the principal weaknesses of the study was that it relied on revenue and census records for village level information and the listing of households carried out during the survey was done only to enable a random sample to be drawn.

The other village, Chaukra, along with a village in Deoria district in Eastern Uttar Pradesh, had been surveyed by me in 1977–8, during the course of a study on the commercialization of agriculture. The survey was based on fairly detailed village-level information as well as several schedules canvassed among a sample of nearly 20 per cent of the cultivators.

The 1985–6 survey, which is the most comprehensive among my surveys reviewed here, was based on a study of three villages, including the above two. It attempted to capture the reasons for inter-village differences in levels of accumulation by rural