

THE POLITICS OF FAMILY IDEOLOGY AND DOMESTIC CONSUMPTION

RAVICHANDRAN, N.

(Indian Institute of Health Management Research,
1, Prabhudayal Marg, Sanganer Airport, Jaipur - 302 011)

Introduction

Family ideology defines women as domestic workers and men as bread-winners; it assumes women's dependence on men within the family and their little attachment to the labour market. It is an ideology, which is culturally bound and class specific; it disadvantages women of all social classes, resulting, for instance, in their greater vulnerability to poverty; it stabilizes capitalism both socially and politically. It does not, however, exist unchallenged¹. This challenge comes from conflicting egalitarian ideologies emanating from various social movements on gender. Family ideology has come to structure the divisions within the labour market and other areas of life as well as within the home. It, therefore, has a material as well as an ideal existence². However, the reality within which choices have to be made reflects family ideology and makes it difficult and potentially disruptive for people to make choices, which do not conform to this ideology. The focus of this paper, however, is not on the public domain of state and economy, which provides the context for choice, but on the family where such choices are made. Its purpose is to explore the relationship between family ideology and food provision and consumption within households. The central question to be addressed is whether the practices

surrounding food and eating behaviour have any relation to family ideology and, if so, what the nature of this relationship is.

Sharing the same table : Consumption and the family

Sharing food is a significant component of family life and is a characteristic of the community³. However, this sharing, although symbolizing a community, is not necessarily equal⁴. But, it has been found that consumption of food within families is dependent upon age and gender; consuming food in larger quantities and of a higher social status than other family members. This is highly relying upon family ideology and if the household is poverty-driven, women go without food in order to ensure that the wage earner and the children get enough to eat⁵. Also in poor households, the distribution of food within families is not equal even when resources are adequate to ensure that food is available to all⁴. Further exploration of these explanations reveals that, far from being based on nature or biological differences, they are rooted in family ideology and have often been consciously constructed on proper household management⁶. On the other hand, distribution of food within households, as the distribution of other resources, is unequal and reflects relations of power and authority, which appear to conform to family ideology⁷. This

paper attempts not only the ways in which family ideology shapes families' consumption pattern but also the ways in which it is used as a means of understanding and justifying practices within families, the ways in which it structures the process of socialization of children and defines socially acceptable eating pattern and behaviour and the ways in which it unites households from different classes.

Materials and Methods

The present study was carried out between 2000 and 2003 by conducting a sample survey in Central India. As the demographic transition is underway in most of the states in India, the case of Madhya Pradesh has been of great interest. But the explanation has not been prominent for the reason that broadly the level of socioeconomic development is not high enough to justify the kind of mortality decline and behaviour changes in the nutrition pattern that the state has been experiencing. For the purpose of the study, 135 mothers of infants and 185 children of 1-5 years were selected. A total of 280 adolescent girls in the age group of 10-19 years were interviewed in the study and rest of the population belonging to the category of pregnant women (120), lactating mothers (120), non-lactating mothers (120), non-pregnant women (120) and rest (120) of the women belonging to reproductive age group of 20-45 years, constituting a sample of 1200, were chosen from five blocks : Seoni Malva, Hoshangabad, Sohagpur, Pipariya and Timarni. The survey and individual discussion with selected respondents were conducted at home. The interviews covered all aspects of food provision and consumption within

households. Many of the questions were open-ended and the respondents were encouraged to talk freely about the issues that concerned them. The interviews were tape-recorded and transcribed making a qualitative as well as quantitative analysis possible.

Results and Discussion

The age distribution of the study population is typical of high fertility category with a large proportion of the population in the younger age groups. The total population covered in the study was 1200, out of which 11.3 per cent were mothers of infants and the proportion of child (1-5 years) population was 15.4 per cent. A total of 23.3 per cent adolescent girls in the age group of 10-19 years were interviewed and the rest of the women population belonged to reproductive age bracket of 20-45 years and equally distributed among pregnant and non-pregnant women, and lactating and non-lactating mothers category.

Regarding household income^a, it was found that 62 per cent of the study population had monthly income between Rs. 2001 and Rs.5000 and 17 per cent earned more than Rs.5000 per month while 20 per cent had an income of less than Rs. 2000 per month (Table I). The average monthly income of the study population was reported to be Rs.1733 per month.

Slightly less than a quarter of the study population belonged to backward community followed by nearly one-fifth (18%) belonging to Scheduled Castes while one-

tenth of the study population belonged to Scheduled Tribes (Table I).

The educational status of the study population was much higher in terms of the level of schooling. The proportion of literates was almost 14 per cent while slightly more than a third (34.1%) completed primary schooling. Only one-tenth of the study population completed ten years of schooling while one-eighth of them were illiterates.

A high proportion of the study population (46.2%) was engaged in own agricultural land

although a quarter (24.8%) of them were employed by somebody else in agriculture related activities. In addition, 20 per cent of the study population did not work in the last 12 months due to pregnancy while nine per cent were self-employed (running grocery shops, tea stalls, etc.)

Food grains availability and use

Madhya Pradesh is a predominantly agricultural state, as 77 per cent of its population lives in rural areas. The state seems to produce adequate quantities of cereals, more than double the requirement of pulses and oil seeds, but it is deficient in tubers, fruits, vegetables, eggs and fish. Although it produces sufficient milk, its consumption is 82g per capita per day and is well below the requirements of 150g. On the other hand, the average level of cereal consumption is 473 g per capita per day as against 420 g as recommended by Indian Council of Medical Research⁹. The consumption of pulses is high at 32g per day as compared to the minimum requirement of 40g. On comparison of these values with national intake, it could be found that except Himachal Pradesh, all other States have very low levels of pulse consumption. It may be because the production of pulses is less than its requirements in these States. But the intake of vegetables and fruits is high during two to three months of winter as compared to monsoon season. The quantity and the variety used are very much lower than the requirements. For instance, dhals and soyabean, though available, are not used adequately. The intake of all food groups is also dependent on the seasonal availability

TABLE I
Socio-Demographic Profile of
Study Population

Details	Per cent
Age Group	
< 1 year	11.3
1-5 years	25.7
10-19 years	27.9
20-45 years	35.1
Household Income per month (Rs.)	
Upto 2000	20.4
2001-5000	62.4
5001 and above	17.2
Caste/Tribes and other classes	
Scheduled Castes	18.0
Scheduled Tribes	9.9
Backward Class	22.4
Others	49.7
Educational Status	
Illiterate	25.8
Literate	12.9
Primary	34.1
Middle	17.4
High School	9.8
Occupation	
Work in family farms	46.2
Employed by somebody else	24.8
Self employed	9.0
Not working in the last 12 months	20.0

as well as on the livelihood and purchasing power. That is, poverty or lack of purchasing power could play a major role for obvious reasons and this is where the crux of the problem lies.

On the otherhand, knowledge of nutritional value, distribution, price and distance from the availability of food seems to affect its use. They are cooked either once a day or two or three times in a week because they do not understand their importance. Similarly, quite a few nutritious food items are either not used adequately or used very occasionally. This appears to be due to lack of knowledge, as they do not seem to know that the use of these easily available foods like gur, groundnuts, soyabean, amla etc. is good for health. Emphasis does not seem to be on expensive but less nutritious food. This reflects that consumers do not seem to know how important they are, hence women use them only if they are available, but do not make any special effort to procure them. On the other hand, most of the food is purchased from the market and so purchasing power dictates their use. This in turn dictates the calorie intake. For instance, the calorie consumption, at the national level, by 10 per cent of the population at the lowest level is only about 1894 K cal per day, whereas in the study area, 12.2 per cent of the population consume less than 1890 calories per day. However this level is higher than the average consumption of dietaries in Southern States of India⁹, such as Kerala and Tamil Nadu, which is about 1500 calories.

Gender and food provision

In a country like India where nutritional improvement has lagged behind economic growth, social discrimination against women is common and women have a tradition of eating after everybody in the house has eaten. Most of the women in the study areas lived in families with parents, in-laws, children and husbands, and as such as they balanced their own needs and desires against those of higher status household members, nutritionally vulnerable children etc.

The consumption of a wide variety of nutritious food is important for adolescent girls and women who are in the reproductive period. In the present study, lactating mothers and pregnant women are asked how often they consumed various types of foods. The study did not find much variation between pregnant women and mothers' consumption of curd or milk, pulses and vegetables. Due to little variation in the data, the samples of lactating mothers and pregnant women were merged to have a meaningful analysis. Fifty per cent of them consumed curd and 28 per cent ate vegetables on a daily basis. On the other hand, 81 per cent consumed pulses or beans atleast once a week. Most of the pregnant women ate green leafy vegetables occasionally but a substantial proportion (22%) of mothers ate green leafy vegetables atleast once a week. In the case of adolescent girls, 60-69 per cent consumed pulses, curd and green vegetables once a week in their daily food (Table II), while milk and meat/eggs were consumed by about 32-36 per cent of adolescent girls weekly. However, fruits (specially bananas) were

TABLE II
Food Consumption by Pregnant Women, Lactating Mothers and Adolescent Girls

Type of Food	Daily	Weekly	Occasionally
Food consumption by pregnant women and lactating mothers			
Curd or Milk	50.2	20.5	23.4
Pulses	18.6	62.8	18.2
Green Leafy Vegetables	24.4	53.5	21.6
Other Vegetables	38	40.9	20.5
Fruits	4.8	15.7	15.7
Eggs	0.8	6.7	78.2
Chicken, Fish, Meat	1.2	5.3	76.4
Food consumption by adolescent girls			
Curd or Milk	18.7	33.3	16.7
Pulses	14.6	68.9	39.1
Green Leafy Vegetables	7.8	42.6	10.2
Other Vegetables	10.7	21.5	13.8
Fruits	7.8	24.2	9.3
Eggs	11.4	32.3	13.1
Chicken, Fish, Meat	20.5	21.6	71.8

eaten daily by less than eight per cent of the study population, weekly by 24.2 per cent and the rest ate occasionally. At least four-fifths of the study population stated that they ate chicken, fish and eggs only occasionally.

Nobody seems to find out whether the women have enough to eat or whether they have eaten at all. It is just supposed that they will find for themselves. If in the process, everybody has eaten and there is nothing left, they just have chappathies with pickles or sometimes only with salt and plain rice, according to 22 per cent of women in the study. The worst is that nearly one-fifth of women do not consider themselves important enough to bother about themselves (Table - III).

The overall picture that emerges is that

- 1) Women do not have adequate knowledge of proper utilization of foods, which are locally available.
- 2) Their attitudes (quite often wrong beliefs) lead to poor nutrition, as they may have food but do not use it appropriately at the appropriate time.
- 3) They do not consider themselves important enough to look after themselves and do not want to project themselves as being bothered about their own health. These attitudes will reflect in the poor nutritional status of the family as well as quite often the child who wants food will be kept waiting while the elders are catered to.

TABLE III

Reasons for Less Consumption by Women in General, Pregnant Women and Lactating Mothers

Details	Per cent
Reasons for less consumption	
No time to eat	16.6
No Food left	21.9
Not bothered about the food	19.2
Not much food available to eat	17.5
Child is sick, not having time to bother about	9.7
Guest arrived, need to keep food eat last	6.8
	8.3
Intake of food during pregnancy	
Lack of time due to over workload	20.8
Not much food available to eat	16.9
Abundant food is available, but no wish to eat	12.4
Eating more leads to big baby	21.3
Don't want to attract the attention of elders	18.6
Lack of appetite or feel like eating something else	10.0
Intake of food during lactation	
Follow what others say	18.4
Not much food available to eat	22.7
Cold foods are not allowed during lactation	15.7
Customs and beliefs play important role	14.9
Blind belief in taboos	28.3

Status of pregnant women

It was found that a majority (62%) of the pregnant women consumed even less than non-pregnant (47.3%) women whose diets were deficient in calories. In the study area, almost two-thirds (63.8%) of the women felt

that when women are pregnant, they need extra food, but they are not clear about how much extra. Slightly less than one-fifth (18.8%) said "little more", and 14.2 per cent stated 'double' the quantity. In contrast, nearly a quarter (22.2%) said that "they don't need extra food", 7.1 per cent stated "eating more won't help" and six per cent said "eat less". There are a number of other factors (Table III) which affect the intake of women. If abundant food is available in the house, there appears to be more chance of women eating adequately but there seems to be no wish or tendency to buy any special or extra food, according to 12.4 per cent of pregnant women. The first trimester results in lack of appetite; often there was weight loss because the food intake became very little due to nausea and even the smell of food was found to be unpleasant. In contrast, 21.3 per cent of pregnant women stated that eating more meant baby becoming big. In other words, quite often extra food was not eaten because it was believed that it will lead to a big baby which might trouble the women at the time of delivery (Table III).

Certain foods are believed to help in the formation of the foetus. Here again the availability of food dictates women's intake. It is very interesting to note that 35.5 per cent of pregnant women felt that supplementary nutrition would help in the growth of the foetus, followed by 18.4 per cent who said eating vegetables was essential. This is because they have found that the extra food has improved the status of babies born. But the most harm seems to be done by food fads which have taken roots in their minds and

which are handled by the elderly women of the family. This seems to do most harm as quite a lot of nutritious foods are not used because of these beliefs. Other factors that play an important role are lack of time and overwork, as most of them continue to work till the end of the day. Ten per cent of pregnant women do not think of buying any special food for themselves. If the parents of the pregnant women think of providing special food like laddoos (sweets) then they may get them. Nearly one-fifth of pregnant women seem to be hampered by the image of self sacrifice for they do not want in-laws or neighbours to think that they think much of themselves (Table - III).

Status of lactating mothers

In general, there are a number of beliefs regarding feeding the lactating women after delivery. Almost in the whole study area, after delivery, women are not given adequate food in the initial days and in some areas this period may extend up to seven days. This is not to say that the women do not feel hungry, but the belief is that early eating will cause the women to have discomfort. On the other hand, a wide variety of foods are considered to be good during the period immediately after delivery. In the study area, foods in terms of preference are : Harira (58%), Dalia Gutki (46.5%) Gur and Milk (12.8%) and whatever is available (12.1%). Harira is the food which is believed to have almost magical properties. It is made of wheat flour, ghee and a lot of dried fruits. This is supposed to be good for the mother and is supposed to help in the

production of milk. Dalia, Khichari and milk are considered as light foods and hence given during the days when regular food is not given.

An interesting fact was 28.3 per cent of lactating mothers did not know why the taboo foods were not good for them but they followed the rule more by heresay (Table-III). Here again, availability of foods and poverty seem to dictate what the women get to eat. On being questioned, during field-testing, about how the poor managed these dried fruits and ghee during this period if they were so poor, they said they all rallied around and helped the poor women during this time. On calculating the cost, they agreed it costed about Rs.50 per day, which was more than their earning capacity of the family per day.

On being told that they could feed a woman adequately with home cooked food in just about 25 rupees, they were willing to try it. Almost all lactating mothers accepted that "harira" fed to them could not be taken in adequate amount as it was not possible to prepare the same food at all time. Most of them were not sure of what harm would befall them if they did not have normal food.

Taboo food items : butter, milk and rice (14.8%), lemon (25.9%) and cold items. Cucumber (33.3%) is not allowed. Here again sour foods, and so-called cold foods are not given during pregnancy. The main reasons are that these foods are 'cold-producing' and lead to stiff joints and paralysis of limbs and they are hard to digest and so cause gastro-intestinal disturbances to the mother as well as to the child. It was also found that women were not given water after delivery

as it is supposed to harm them. This is unfortunate because women sweat very profusely during delivery and if they are not given water, they may suffer from dehydration.

Status of the newborn / infant

Feeding practices in the newborn during the first few days after birth shows considerable regional variations. A detailed study by ICMR⁹ reveals that in India, the majority of the newborns received water sweetened with either sugar or jaggery (gur) or honey or an infusion of ajwain and saunf during the first twenty four hours as the first feed. The major reason is that a majority of the mothers think that lactation gets established during the third day only. Table IV, which reflects the feeding practices in the newborn during the first few days after birth shows considerable variations across families.

Around 26.6 per cent of the infants were fed within an hour, followed by 21 per cent fed after few hours, 17 and 19.5 per cent fed during the first day and third day respectively, and only 1.8 per cent were fed during the second day. Social reasons play a major role in delaying breast-feeding. The other reason is that they do not consider colostrum as milk. Some of them discarded it because they just wanted to follow what was told to them.

Regarding food habits, only eight per cent of mothers took advice on what type of food should be given to children. And they took advice mainly from their family members and elderly neighbours. It was also reported by mothers that they provided food

according to the child's liking. The interesting results are that over four-fifths (84.4%) of the respondents feed the baby something or other besides breast milk during the first month itself. One half of the mothers fed the baby with 'janam ghutti' (honey) and 21 per cent gave water and 8.5 per cent honey.

Supplementary nutrition

The infant morbidity and mortality rates show a lot of variations depending upon the age of introduction of supplements and the type of supplements used. The two main causes of giving top feeds is the illusion that breast-feed is not enough and the doctor or the nurse or the elders advised that the baby needs top feed. Often in many cases, investigations in the study areas have shown that the milk output is normal and the growth of a breast-fed infant is very satisfactory. However, the results of the studies undertaken among poor segments of the population in developing countries indicate that bottle-feeding and early introduction of processed supplements have been accepted as a symbol of sophistication⁶. In the study population, almost all women often work in agricultural fields, poor hygiene and unsanitary conditions under which the feeds are prepared, and over dilution of feeds lead to increased infective morbidity, which leads to infant mortality. The other reasons for the introduction of supplementary nutrition were mother's illness or subsequent pregnancy.

In most areas under study, very few mothers made any special effort to feed the child at the proper time. In most of the regions

special weaning foods were not prepared at home due to lack of awareness of the special nutritional needs of the children. Only 14.1 per cent mothers of infants stated that they gave supplementary food at the right age of six months. Most of the women said that the child did not like to be breast-fed. On further discussion it was known that they usually breast-fed the baby first and that is also the reason why the baby then refuses to eat supplementary food on a full stomach.

Quite often dhal water was given. The various foods introduced first were : kheer (a sweet recipe-mix of rice, milk, sugar and dry fruits) (35.5%), dalia and juice (30.1%), dal-roti (10.6%) and biscuits (6.4%).

During illness and diarrhoea, usually light liquid or bland and sloppy foods were given. Foods given during illness were honey (2.4%), water (10%), kichari (20.9%) and fruit juice (13.8%). One major fact was that the mothers did not know what to feed. The elders often hampered them. These were some of the restraining factors in feeding the child at the right time and of course poverty and lack of time again played a major role in supplementary nutrition of the child. About 14.2 per cent of women bottle-fed the child and about 10 per cent of them did so because they were under the impression that mothers milk was not sufficient and only 18 per cent of them used hot water to clean the bottle. On being asked if they knew how to find out whether a child was getting adequate breast milk, they answered no. They supposed

that it was not sufficient because elders said so and also because bottles are a sign of sophistication.

Status of adolescent girl

The growth spurt for girls usually occurs between the ages 11-14 years. An adolescent girl required all the foods required by any adult to meet her growth requirements. In addition to adequate calcium, protein and calories etc., she requires adequate iron as well. There are hardly any studies done on adolescent girls and their nutritional intake, but it has been seen that teenage girls constitute one of the poorest fed groups in any population. In the study area, it was found that a majority of the girls who reached the age of adolescence were 12 to 15 cms shorter than their well-to-do peers in the same society. Fortunately, given proper food during adolescence, girls can catch up on the growth spurt and reach satisfactory weight and height. Unfortunately, the girl child faces gender discrimination right from the beginning of the childhood, this has been highly reflected in the study areas. This does not mean that the mothers are not aware that a young girl requires more food.

When asked whether an adolescent girl needed extra food, a very large number of respondents (82.7%) said yes (Table-V). This shows that the awareness is there. Reasons for increase in food intake are quite well understood. But women were not sure that they could provide the adolescent girls with adequate nutrition from the very foods which were available at home, and that good

nutrition would make her a better mother. They were also not aware that they could make up for any nutritional deficiency of childhood to some extent by giving them adequate food. To the question which foods were helpful in the growth of an adolescent girl, there were a variety of answers such as milk and ghee (15.6%), fruits and vegetables (23%), all eatables (9.6%) and supplementary nutrition (21.3%). Thus, it is evident that although women were aware that girls require extra food and even though foods like fruits, vegetables and milk were required, lack of purchasing power and gender bias was the two main reasons for low intake.

Surprisingly, 60 per cent of the girls seemed to eat three times as compared to 67 per cent who stated that they ate two times a day. But the type of food eaten at these times may not be nutritious and left over bread from one meal was used whenever the girl was hungry. The quality of food is dependent on the quantity and quality of food available in the house. In general, the food intake in terms of quantity was very low in comparison to what it should be.

To the question which foods should not be eaten by an adolescent girl during her menstrual cycle, almost all adolescents said sour foods. Mirichi items (chilly items) (16%), jaggery (gur) (16.4%), imli/khati (32%), cold items (12.7%) and gur and channa (15.7%) were mentioned. The reasons for avoiding these foods are varied : swelling (24.7%), painful periods (22.1%), cause heat (18.9%) and stomach pain (20.8%). These are the usual misgivings about these foods almost

TABLE IV
Food Habits and Family Ideology of
Adolescent Girls

Details	Per cent
Adolescent girl needs extra food	
Yes	82.7
Not necessarily	11.4
No	5.9
Type of food necessary for adolescent girl's growth	
Milk and ghee	15.6
Fruits	23.0
Vegetables	23.0
Supplementary foods	21.3
All eatables	9.6
Normal food	7.5
The food that is not to be consumed during menstruation	
Mirichi items	16.0
Jaggery	16.4
Imli/Khati	32.0
Cold items	12.7
Gur and channa	15.7
Don't know	7.2
Reasons for avoiding sour foods	
Swelling	24.7
Painful periods	22.1
Cause heat / flatus	18.9
Stomach pain	20.8
Excessive bleeding	13.5

everywhere. A young girl who doesn't get enough to eat otherwise is not allowed to eat these foods during monthly periods resulting in further deficiencies (Table IV).

All though in the present study, these foods have been blamed for causing harm to various groups like adolescent girls during periods, pregnant women, lactating mothers

etc. surprisingly, some of the foods find mention as both hot as well as cold foods for example gur and tuar dal. Another interesting point is that rice is all right in kitcheri (mixed with dhal), but not by itself. It is considered cold by itself. All sour foods like lemons, guavas, orange, imli etc are high in vitamin C. These beliefs are unfortunate as they deprive the population of a vitamin, which helps to develop immunity against diseases and helps in absorbing iron from food. Similarly, channa, soyabean, and buttermilk / curd are locally available high protein foods and when combined and used with cereals would improve the overall quality as well as quantity of the diet. Some of them are supposed to cause pain during menstrual period. The absurdity of the facts is evident when one finds that the foods avoided in one State are recommended in other States of the country. For example, 'papaya' is strongly considered as a food which can easily cause abortion, and often women wanting to abort have eaten kilos of it in the hope that they will abort, but without any results. This probably results from the fact that raw papaya is helpful in cooking meat. In earlier times sugars were only available in the form of crude sugar or gur and our ancestors cautioned against excessive use of it, but didn't mention white sugar as it was not available then. That is why there is no fad against excessive use of white sugar but gur is under wrong notions. Similarly, buttermilk is a highly nutritious drink abundantly available in most villages in the study areas but it is discarded as cold food as they think it affects the pregnant and lactating women.

The truth is that very sour buttermilk may cause some irritation, fresh buttermilk is refreshing, nutritious drink.

Potatoes, pumpkins and dhal are considered flatulose producing as well as hot or cold foods and are avoided in the central India. But they constitute part of a regular diet in south India. These foods are supposed to cause cold as the so-called cold factor will pass from the mother's milk to the child.

Conclusion

The study found that the social status of individuals is reflected in the food and the amount of food that they consume. The difference of consumption between men and women is often related to the fact that men go out to work and women stay at home. Hence, the gender division of labour associated with family ideology is used as justification for women and men's different access to the resource of food within the family. This confirms to family ideology although women view it as an unequal relation of power and authority which are an integral part of family ideology and which structure every aspect of the family meal.

The pre-pubertal growth spurt is the last opportunity during which nutrition interventions can predictably change the adult size of a woman. Adult size, measured readily by height, also reflects an entire array of physiological measurements which determine the woman's capacity, safety and care of child birth and thereby obstetric risk to mother and child as well as the incidence

of low birth weight. Thus nutritional opportunity prior to the onset of menarche may be the most important time in the life of a woman to receive optimum nutrition. Upon the success of proper growth and even catch-up growth during the period rests her own health, her own work capacity, her ability to have healthy pregnancy and safe delivery and the health of the next generation. Increasing awareness on the critical importance of women to the overall process of development as well as to the health and well being of families has led to a wider array of women's programmes in health and nutrition. The condition of many women is increasingly recognized as a linking factor to the success of these efforts. Many women attained adulthood carrying a great burden of social conditioning and deprived of even basic experience and the wherewithal to prepare them for a healthy,

productive and happy adult life. To sum up, for any community to have sustainable improvement in health and nutritional status of its members, it is important that the issues involved must be understood and local solutions be found to solve the problems. Moreover, community, women's groups and adolescents should be educated on the importance of basic nutrition.

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