The North-South Difference:

Contrasting Cultural Traditions of Two Migrant Groups in Delhi

by
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THIS study of two regional groups now settled in Delhi investigates how regional and cultural differences may influence child death rates, particularly the difference in death rates between boys and girls. Our sample consisted of 976 households from Jaunpur and Pratapgarh in eastern Uttar Pradesh (UP) and 614 households frorn south Arcot, north Arcot, Salem and Madurai in Tamil Nadu. All these households are living in a large resettlement colony or upgraded slum, across the Yamuna, in east Delhi.

We already know from several sources that in both rural and urban UP child death rates are appreciably higher than they are in Tamil Nadu. For example, the Registrar General's 1981 survey of infant and child mortality in rural UP was 1.43 times higher than in rural Tamil Nadu and as much as 1.75 times higher in urban UP than in urban Tamil Nadu. This survey also found that the death rate of girls (among children born in 1978) was much higher than for boys in UP, while in Tamil Nadu girls had an edge over boys.

Although the two regional groups settled in Delhi are at a similar socioeconomic level and have a very similar external environment, with a similar access to health facilities, their experience of childhood mortality showed the differences found in the two states of origin. The Tamil women had lower proportions of their children dead, and also smaller differences between the proportions of girls and of boys who had died.

Indeed, there is some reason to believe that the differences between the two groups may be even more marked. It appears likely that in spite of our repeated probing of UP women on this question, they have significantly under reported dead daughters. This would mean that the sex ratio of child mortality would fall even further for UP. From our data, it appeared that girls from UP households have a much lower probability of surviving early childhood than boys, while in the Tamil households the two sexes have about equal chances.

Another interesting feature was the large number of female children born to UP women for whom all they reported was that they were born and they died. The mothers did not give any particulars such as age at death or cause of death. It is not clear if such forgetfulness is a genuine outcome of the lesser importance given to the birth and survival of a female, or a desire to hush up an event which stirs up uncomfortable feelings.

Our hypotheses were that

a) the mother's status, defined in terms of her autonomy, crucially affects child health and mortality;

b) women's low status is linked to high female death rates and the larger gaps between male and female death rates, especially amongst children;

c) differences in different regional groups in the status of women in matters relevant to child health and mortality cannot be explained away by other regional differences such as income or caste.

The Status of Women

The position or status of women is a complicated and often confused concept but in the present context, we consider only three aspects of it to be relevant:

a) the extent of women's exposure to the outside world

b) the extent of women's interaction with the outside world

c) the extent of female autonomy in decision making.

Let us examine our two sample populations from this point of view.

Most of our sample households were landless labourers or marginal farmers driven to Delhi by poverty or in search of employment. While the men migrated for economic reasons, the women generally migrated with husbands or parents. South Indian women rarely and north Indian women never migrated on their own.

In the UP sample, there were 140 men per 100 women while in the Tamil sample, there were 103 men per 100 women. The Tamil men who lived on their own were more likely to be unmarried or widowed, while 85 percent of the UP men who lived on their own had left their wives in the villages. Amongst the women of 40 and above, a much higher proportion of the Tamils were widows or separated than the north Indians. This does not mean that such events were less frequent in the UP population. It means that the UP women, after such an event, tend to go back to the village, while Tamil women are more likely to continue living on their own. This may be an indicator of their greater autonomy.

Another indicator is employment. Only 46 percent of Tamil women aged 19 to 59 were unemployed, while the figure was close to 95 percent in the north Indian group. Despite this, the households from Tamil Nadu were worse

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* The present article is taken from a larger study, *Culture, the Status of Women and Demo-graphic Behaviour: A Field Examination of some of the Relations*, undertaken for the National Council of Applied Economic Research, 1988. The study was conducted by a team of investigators, male and female, using questionnaires, extended conversations and observations.

The photographs are not taken in the colony studied but in similar colonies in Delhi, and show the same two regional migrant groups.

off economically than those from UP. This economic difference is interesting because the Tamil sample had lower childbirth and death rates in spite of their relatively greater poverty.

Another indicator is literacy and education rates. The regional pattern in the two states of origin as well as among our women respondents is that Tamil women are about twice as likely to be literate as UP women. However, Tamil children in our sample are at a general disadvantage in education. For example, in the age group 20-39 years, eight percent of women from UP and 15 percent of those from Tamil Nadu were literate but there is an abrupt reversal for the younger (and supposedly more advanced) age group of 10-19 years. In this group, only 30 percent of Tamil females are literate as compared to 70 percent of UP females. Thus, households from this UP sample are taking much greater advantage of the particular types of educational facilities available in Delhi.

Our data suggest that most of this Tamil disadvantage in schooling can be attributed to practical rather than cultural factors. The factors militating against Tamil children's schooling include the language barrier (Tamil medium schools being too far away from the colony and Tamil children being at a great disadvantage in the accessible Hindi medium schools) and the greater poverty of Tamil families in our sample with the consequent need to employ children either with their parents or at home when the mother is employed.

However, Tamil boys are much more likely to receive some schooling than the girls and to receive schooling beyond a certain age than are girls. But while overall school attendance rates are higher for UP children, here too the gap between boys' and girls' rates is visible. For both groups, the greatest gap occurs in the 10-12 year age group.

Tamil girl domestic servant

But while the Tamil girl is badly hampered in educational progress, it is not easy for her brothers. Indeed, even here, Tamil households continue to show a relatively greater equality in their treatment of boys and girls than do the UP households. As many as 25 percent of boys aged 10-12 are employed and even in the five to nine year age group, nine percent of them are needed to help out at home which is much less than the 19 percent of girls so needed, but is a high figure nevertheless. However, in the UP sample girls are withdrawn from school because they are needed at home but boys are not withdrawn for this reason.

Another interesting cultural response emerges in the notion of how far is too far for a child to go to a school. In a high percentage of cases, UP parents say girls aged 10-12 years are not sent to school because the school is "too far." However, given that all the local Hindi medium schools are within easy walking distance, the space to be traversed from home to school is psychological rather than physical and fits in well with the greater protectiveness from the outer world towards daughters in the UP homes. On the other hand, this reason of the school being too far is far less frequently proffered by Tamil parents for their not sending girls to school even though to attend the Tamil medium secondary school they do have to travel a fair distance into the heart of the city. In other words, Tamil parents more often give reasons tending towards the economic and the practical rather than reasons linked to the necessity to protect females than do UP parents.

At a primary school

The UP women, even when they earn an income, are likely to do so by activities which involve minimum interaction with the outside world, and certainly no interaction with men from the outside world. Almost all female employment is household based and centres on traditional feminine skills such as sewing, food processing or manufacture of knick knacks for sale by others.

On the other hand, Tamil women are willing to consider many more kinds of employment. Domestic service is the most popular

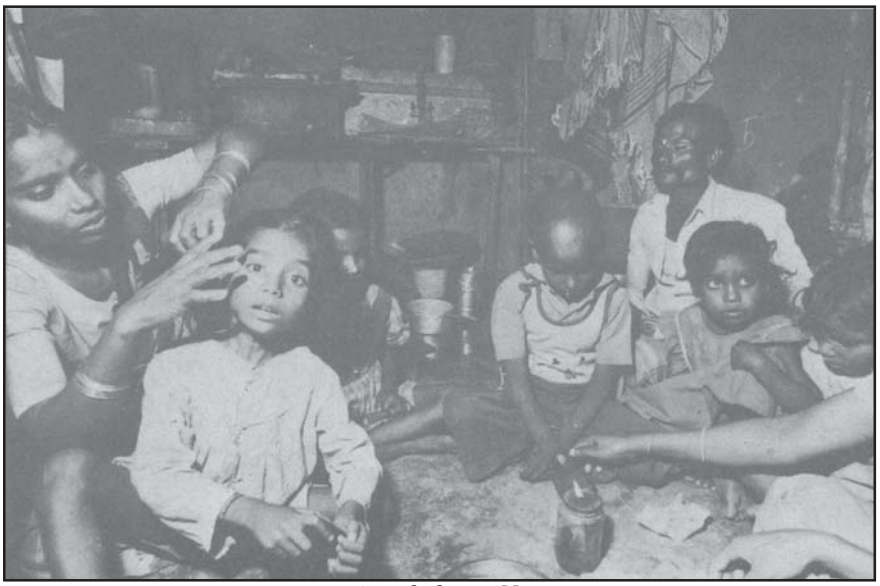
form of employment for these women. The other form of employment is to fry *dosas* and *vadas* at home and then hawk these snacks in the colony in the evening, to men and children of all regional groups. Both forms of employment help increase their self confidence and ability to deal with strangers. Such self confidence is also boosted by the knowledge that they are often the main breadwinners in their families. The Tamil women are much less likely to have husbands with regular jobs than are the north Indian women.

On the whole, it appears that the Tamil women's parental home is likely to be much more backward economically and yet much more innovative socioculturally than the UP women's home. The Tamil woman's father is more likely to be an agricultural labourer than a farmer while the reverse is true of the UP woman; he has also fewer assets in terms of land and property than the north Indian father. But educational levels of our Tamil respondents' fathers and even of their mothers are appreciably higher than those of the UP women's parents; our Tamil women have fewer siblings born and a smaller proportion of their siblings have died.

The kind of fuel used is an indicator of the value attached to the woman's time by the household. About 95 percent of Tamil households use the more expensive gas or kerosene for cooking rather than the more time consuming and inconvenient fuels such as coal and firewood, while the figure is 82 percent for the UP households, even though the latter group is better off than the former.

Similarly, a small but significant proportion of the Tamil men help in housework while none of the UP men do so. The latter do some shopping for food, but this again deprives the women of an opportunity to get around outside the house. The Tamil women are more likely to be employed outside the home so one would expect them to have less leisure, yet it is the Tamil women who seem to find more time to watch television and to interact with friends both within and outside the colony in spite of their long hours at the place of employment. This says a lot about the greater control they have over their lives to be able to indulge their desire to interact with the outside world. The UP women spend more time than Tamil women do in chatting with their female neighbours. But these are usually women from their husband's group, given the UP pattern of village exogamy. The Tamil women appear to have much greater access to contact with and support of their parental homes.

The three ways, then, in which Tamil women, while poorer and from poorer families, differ from UP women in our sample are that the former have greater exposure to the outside world, greater interaction with it, and greater autonomy in decision making.



Interior of of Tamil home

Mechanisms

Apart from the motivations which cause girls to be less highly valued than boys in northern India, how might these differing evaluations be translated into a higher death rate for girls? Direct action, that is, female infanticide, has never been the general norm even though it was once practised in some localised areas, and certainly it is not believed to be a common practice in any region today, yet regional sex differentials in childhood death rates continue to exist.

First, we must dismiss biology as a cause. It is now well established that the newborn female is biologically hardier: all other things being equal, death rates of newborn boys are higher than those of girls. Young girls at all ages tend to have lower death rates than boys in most societies where there is no socially based mortality related bias against girls, and also in societies where there is such a bias but where the bias is not sufficiently extreme to be translated into action. So, genetically determined physiological advantage cannot explain why girls face a greater death risk than boys in some parts of the world, including most parts of India.

Overall, in our sample, the UP child is at a relatively greater disadvantage - 111 children from UP die for every 100 Tamil children that die. Among newborn babies, sex differences in death rates in our study population are in the expected direction with girls having a relative advantage over boys. But after the first month of life, our two regional groups diverge greatly. In both cases, girls lose their earlier advantage but the Tamil girls now die at approximately the same rate or only a slightly worse rate than boys, while UP male survival rates leave female children far behind.

The important point is that the

regional difference in the sex differential in children's death rates is an important determinant of the overall difference in death rate of children between the two groups. The much larger gap in female death rates between Tamil Nadu and UP accounts for a substantial part of the difference in overall child death rates. For boys, the northern Indian disadvantage is nowhere near as large.

Environment

While the basic physical environment for both our cultural groups is the same, our results suggest that differences in regional household practices related to sanitation and hygiene lead to regional differences in the levels of potential exposure to disease which are reflected in regional differences in the incidence of illness.

Contaminated food and water are the main source of most intestinal infections, and sanitary waste disposal, avoidance of faecally contaminated water, and the adoption of personal hygienic practices play an important role in controlling their spread. On most of these counts, our UP households do somewhat worse than those from Tamil Nadu. While about 80 percent of the Tamil households throw their garbage in the official garbage heap in the colony from where municipal vans are supposed to collect it regularly, only 67 percent of UP households do so, the rest just dropping their rubbish outside the front door, either on the pavement or in the water drain which runs along each row of houses.

Very young children of both groups keep away from the inconvenient public toilets available. But even among girls aged 10-12 years, as many as 51 percent from UP use the space just outside the house to urinate; 25 percent even defecate here. For the Tamil girls the corresponding figures are 36 and 15 percent. These high figures for both groups may be in part due to embarrassment and insecurity felt in sending young girls to public toilets. This fear should be taken into account when designing toilets for slum

UP woman, stitching at home

populations.

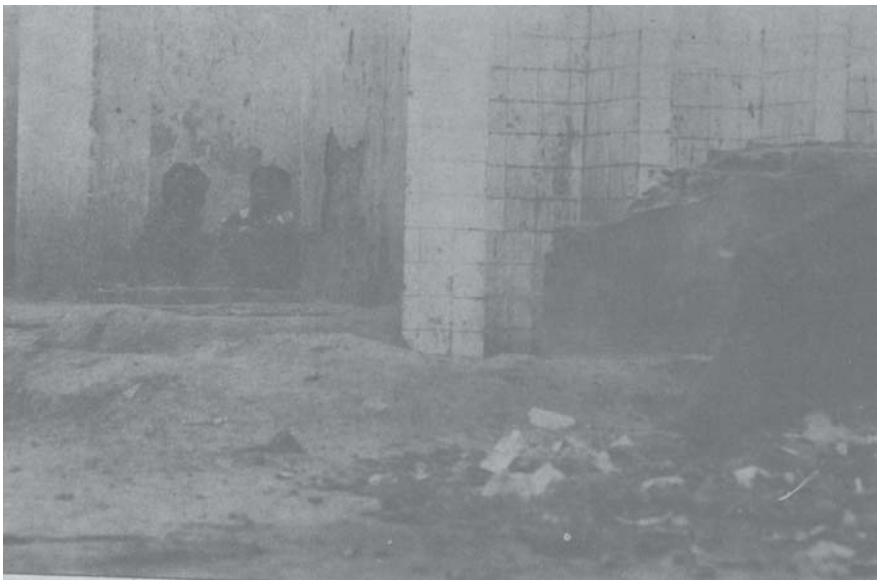
Only about 18 percent of UP households boil water for babies while 30 percent of Tamil households do so. This, especially coupled with the fact that about 84 percent of UP women delay the onset of breastfeeding for three or more days (this figure is 54 percent for Tamil women) and water constitutes an important ingredient of food during these first days, means that the chances of infections amongst newborns are much greater for UP babies.

However, it is unlikely that such exposure selectively affects girls, as any environmental or food or water contamination would affect both sexes equally. Therefore, this cannot be a cause of the wider gap between boys' and girls' death rates amongst UP children

Nutrition

Our data suggest that malnutrition is probably not a good explanation for regional differences in child mortality especially because Tamil children tend to score worse on this indicator than UP children, even though the former have lower death rates. Even in the states of origin, nutritional levels in Tamil Nadu are much worse than in most other parts of the country. One important way this occurs is through rice being the sole cereal of most south Indian households, while north Indians consume more than one cereal with a wide range of legumes and pulses.

However, in our sample, Tamil children face better nutritional prospects in the first few months of life than UP children. This is mainly through the difference in initiation of breastfeeding. The custom of delaying breastfeeding is prevalent in both groups but the Tamil women seem more open to change in this regard, with 40 percent of the younger women having accepted that breastmilk is good for the child from the day of birth.



Public toilet, East Delhi

This is probably partly responsible for the regional differences in newborn death rates. The reason is not just the absence of protective breastmilk but the dangers inherent in the substitutes fed to the child, the two favourites being sugar water and outside milk, with sterilisation of either by boiling being rare.

Our data suggest that malnutrition is probably not a good explanation for sex differences in child death rates as no significant differences in nutrition levels of young boys and girls emerged from our observations.

In our sample, there was no major regional difference hi the immunisation pattern, overall immunisation levels being astonishingly high for both groups, with the UP mother being, if anything, more likely to have her children immunised than the Tamil mother. However, a cultural difference is visible when one looks at perseverance. There is a sharp fall in the numbers of UP children taking the full recommended course of three doses of vaccine. Our data suggested that the UP woman was much more alarmed by the side effects of immunisation such as fever than was the Tamil woman.

In the area of childbirth too there are important ethnic differences. According to the Registrar General's 1979 survey, 94 percent of rural UP births had been delivered by untrained personnel while in rural Tamil Nadu this figure was 50 percent. In our sample, even for the births in Delhi which had the same institutional choices, the UP sample clings to home delivery. For Tamil women, births in Delhi are three times more likely than UP ones to occur in a hospital. However, the figure of hospital births amongst UP women is higher than it is in the home state itself, while for Tamil women the figure is lower than for the home state. This is probably a result of the unfamiliarity of the Tamil women with many hospital based health services in Delhi than in Tamil Nadu, especially because they face a major language problem when they first arrive.

What explains the UP woman's greater reluctance to have a hospital delivery? The first reason appeared to be fear. Brought up in an area of extremely limited health services and in a tradition of much less female autonomy than their Tamil counterparts, UP women have a greater mistrust of hospital delivery. Added to this is the fear of forcible sterilisation after delivery and the fear that the baby born to them, especially if it is a boy, might be exchanged for a worse, generally girl, baby from a more influential mother.

In our survey, the hospital delivery turns out to be more successful than a delivery conducted at home in ensuring a child lives beyond a week . For the UP women, this difference is significantly larger than it appears because more UP women tend to go to the hospital for delivery when complications develop which means that the hospital gets a larger proportion of high risk cases.

Our most striking finding was the overwhelming faith in the curative power of what they see as modern medicine, whatever the ethnic origin, nature of illness or age of the sufferer. This faith seems to remain unshaken however backward the household in other respects, with the uneducated or lower castes often even more eager to seek what they perceive as qualified medical help than are their socioeconomic superiors.

Our sample households believed strongly in the curative power of injections in sharp contrast to their fear of preventive vaccinations. The logic behind this could not be easily faulted - they could plainly see how curative medicine got rid of the symptoms of ill health while immunisation actually produced such symptoms in a normally healthy child.

Even more interesting is the uniform tendency to consider the private practitioner superior to the government one, even though the latter's services are free. The reasons include the much longer wait for attention at the government clinic, the greater impersonality of the government clinic, and the inclination to devalue what is free. Most important, the private practitioner believes in quick results, and uses a wide variety of drugs more freely than the government dispensary which is chronically short of drugs.

In both groups, fevers tend to receive treatment much sooner than a cough or diarrhoea which is perceived as irritating but not incapacitating like a fever. Respiratory and gastrointestinal ailments are accepted as an inevitable part of life because of their greater frequency which makes them seem less threatening. Fevers are also seen as more easily curable by modern medicine.

The more secluded UP mother is more likely to treat fever than the Tamil mother. But the Tamil mother is much more likely to treat respiratory or diarrhoeal problems than is the UP mother.

The greater self confidence of Tamil households is also apparent in the much greater ease with which they resort to self medication with modern drugs. This is the case for all illnesses but especially for fevers and respiratory complaints. About 25 percent of Tamil households reported keeping painkillers at home and close to 32 percent kept at least one kind of modern medicine, while for UP the corresponding percentages were 14 and 25 respectively.

Such confidence in one's ability to handle one's illnesses maybe misplaced and even dangerous but even more worrying is the finding that the only group for which the UP households are more likely to try modern home remedies more frequently than Tamils is the highly vulnerable group of children below the age of one. The Tamil sample tends to leave this age group out of its household medical practice experiments.

More disturbing is the finding that for both groups, infants are much more

likely to be untreated for an illness than children over one. One of the reasons for this may be that manifesting a high degree of concern for an infant might be seen as inviting the evil eye.

The UP households resort more often than Tamils to traditional home remedies and other nonallopathic forms of treatments, especially for coughs, colds and diarrhoea. This often involves the use of other treatment prior to, subsequent to, or sometimes simultaneously with modern treatment.

Discrimination in Health Care

It appears that preventive health care, such as immunisation, is not a significant determinant of sex differences in death rates. In our sample, there were very small sex differences in the percentages of living boys and girls who had received some immunisation. We are left with the possibility of sex differences in the treatment of illness episodes as a cause of differences in boys' and girls' death rates. There are a few clear regional differences in this area.

When the ailment is a fever, which is the illness most likely to be treated by UP households, girls are at the greatest disadvantage vis-a-vis boys. On the other hand, amongst Tamil families, there seems to be a much greater urgency to do something about a fever when the sufferer happens to be a girl. The possibility must be admitted that this is because of greater costs of an inactivating illness such as fever in girls than in boys. The Tamil girls were much more involved both in housework, especially if their mothers were employed, and in income earning activities outside the home than were boys. This was true even in children in the five to nine year age group.

The difference in the amount and kind of medical care provided during illness may be an important determinant of the difference between boys' and girls' death rates observed in our UP sample, and indeed in many of the areas of India which show such a female disadvantage in survival.

The UP boys in our sample are more likely to receive modern, professional, privately obtained and paid for medical care than their sisters, and are also more likely to receive more than one bout of treatment for the same illness episode.

UP woman at government hospital

The Hold of Culture

Female education is one way of raising the status of women. But there are also strong cultural differences in the position of women in different groups and regions which are not reduced by small amounts of modern education by itself. Education may have a substantial impact among groups in regions where women are relatively more independent to begin with.

The lower income groups and lower caste groups in our UP sample are fairer in the medical treatment of boys and girls than the better off UP categories. However, somewhat educated UP mothers tend to be more unfair to girls than are uneducated UP mothers. Amongst Tamils, the tradition of overall greater female autonomy seems to be reflected in the much weaker association between the indices of socioeconomic status and sex differences in the handling of illnesses in young children.

Our south Indian sample was found to have a history and a culture of greater freedom of movement and autonomy in household decisions than the women from north India. This was not just a result of the Tamil women's higher rates of education and employment. Indeed, these higher rates are likely themselves to be a reflection of the already existing higher autonomy of Tamil women as compared to UP women. The greater gender inequality in UP households (caused by the prevailing kinship system, the low economic productivity of women, and a high physical seclusion system) appears to lead to the women's lower status. Even when some of the UP women have some control over resources, they seem to believe it only right to use these selectively to favour boys over girls.

The lowest autonomy levels are seen for women aged 25 to 29 belonging to UP (in both groups, autonomy rises with age). But the 25 to 29 age group for mothers is also the age range in which their children's deaths are most likely to occur, so the consequences of women's position are more drastic than they would have been had the overall low levels of autonomy of UP women been evenly distributed across women of different ages.

This study suggests that regional differences of a cultural nature including those affecting health habits, autonomy of women, education, caste, socioeconomic status, are likely to be correlated with death rates among young children. Further research should attempt to explore whether these cultural patterns brought from particular rural areas to distant urban areas by migrant groups, and their effects on mortality rates and the bias against girls' survival, continue to hold good even for the children of parents who were bom and reared in the urban environment.

-Manushi