Dietrich, Gabriele.: Vistas of Change. In search of Our Bodies: A Feminist Look at Women, Health and Reproduction in India. Edited by Bhate, Kamakshi; Menon, Lakshmi; Gupte, Manisha. Shakti. June 1987.p.113.

Vistas Of Change

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A Feminist Health Movement

Among most of Tamil Nadus rural population, especially if the villages are in remote areas, health is not very much a 'felt need'. If one discusses with poor villagers their needs and aspirations, there are many other priorities of a higher order e.g. work, food, shelter, clothing, education, arranging for the marriages of one's children, repaying one's debts etc. Health tends to get the eighth or ninth rank in the list of priorities, though in cases of emergency, when life is endangered, especially if it is the life of an earning member of the family or a male child, heavy expense may go into life saving measures. Oftentimes, such measures prove futile and result in further indebtedness. This situation is quite different from neighboring Kerala which has a more close-knit infrastructure of primary health services, a higher literacy rate, a very developed people's science movement and a lower mortality rate among women and infants.

The present case study is not the evaluation of a 'health project'. It is the result of participatory research among women who are mostly agricultural laborers and who are organized in a rural women's liberation movement. Health In this movement was used as an 'entry point'. This resulted from the perception that health, though not a "felt need", is at the same time a constant problem especially for women who suffer from malnutrition and ill and health themselves and have to look after the sick. The study was trying to find out with what kind of perception pf health, the rural women's movement had started off; how this perception and the style of work had changed while the work went on and what the conclusions, were if any, for any health work which tried to be aware of a feminist perspective or, for any women's work which tried to use health as an entry point. If one tries to characterize the change in the approach to health, one can observe the shift from a propagandistic or advertisement approach to health, to an appropriation of health as a basic human right.

Brief History of the Organization

The organization, - a non-governmental organization (NGO) receiving foreign funds, Society for Rural Education and Development (SRED) started with health work. Working, in villages near Arkonam in North Arcot district in Tamil Nadu. It had emerged from a network of various organizations of a similar nature working since the early seventies which had focussed on organization of landless agricultural laborers, first among dalits only, and later attempting to work along class lines. These organizations had focussed a lot on humanitarian issues (caste atrocities) as well as on wage and land issues. SRED had been founded in 1979 by a woman animator who had been the only woman in a team of male animators and who realized that it was very difficult to organize woman within a male-dominated organization. She branched off and formed her own organization, heading a mixed team of female and male animators. The work continued to be among landless agricultural workers, mostly dalits, while the agricultural Coolie Sangham continued to be male-dominated. This was, however, counter-balanced by forming a separate woman's liberation organization which first focussed on atrocities against women - like rape, murder and battering.

The women's movement tries to be organizationally independent of SRED. However SRED runs training programs for women like sewing classes. Weaving, carpentry, cycle repair, with the objective of enabling women to set up some income-generating, activity. SRED was also running a primary health program as one of their attempts to make women more self-reliant. From the beginning, health work was run by a small team of young girls who had undergone a crash course in rural health. The program was developed and coordinated by a trained nurse who had undergone an additional half-year course in rural medicine. Occasionally health work involved the weekly services of a private doctor, who comes to remote areas for consultation. On the whole, the program works without highly trained medical experts. The outlook was from the beginning, one of making village women more self-reliant in the medical field.

An important aspect was the training of elderly village women, often widows, as village dais, (traditional birth attendants). Traditionally, in some of the villages, deliveries had been conducted by an old "dai" who was as good as blind. With the formation of women's organizations in the area, it became possible to identify women with interest in health work. Training went on at monthly meetings of two days each and, role plays were an important medium of instruction. Trained women were equipped with a delivery box containing a rubber sheet, scissors, etc. and the standards of delivery services markedly improved while

independence from established health institutions has been maintained. Only in critical cases were women hospitalized. This program has, at the same time, helped to socially rehabilite elderly widows who enjoy a certain amount of respect among health workers. They charge a normal fee for their services but earn a living as agricultural laborers.

Self-reliance Through Use of "Nattu Vaithyam" (Native Medicine)

Initially, distribution of allopathic medicines for common ailmes was widely practiced. Even antibiotics were handed out in this way. This did, however, leave the workers with a certain sense of frustration since they, themselves, felt that they often could not judge all the implications of the treatment they were inducing. It was also difficult to check whether people were really following a full course of treatment and it was felt that a more comprehensive approach was needed. The health workers went into an analysis of people's food habits and launched a program for spreading the use of "papaya" and drumstick trees, to fight common ailments like night blindness and anaemia. The use of "papaya" and green leaves was also propagated and seedlings were made available to be planted close to the house. Side by side, home remedies against diarrhoea, colds, bronchial infections, jaundice and other common ailments were documented and tried out and it became possible to distinguish between an effective use of herbal medicines and superstitious beliefs. The use of herbal medicines became an integral part of the training of health workers and the use of allopathic medicines was drastically reduced. This went together with training in oral rehydration.

It is important to note that the indigenous herbal medicine ""nattu vaithayam" is a system which is traditionally not under expert control to the same extent as allopathy or the other indigenous systems like ayurveda, siddha or unani. The home remedies are generally common knowledge and it is a knowledge which is traditionally controlled by women. Ironically, it was the remoteness of the villages and the lack of financial resource to be spent on transport and drugs, which facilitated the use of "nattu vaithyam". During the process of the participatory research, a number of health festivals were conducted to review the different approaches of health work. It required a considerable propagandistic effort to establish trust in some of the simple methods of treating common ailments since mystification of medical knowledge created an impression of superiority. Such propaganda was carried out in street plays and "pattimanrams" (oratory competitions).

Making Government Services Available

It was decided to document such situations in which struggles were carried out to make government health services available. In some of the villages covered by SRED work, primary health clinics run by the Government are available. These proved, however, to be defunct in some crucial situations. Over a period of six years, about thirteen struggles were documented where government health services had been made available by demonstrations and sending telegrams to higher authorities.

While such struggles were in tune with the SRED approach of encouraging people to struggle for their rights and promoting self-help, the struggles resulted in a distribution of health services which are again entirely outside the control of people and the logic of which was not always fully comprehensible. For example, inoculations during a chicken pox epidemic seemed to be of questionable value. The group started to see that it faced a widening contradiction between the attempt to make people as self-reliant as possible in controlling their health and the actual functioning of established medical systems. Since in some critical situations, institutional health services are needed, it seemed to be impossible, for the time being, to resolve this contradiction. The only method to democratize the use of the established health system seems to be to train people in asking questions about diagnosis and treatment and, to reduce blind faith in injections through role play and street theatre.

Health Festivals with a Difference

Initially, health festivals and health exhibitions were held in a conventional way, frequently borrowing all kinds of charts and educational materials from existing health programs like RUSHA near Vellore. While such efforts had a limited educational value in the sense that they imparted a certain amount of information, it turned out that some of the information tended to remain abstract and external to people's lives. For example, while emphasizing the need for personal hygiene it turned out that women had access to taking bath only once in a week on Friday before going to the temple. This was, on the one hand, related to the fact that public bathing facilities are less available now than 10 years ago. The tanks have either dried up due to lowering of the water level or they are used for washing lorries. On the other hand, with the scarcity of water and fuel, a woman's working day has lengthened so much that there was no time for taking a bath, while most men somehow managed to take bath daily. It thus turned out that even a simple question like personal hygiene could not be dealt with

without going into complex issues like deterioration of the environment and sexual division of labor.

One important ingredient of health exhibitions and health work in general was information about the reproductive cycle and the use of contraceptives. As usual, the main emphasis was on the female reproductive system and on the usefulness of tubectomy. Even among young girls who were trained in health work it was obvious that a considerable embarrassment, was connected with the whole issue of fertility control. Voluntary Health Association of India's (VHAI) slides on reproduction had to be shown behind closed shutters and they were met with protracted bouts of giggling and exclamations. Through intensive discussion during the participatory research it turned out that imparting information on bodily functions and on possible choice of contraceptives was one thing, whereas making use of any of these options was quite a different matter. Since the health program did not work with fixed targets on family planning and was based on conviction and not material incentives, it became necessary to find out the actual attitudes towards birth control. In one of the discussions it turned out that most women had not used contraceptives but that a large number of them had undergone or performed illicit abortions which were often very injurious to health. Some of the common techniques were to use raw "papaya", camphor, turmeric or to induce uterine infection with the middle part of the yellow leaf of a poisonous plant". (irakkam-chedi").

One of the ways to deepen the discussions on this subject was to develop a poster exhibition on the production of life which focussed on the female cycle, fertilization, different stages of pregnancy, childbirth and lactation and also cancer prophylaxis. This method proved to be superior to showing slides, since it was independent of electricity and technology and allowed women to take their own time in going through the posters, comment, ask questions or go back to earlier ones. While putting up the exhibition for the first time, we noticed that it again focused entirely on the female body. The male contribution to procreation only became visible on one poster which depicited a giant sperm wriggling its way towards the expectant egg. It was then discussed why the origin of the sperm had not been made visible. It turned out that feminist assumptions had got mixed up with the traditional assumption that fertility is a 'women's affair' and also with the widespread attitude of depicting women's insides and outsides very, freely while expecting modesty of them in actual life. Men, on the other hand, need not practice modesty, they can relieve their bodily urges in broad daylight along the roadsides and railway-lines, but to put their genitals on a poster seemed to be an act of outrageous boldness. After discussing the matter from all angles, it was decided to add a few posters depicting the male reproductive organs and also to give an indication of the relationship between

sexuality and fertility. Also, vasectomy was depicted side by side with tubectomy.

Awareness of the Right to Control One's Own Body

Frequent pregnancies and abortions were indeed a major health hazard for women. Some of the reasons for reluctance in family planning were the following:

(1) Operations were mostly rejected because of the risk of child mortality. Men rejected operations because they feared loss of their virility and their strength to work. Women feared loss of social standing after losing the capacity to bear children. They also feared that sexual demands might be more and that their fidelity would be questioned. This last aspect applied also to other methods of birth control.

(2) Women were reluctant to use IUDs because they had heard of cases of women suffering from irregular bleeding and pain during agricultural work.

(3) Men rejected the use of condoms because they felt it deprived them of 'full satisfaction'. This was an acceptable reason even to women because 'full satisfaction' was looked on as a man's birthright, whatever the physical price the woman might have to pay for it.

(4) Hormonal contraceptives were looked at with suspicion. The pill posed the disadvantage that it required utmost regularity while injectable contraceptives, which were used by some private medical practitioners in the area, were thought of as causing bleeding and possibly cancer.

(5) Some women had used sexual abstinence in order to space births and even though this led to marital power struggles those who have succeeded insist that it was as good a method as any other.

(6) While probing into the causes for frequent abortions, three aspects became visible (a) Abortion often seemed to be a matter of crossing the bridge when you reach it, even though information on fertilization and early pregnancy were available. These processes are difficult to observe in actual practice and only after missing one menses or two, was there a sense of urgency to take action. (b) This

attitude was reinforced by the fact that other birth control methods were physically uncomfortable and hazardous and fraught with risks like child mortality and social ostracism. (c) Since the abortions were carried out secretly, they remained to a large extent within the control of the women themselves. This was thought of as an advantage, even though many women had to seek medical assistance finally because of severe infection.

These observations led to discussions about the relationship between sexuality and fertility. Women described sex as one of their household chores like fetching water, cooking and serving food. They experienced fertility as a health hazard resulting from this particular household chore. On the other hand, men were looked at as primarily sexual beings who had a virtually unquestionable right over a women's body "because they had tied the "Tali". Their right to "full satisfaction" and to maintenance of their "virility" was looked at as a social - given, if not as a biological condition. It was only in the course of discussing the enlarged poster exhibition that it was pointed out that the health hazard for women consisted in the fact that male sexuality is much more closely linked up with fertility than female sexuality, male organ invariably expels the seed which makes women pregnant unless the man had undergone operation. This led to a lot of questioning of men's rights over women's bodies and men's responsibility to control fertility.

Most of the above-mentioned discussion took place among women only. However, since SRED consists of a mixed team and since the women's movements operates in villages where agricultural laborers "Sangam" also at work, a certain interaction with men was absolutely essential. While the general health exhibitions had been visited by all and sundry, the others were held in remote places where it was possible to screen the public which entered. Only a few men were admitted on the ground that they were animators or activists in the agricultural coolies sangam. While these men were in principle supportive of the women's movement, they faced their own cultural difficulties when women started to speak out about the relationship between sexuality and fertility and to pinpoint male sexual control over women as a major health hazard. Some of the difficulties were rooted in the fact that these male animators were facing a different type of women, in the women's movement, than what they were used to at home.

These men played an important role as mediators between ordinary village men, many of whom were members of the agricultural laborers "sangam", and the women who in the women's "sangam" had undergone a very far reaching process of conscientisation. There were many related issues which were raised in

the processor discussions - for example, the right of the husband to beat his wife and the distribution of goods within the family. Taking into consideration that malnutrition, frequent pregnancies and abortion are major causes of rampant anaemia and that anaemia lowers the level of resistance to infection, it is obvious that social constraints and controls are major health factors which have to be tackled simultaneously with technical information on nutrition, hygiene and birth control.

Acknowledging a Dilemma

While the process of participatory research in which the health work of SRED was reviewed, opened up many new perspectives, it produced more questions than it could answer. In fact the process of reflection led from readymade answers (about hygiene, family planning) to many open questions. Some of the questions which could not be fully answered and which obviously need more practical experimentation are the following:

(1) If the objective of a medical program is self-management, self-reliance and demystification of medicine, how does one combine indigenous herbal medicine "(nattu vaithyam)" with expert controlled systems like ayurveda, siddha, unani, homoeopathy or with allopathy?

(2) What would a feminist perspective on birth control imply, short of radically new methods which are, as yet, not in sight?

[a] Should more emphasis be put on male contraception (use of condoms or vasectomy,)?

[b] Is it responsible to try to convince women to use methods in spite of the side-effects to which they have objections, in order to prevent abortions which may be more injurious to health?

[c] It is possible to work on sexual practices which help to control fertility, for example: natural family planning methods and intercourse not focussed on penetration?

(3) What are the best methods to weaken male control over a woman's sexuality and fertility? Does fertility control reinforce male sexual control? If a woman's

organization discovers that special controls prevent women from taking charge of their own sexuality an can this problem be tacked by a woman's organization alone or does it need mixed organization to make an impact on the men?

References

1. Alice Clark: 'Limitations on Female Life chances in Rural Central Gujarat'. The Indian Economic and Social History Review, Delhi, Vol. 20, No. 1.

2. Ammu Abraham and Sonal 1983: "Sex Determination Tests". Women's Center.

3. Ammu Abraham, 1984: "Larsen and Toubro Seminar on Amniocentesis", Women's Center Newsletter, Bombay Vol. 1, No.4, October.

4. Amrita Chhanhhi, & C. Sathyamaia 1983: "Sex Determination Tests: A technology which will Eliminate Women', Medico Friend Circle Bulletin, India No. 95, November.

5. Dharma Kumar, 1983: Male Utopia or Nightmares? Economic and Political Weekly, June 11.

6. EPW, 1986: Editorial Economic and Political Weekly, October 25. Financial Express, 1984: 'Drug Issues, November 28.

7. Gayatri Singh: "Amniocentesis and Legal Provisions Pertaining to it". A paper presented at the workshop organized by Forum Against Sex-determination and Sex-Pre-selection Techniques, Bombay, March, 1986.

8. Gina Kolata 1983: "Beyond Amniocentesis - New Techniques in Fetal Testing". New York. Ms. Magazine, December.

9. Helen Bequart Holmes and Betty B. Hoskins 1984 - "Prenatal and. Preconception sex choice Technologies - A Path to Femicide?" Paper presented at International Interdisciplinary Congress Women's World, Gromingen, The Netherlands, April 1984.

10. IHT, 1983: 'India says it plans to develop injectable contraceptives, West Germany Restricts use' International Herald Tribune, July 6.

11. Jovelyn Kynch, and Amartya Sen 1985: "Indian Women: Wellbeing and Survival," Cambridge Journal of Economics, 7, 363-380.

12. Lata and Harpal: Campaign against sex determination and pre-selection techniques, A paper presented at the workshop organized by Forum Against Sex-determination and Sex Preselection Techniques, Bombay, March 1986.

13. Leeta Dube 1983: 'Misadventures in Amniocentesis', Economic and Political Weekly, February 19.

14. Leeta Dube September 1983 'Amniocentesis: The Debate continue, 'Economic and Political Weekly, September 17.

15. M.H.Oanthaki, D.D. Banker, K.V. Kulkarni and K.P. Pati 1979: 'Prental Sex Prediction by Amniocentesis - Our Experience of 600 cases', Paper presented at the First Asian Congress of Induced Abortion and Voluntary Sterilization, Bombay March, 4.

16. Pranab Bardhan, 1982: 'Little Girls and Death in India, Economic and Political Weekly, Bombay, September 5.

17. Ramala Buramusa, 1984: The price of assistance - Family Planning in India and Impact of Foreign Aid and Loans' Socialist Health Review, Vol. 14, March.

18. Rayna Rapp: 1984 'The Ethics of Choice', New York: Ms. Magazine, April.

19. Ravindra R.P. 1986: 'The Searcer Half - A report on Amniocentesis and other sex - determination Techniques, Sex Pre-selection and new Reproductive Technologies', A Center for Education and Documentation Health Feature, January, Counterfact No. 9, Bombay.

20. Ravindran R.P. 1986: 'Refined Techniques of Femicide', Paper resented at the workshop organized by Forum Against Sex-determination and Sex-Pre-selection Techniques, March.

21. Roger Jeffery, and Patricia Jeffery 1983: Female Infanticide and Amniocentesis', Economic and Political Weekly, April 16-23.

22. Roger, Jeffery, and Andhew Lyon 1984: 'Female Infanticide and Amniocentesis,' Social Science Medicine, Vol. 19, No. II.

23. Sanjeev Kulkarni: 'Prenatal sex Determination tests and female Foeticide in Bombay City', Foundation for Research in Community Health, Bombay.

24. Shirish Sheth, 1984: 'Place of Prenatal Sex Determination', Larsen and Toubro Seminar, August 30, in Bombay.

25. Sonal Shukla, and Sanjeev Kulkarni 1986: 'Social Implications of Sex-determination Tests', a Paper presented at the workshop organized by Forum Against Sex-determination and Sex-Pre-selection Techniques; Bombay, March.

26. Vimal Balasubramanyam 1982: 'Medicine and the Male Utopia', Economic and Political Weekly, Oct 23.

27. Vibhuti Patel: 'Amniocentesis - Misuse of Modem Technology', Social Health Review, Vol. 1, No. 2, Sept., 1984.

28. WHO, 1983: 'Multinational Comparative Clinical Trial of Long-Acting Injectable Contraceptives. NET-EN Given in 2 Dosage Requirements and DMPA. Final Report". Contraception, Vol. 28, No. 1, pp. 1-20. July.

29. WHO, 1984 Special Program of Research Development and Research Training in Human Reproduction, 12th Annual Report, Geneva.