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Chapter 14 - The Neglected of the Earth

Subhadra is not one to sit around and twiddle her thumbs. So while I was recuperating from my illness in Machla and writing reports she had begun to work on a voluntary basis from the summer of 1995 with the Kasturba Gandhi National Memorial Trust in its field area in the Barwah tehsil of Khargone district and Bagli tehsil of Dewas district about fifty kilometers from Indore. The Trust used to run a mobile health clinic in the area at that time. The clinic with a qualified doctor and a rudimentary dispensary used to pay a visit to the villages in the area three days a week. In addition it had provided training from time to time to thirteen dais, traditional birth attendants, of the area in better delivery practices and basic medicine and used to give them a monthly stipend of a hundred rupees. Subhadra began to work with the two female supervisors who were based in one of the villages there. Thus she was already familiar with the area and the people when we decided to start our own mass organisational work with women there in the autumn of 1996. But before we started our fieldwork we decided to get our theory right.

The failure of the Sangharsh Yatra and the subsequent repression let loose by the government which had reversed the rising tide of environmental mass movements in Madhya Pradesh had troubled me for quite some time in Alirajpur. I used the free time I got in Machla to undertake a serious review of the modus operandi that we had adopted thus far. We activists of the environmental movements fighting against the destruction of the environment and the consequent dispossession of the rural poor by the modern Indian state's thrust towards industrial development were mixing both the understanding of the deep ecologists that the preservation of nature could only be possible by abandoning modern industrial development and the concerns of the affected people about the serious threat to their livelihoods that this development posed. Thus the environmental mass movements we were taking part in constituted an "environmentalism of the poor" as distinct from that of the rich in India and in the West which were concerned with only sequestering environmental niches like National Parks and wildlife sanctuaries and not genuinely bothered with the people who live in proximity to them (Gadgil & Guha, 1995).

We were making demands for fundamental and radical changes in the nature of the state, the forms of governance and the mode of development. We were in fact one jump ahead of the Marxists who acknowledged the need for a centralised state in the transition period after the revolution that would wither away later only as productive forces grew enough to make a communist stateless society possible. Whereas we were rooting gung ho for hamara gaon mein hamara raj or village self rule right from day one and calling for a roll back of centralised modern development. Unlike the Marxists who have a practical understanding of the violent and arbitrary power of the state apparatus, we were labouring under the delusion that the centralised Indian state or the global development institutions that were propping it up were going to bring about their own demise voluntarily by acceding to our demands as a consequence of a change of heart brought about by the moral pressure we were creating through sit-ins and hunger strikes! This could only have happened through a vastly larger, many times more militant and far more resilient mass mobilisation than what we had been able to achieve up to then. It called for a far greater leadership role for the grassroots people who actually are fighting for their rights with activists like ourselves playing only a supportive and educative role instead of the vanguard one that we had played so far. It would also require the building up of a strong alternative cultural movement that could counter the cultural onslaught of western consumerist propaganda and its hegemony

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over the minds of the people. Consequently nothing short of a complete overhaul of the mobilising strategy adopted so far was essential.

There was also the question of addressing the needs of women on a priority basis. We had never worked specifically with women before and so for this too we had to clean out the cobwebs and light up the dark spaces in our mental cupboards. Fortunately there is a rich theoretical and empirical tradition of feminism and we drew considerable inspiration and guidance from it. Modern feminism can be said to have started with the publication of Mary Wollstonecraft's classic "Vindication of the Rights of Women" in 1792 (Wollstonecraft, 1982). The effects of the European Enlightenment were no where more pronounced than in the emancipation of women from centuries of bondage decreed by religious obscurantism. Wollstonecraft was a strong advocate of women controlling their own bodies and taking on manly characteristics. Since then through a tortuous process women in the West have gained many rights both economic and political as a result of struggle. A new wave of feminism started in the post World War II era in the nineteen sixties, which spoke of a global sisterhood that could challenge patriarchal power and dominance. Soon, however, there were differences regarding the causes of women's subordination and hence the proposed strategies for change. The different streams resulting from this split were - liberal, Marxist, Socialist and radical feminism (Ollenburger & Moore, 1992). The last school has made the significant contribution of the concept of patriarchy or the deep-rooted structural oppression of women by men, which has now become universally accepted.

Black and coloured women hailing from poorer backgrounds later provided a new dimension complementing and also opposing this Euro-American feminism. Simultaneously third world women considerably widened the scope of feminism by analysing their experiences in the historical context of colonial and neo-colonial exploitation (Mohanty et al, 1991). Earlier the mid nineteen seventies had seen the emergence of eco-feminism with the publication of Rosemary Ruether's seminal work "New Woman, New Earth" (Reuther, 1975). This last challenges the male domination of nature and women and their picturisation by men as passive objects submitting meekly to reason and force. They argue that the tendency to control others and the aggression arising from this are patriarchal attitudes that enslave both men and women. This school has emerged from the ecology and peace movements that are under way round the world and is currently the only feminist one that rejects the dominant mode of development and governance along with the deep ecologists (Plumwood, 1992).

This theoretical and empirical work done to establish the identity of women over the years bore fruit in the form of universal recognition of the rights of women as embodied in the United Nations Convention on Elimination of Discrimination Against Women (Boland et al, 1994). A watershed was reached with the International Conference on Population and Development held in Cairo in 1994. There for the first time the reproductive rights of women were recognised. Thence forward population control policies, which targeted women as objects without any decision-making powers of their own were rejected. This process was further reinforced at the International Women's Conference held at Beijing in 1995. There the importance of women enjoying their sexuality for the achievement of complete reproductive and sexual health too got recognition for the first time in an international forum despite some stiff opposition from religious fundamentalists. The far reaching liberating scope of this conference can be gauged from the fact that the male dominated ruling establishments of the various countries have stymied the holding of the

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next decadal UN Women's Conference which is overdue. Women's empowerment and the establishment of reproductive and sexual rights have become the key issues in the feminist movement ever since. So much so that the Indian Government too jettisoned its earlier sterilisation target based population control programme in favour of a reproductive health and rights approach.

Indian women too have come a long way from the early beginnings in the anti-colonial and anti-feudal struggles. The women's movement in independent India started in a conscious manner in the mid-nineteen seventies with mobilisations against male violence, both physical and sexual, and later extended to the violence of the government's policies. Later the economic marginalisation of women became a focal point. Thus attention was directed at the development policies that put women in severe stress. The women's movement has succeeded in getting the government to take note of the pitiable condition in which most Indian women live, enact protective laws and frame favourable policies. Like in the West here too there are a lot of differences within the movement but these tend to get blurred when strategic choices have to be made (Agnihotri & Mazumdar, 1995). There have been struggles against the government's population policies and especially against the introduction of harmful contraceptives like depo provera and norplant and the testing of anti-fertility vaccines (FWH, 1995). Issues such as the sati, the burning of a widow on her husband's pyre, in Deorala in the state of Rajasthan, the rape of the women's development programme worker Bhanvri Devi also in Rajasthan and reservation of seats for women in the parliament and legislatures too have been important rallying points. In recent times there has been a lot of activity around the implementation of the new target free approach to population control based on the paradigm shift in the thinking on women's health following the population conference at Cairo. A particularly vexing problem of serious proportions that has exercised feminists of late is that of "the missing Indian females", the declining sex ratio which has gone down to as low as 861 females to a 1000 males in the state of Haryana and 933 for the whole of the country according to the 2001 census (Mari Bhat, 2002).

The problem with organising women is that the deep-rooted patriarchy in rural societies prevents women from coming out of their homes. In most cases patriarchy has been internalised by the women themselves thus making it difficult to make a beginning in organising them by focussing on patriarchal oppression alone. As is well known a combination of patriarchal oppression and destructive development policies has resulted in alarming health problems for poor women. In the case of rural women this is compounded by inadequate medical facilities and illiteracy. The most worrisome problem for women relates to their reproductive health. Thus for poor rural women improving their health is most often an urgent need that they have perforce to neglect (Jeejeebhoy, 1991). Health being an issue that affects everyone it is relatively easy to get the acquiescence of the men to let their women do something about improving it. Thus both felt-need wise and strategically health provides an ideal entry point for organising poor adivasi women and helping them to create a space of their own in society.

Women's health, however, is a much more complex issue than just the provision of adequate healthcare services. It has come to be recognised that women's health, safe motherhood, population control, and poverty alleviation are all dependent on women having reproductive health rights apart from economic and political rights at par with men in a society that is egalitarian in all respects (Correa & Pechinsky, 1994). Thus the basic requirements for improving the health status of women are a direct multi-pronged attack on poverty through the creation of labour intensive work opportunities, removal of social

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inequalities of all kinds, a campaign against traditional and modern myths and a comprehensive community health care system with primary and referral services (Quadeer, 1995). So any programme aimed at improving the health status of poor adivasi women has to necessarily incorporate both the service delivery and the mass organisational approaches to community work if it has to be successful. This was amply borne out by the experience of the Kasturba Trust, which had been providing exemplary health and education services for rural women in the Malwa and Nimar regions of Western Madhya Pradesh for more than fifty years without having made any substantial dent in the patriarchal structures, which stifle the lives of the rural women of the area. Even before we could start our work a heartrending incident gave notice to us of the abominable health condition of the adivasi women and their helplessness due to poverty.

On a biting cold morning in the winter of 1996 a Bhil woman lay naked shivering on the earth floor of her ramshackle hut in village Rajna. Beside her also shivering, lay a shriveled new born baby. The woman had so lain for the whole night and her ordeal hadn't ended. There was a twin yet to be born but for the last three hours there had been no movement from within and so the baby was stuck inside the womb. The earth beneath the woman was wet with blood and placental fluid but neither she nor the dai seemed to be least bothered. Just then the mobile dispensary of the Kasturba Trust happened to pass by and was stopped by the people in the village. There were five nurses but they expressed their inability to help as they did not have any instruments. When the villagers beseeched them to take the woman and the baby to the Primary Health Centre at Barwah they pleaded their inability saying they were on their way to different villages to administer vaccines under the Pulse Polio immunisation programme.

Sometime later a jeep came along with a doctor from the PHC at Barwah. The villagers stopped this jeep too. The doctor also after seeing the woman said that he was helpless as he did not have any instruments with him. He too advanced the responsibilities of supervision of the Pulse Polio programme as an excuse for not taking the woman to Barwah. He even went to the extent of saying that the lives of thousands of children were at stake and he could not put them at risk for the sake of one woman and child. Eventually the husband of the woman had to borrow money from a moneylender at an exorbitant interest rate and hire a jeep to take her to Barwah. The woman just about survived but her twin babies died. Later tests revealed that the woman had a haemoglobin count of just 4 grams per decilitre dangerously below the ideal level of 12 or above. Clearly the achievement of health, which according to the World Health Organisation means a state of complete mental, physical and social well being and especially reproductive health for poor adivasi women was going to prove to be a daunting task. There are various socio-economic and political factors that pose a near insurmountable barrier to the achievement of health for poor rural women.

The primary cause of ill health in women is their low status in society. Relegated to a position of subordination from the moment of birth, girls eat last and least, are over-worked and under-educated and have to bear children from an early age. They receive inadequate medical treatment when ill and are often passed over for immunisation. Despite the biologically proven fact that women have a longer lifespan than men, in reality, in India the reverse is true in rural areas where more girls are likely to die than boys leading to a sex ratio skewed against women in the population as mentioned earlier. Adult women lack property rights and control over economic resources, which contributes to the general preference for a male offspring as an insurance against old age incapability. This in turn

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results in women having to go through the rigours of repeated pregnancies and childbirths to produce sufficient male children that can survive through to adulthood overcoming the uncertainties of an insecure childhood. Malnutrition, lack of sexual hygiene, repeated pregnancies and overwork lead to most rural women being anaemic and so prone to other diseases in general (Mehta & Abouzahr, 1993)

The prevailing pattern of development has been particularly harsh on women. Destruction of resource bases has led to the workload increasing with a corresponding decrease in nutritional levels of the food intake. The introduction of artificial input mechanised agriculture has deprived women of the little control that they had over production processes in traditional agriculture and further reinforced patriarchal power relations. Forced migration either temporary or permanent has exposed women to sexual violence in unfamiliar surroundings. The loss of traditional livelihoods has been accompanied by the induction of women into low-paid jobs in the informal sector where the work environment is unhealthy and the workload high. The general level of violence in society has gone up, to further sequester women in their homes thus reducing employment opportunities. All this has had a negative impact on the health of these women (Duvvury, 1994).

Last but in no way the least harmful have been the government's health and population control policies. Primary health care has received short shrift both in terms of financial outlays and in terms of the introduction of participative health care systems. Thus apart from the foreign funded immunisation campaigns like the Pulse Polio programme mentioned above, rural populations rarely ever receive any effective healthcare from government health services (Bose & Desai, 1983). Consequently for the poor infant mortality levels are still dangerously high as are maternal mortality and morbidity levels (IIPS, 2003). Again spurred on by the neo-Malthusian myth that population growth is responsible for poverty the government had launched an aggressive population control programme in the 1970s, which targeted women for sterilisations and the use of various unsafe and unhealthy contraception measures (Mamdani, 1973). Even though with the introduction of the sterilisation target free reproductive health approach from 1996 onwards there had ostensibly been a so called paradigm shift at the policy level in population control and maternal and child health care, the ground reality in rural areas had remained much the same as before (Rahul, 1997c). Thus health, we realised, like any other social attribute, was primarily dependent on the urgency with which people sought it. The adivasi women with whom we were going to work were too burdened by the multiple oppressions enumerated above to be able to seek anything at all let alone health. Specifically in the sphere of reproductive health, moreover, there existed an intimidating culture of silence (Dixon-Mueller & Wasserheit, 1991). So we decided to start the organisation process in Barwah tehsil with an attempt at opening up this dark and forbidden area. Weeks were spent in visiting the villages and going from house to house to talk to the women.

We spent a whole day in Chainpura village going to the houses and the fields where they were working to talk to the women and call them to the meeting to be held in the evening. Only five women came to attend. The women listened silently as the conversation was directed gradually towards reproductive health. Initially this did not draw much of a response. Then when specific problems like white discharge from the vagina, leucorrhea, were mentioned, one woman said that she was suffering from it as well as back pain. Another revealed that she had a slight prolapse of the uterus at times when she did hard work. It was decided to hold a bigger meeting on a later occasion.

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The village Golanpati, which is about six kilometres away, is picturesquesly set on the banks of the Kanar river in a depression surrounded by hills at the foot of the escarpment of the Vindhya hills descending from the Malwa Plateau. It is unfortunately without any electricity. Consequently most of the men and the young unmarried women were away labouring on the fields of rich farmers atop the Malwa plateau to earn the money needed to buy diesel for running their engine driven pumps with which to irrigate their winter crops. A death of a close relative had taken place in a village some distance away from where most of the young wives of Golanpati hailed and so they too were absent. So we spent our time in desultory conversation about various things and after some time some of the women decided to go fishing in the Kanar river with small nets called "dahwalia". The people of the area are able to supplement their normal simple diet with such occasional infusions of rich fish protein.

The village Akya too was without electricity at that time though later efforts have brought it onto the electrification map. It is situated on the banks of the Sukhri stream. Here the people had already arranged for the diesel and were busy in the fields irrigating the standing crop of wheat and gram. Once again we spent the day visiting the women in their houses and fields. The houses here are all on the farms of the respective people and so scattered over a distance of some three kilometres. In the evening upwards of thirty women attended the meeting. The meeting went off well. As many as twenty-three women reported various kinds of reproductive health problems and demanded that something be done to relieve their sufferings. The women complained that local quacks only gave them injections, which did not relieve their pains or suggested that they get their uteruses removed. The government health worker rarely visited the village.

The villages Okhla and Chandupura are adjacent and for all practical purposes are like two hamlets of the same village. The district administration, however, displaying typical bureaucratic perversity has put the two villages in two separate panchayat clusters. These villages are lucky to have electricity because there is a Hanuman temple in Okhla where the epic Ramayan has been recited day and night continuously for the past twenty-five years. Even though the adivasis and their Gods hold no value for the government the same is obviously not true when it comes to Hindu Gods and their devotees. The people here too were busy with their agricultural operations. The people here have been enterprising enough to draw water over great lengths from the river Kanad using electric pumps and PVC pipes. Here during the initial house visits one woman in Chandupura said she could get all the women together in a jiffy if she was given a share of the pickings from the project being planned for them! Here for the first time women brought up the behaviour and attitudes of their men for discussion. The lust and violence of their men fuelled by alcoholism they felt was the main deterrent to achieving a healthy status. A health clinic in which specialist doctors could diagnose their problems would be immensely beneficial they felt. There are in these two villages, in addition to adivasis, dalits also.

The next set of villages has mixed populations and is dominated by upper caste people. Limbi is a village of Jats. These are a farmer caste, which had come here originally from the state of Rajasthan. They owned most of the land in the village on which the dalit and adivasi people worked as labourers. Here there was a pretty good meeting among the poorer people where most of the problems identified in the earlier villages came to the fore once again. The Jat women were prepared to talk individually but none of them came to a meeting, which was organised separately for them. There was one Jat woman who had lost her mental balance because she could not bear the mounting pressure on her to produce a

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male child after repeated births of girls. There is another woman who was tricked into marrying a doddering old Jat in his seventies. The old man had died later and she had been left to make a living on her own with a small girl of five and some land.

Mundla is another village dominated this time by a different farmer caste, the Dangis. These people too own most of the land in the village and make the adivasis and dalit people work for paltry wages as low as Rupees twenty a day which is less than half the statutory minimum wage. Here the men instead of the women attended the evening meeting. The men listened and went on saying "Ha bahenji, Sach Bahenji" - yes sister, true sister, but did not make any comments of their own when they were told that they should be more considerate of the health of their women. Even though they promised to send their women to the repeat meeting to be held in the morning no one came then either.

The village of Palsud is situated between these two villages and the villagers there, some dalits and some adivasis, are continually troubled by the Jats and the Dangis. There have been murderous fights and two dalits from Palsud are serving a life sentence in Indore jail for having murdered a Jat from Limbi. The women in this village enthusiastically took part in the meeting and talked about their reproductive health problems quite freely. There are two other villages Bargana and Barkhera nearby but in both of these the meetings drew only four or five women each. One of these women a Jat went around wearing a cloth belt around her loins to prevent her uterus from coming out. She would have liked to have a hysterectomy but did not trust the private doctors in Sanawad where most of the other women had got themselves operated. In the local dialect this is referred to as the "burra operation" to distinguish it from the sterilisation operation which is called just "operation" and is done free by the government doctors as part of the family planning programme.

The last set of villages is in a cluster on the banks of the Choral river. The villages of Aronda and Kundia lie to the west of the river while the villages of Sendhwa and Karondia lie to the east. In Sendhwa village the Brahmins and Patidars who are higher up in the caste order do not let the dalits draw water from the public hand pump and the latter have to drink water from the Choral River. Consequently during the monsoons there is an annual epidemic of waterborne diseases among these people and in 1995 there were three deaths due to gastro-enteritis. Here too the meetings were sparsely attended but the women who did come all complained of reproductive health problems and of the the insensitivity of their men. The upsarpanch was a Muslim who as a community are notorious for their anti-women attitudes. The upsarpanch's wife herself suffered from anaemia with a haemoglobin count as low as 6 grams per decilitre despite their being quite well off economically. She spoke about her problems individually but did not come to the meeting.

Katkut village is located roughly at the geographical centre of this area and by virtue of being the weekly marketplace and also having a civil dispensary, banks, the forest range office and a police outpost it is also the commercial and administrative centre. It is a peculiar village. It is dominated by the Jats and the sarpanch at that time in 1996 was a Jat woman. The husband of the woman operated in her name. The Jats of Katkut are held in low esteem by their caste men from other villages because of their arrogant and boorish behaviour and the men find it difficult to get brides. One young Jat woman complained that she repeatedly aborted and would like to know whether there was any solution. She was the only daughter-in-law in a house of four sons. There was no father-in-law who had died very early. The mother-in-law Karmabai fought a long legal battle with her brothers and gained possession of her share of her father's land. She was a panch in the panchayat. She said that the Jat women were extremely oppressed and it was not possible to get anything done in

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their interest given the attitude of the men. This area is just fifty kilometers away from the city of Indore. Yet the women here regardless of whether they are from relatively well off households or from the extremely poor adivasi and dalit ones, are uniformly oppressed by various forms of patriarchal oppression. Despite all the rhetoric and policies of women's empowerment, there is a laudable women's policy document of the government of Madhya Pradesh, the stark reality that came through from our initial forays was that the women of this area suffered from severe neglect both from their families and from the society and government. Truly these women are the neglected of the earth.

Katkut being the local market village has a lot of traders and moneylenders and also five quacks. There is an ayurvedic dispensary of the government with a doctor and a compounder. There are little or no medicines available in this dispensary and mostly the doctor spends his time reading a newspaper or treating patients with allopathic medicines for a fee. The other government health functionaries, who are para medics, too are engaged in the same clandestine allopathic practice. All the local government servants working in various departments stay in rented apartments here. These people along with satellite television, a licensed and many unlicensed liquor shops make the ambience of the village more akin to an urban one than rural. The hybrid half Western, half Indian pop culture being spread through television soap operas and their sponsoring advertisements has spread among the youth whose aspirations have become urban. Despite this the people still retained their traditional abhorrence for constructing latrines in their houses and preferred to defecate on the sides of the roads and fields. Thus the approach roads to Katkut would all stink in the morning with the stench of stools and urine until the pigs polished them off. The Kasturba Trust in true Gandhian fashion offered to supply the material for the construction of latrines and soak pits for the people if they would only contribute their labour. The people treated this as some kind of a ruse that had some catch in it that would trap them sooner or later and turned their noses up and went on defecating on the sides of the roads forcing visitors to turn their noses away. We took up residence in this village in a rented accommodation at the beginning of our work, as we still had to make friends with the people and earn their confidence before settling into one of their villages. Needless to say we too had to get up early while it was still dark to defecate on the roadside!

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