Rahul Banerjee, 74 Krishnodayanagar, Indore, India - 452001, cell no: +919425943023
email: rahul.indauri@gmail.com homepage: www.rahulbanerjee.notlong.com

Chapter 15 - Gynaecology in the Wilderness

Following on their policy of opening up the forested areas of Nimar and Malwa to agriculture and trade the British had brought a whole village consisting of jat farmers, traders and lower caste menials from Rajasthan and settled them down in Katkut just after the revolt of 1857. The stone for the ballast for the railway line from Indore to Khandwa and the wood for the sleepers too were sourced from this area. For this the British brought in adivasi labourers and settled them in forest villages. So right from the start the British had created a hierarchy here with the Jats on top and the adivasis and dalits at the bottom. Thus this area was different from the areas in Jhabua and Dhar where we had worked before in that there was a powerful exploitative non-adivasi presence in the villages apart from the traders and the government servants whom we had to tackle earlier. We had initially introduced ourselves to the people as workers of the Kasturba Trust. In this way we could allay the suspicions of the non-adivasis and the government staff who had all become very edgy over the adivasi mass mobilisation, which was going on in other parts of Western Madhya Pradesh. Under the circumstances we would not have been allowed to begin our work if it had been made known that we were activists of these adivasi movements. The arrangement with the Kasturba Trust had been that we would do the organisation work among the women and so boost up the demand for the clinical services being provided by the former's mobile clinic cum dispensary and dais.

We had surmised beforehand that we would find women suffering from serious reproductive health problems and so we had planned reproductive health workshops to follow up our preliminary meetings in the villages. We had intended to use these workshops to familiarise the women with the workings of their bodies and the causes of their health problems. This we had thought would be a good preparatory step towards pepping up the women to act in a concerted manner both within the home and the village and also outside to improve their health. All these plans were dashed by the response of the women in the preliminary meetings. The general reluctance of women to talk about their reproductive health problems in a women's group puzzled us initially. Finally Ramanbai of Chandupura provided the answer. She said that in her village there was tremendous infighting among the different families over various issues. There was a lot of backbiting. So women did not want to reveal their illnesses, the public knowledge of which could be used against them. Consequently, even if individually they would talk freely about their problems, often women refused to come to the meetings. Later inquiries in other villages confirmed this to be true. This was an absolutely new problem that we had never encountered before because we had never ventured into the personal sphere of village women. So getting women to come together to discuss health problems turned out to be a tough nut to crack.

One woman from Okhla had recently had a baby at the Primary Health Centre (PHC) at Barwah. During the delivery the vaginal opening had been ruptured and had had to be stitched. She was told that she could later get the stitch removed by the auxiliary nurse-medic (ANM) of the government in Katkut. This ANM, however, said she was not competent enough and that the woman would have to go to Barwah again. This woman mistook Subhadra for another ANM when she went to talk to her and gave her a tongue lashing for not providing her with proper care for which she was being paid by the government. Similarly Bansi of Akya village asked "How will it help if I understand my problem if I do not have the technical expertise to solve it?" She had been ill ever since she had given birth to her fourth child under complicated conditions some three years ago. The women everywhere insistently demanded that arrangements should be made for proper

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medical attention instead of holding reproductive health workshops. The demand of the women was for checkups by women gynaecologists from Indore. The gynaecologist in the PHC in Barwah had never set foot in these remote adivasi areas.

The governmental health services were in a sorry state. Not only was there inadequate staff but there was also a shortage of medicines. There was no supply of iron and folic acid tablets with the PHC in Barwah for some six months in 1996. In Bagli Tehsil these were available but there was a severe lack of staff to distribute these and the medical officer there gave us the responsibility of distributing some of his stock. Obviously there was no ante-natal care. When the health records of the PHC in Barwah were studied we found to our surprise that all the reproductive health services, especially ante-natal care, were being provided to the full. Investigations revealed that the government village level health workers were submitting false reports of the services they had in fact not provided. The falseness even extended to the reports of births, infant deaths and maternal deaths. The village level workers brazenly admitted that they could not possibly travel on foot through remote areas attending to the needs of women and so the only option was to submit false reports in the monthly meetings. The provision of reproductive health services is difficult to monitor as compared to the completion of sterilisation targets and so for years together the health records of the Barwah PHC and possibly most other rural PHCs in Madhya Pradesh have had no relation to the reality actually prevailing on the ground. This then was the state of the much vaunted target free approach to reproductive health care for women in the area. Yet when it comes to one-shot affairs like the polio eradication or sterilisation campaigns, there is no dearth of enthusiasm or resources. This was the dismal scenario in which we had begun our intervention to try and improve matters.

As mentioned earlier the Kasturba Trust had been running a minimal community health programme under which the community organisers along with the dais motivated the people of the village to improve their health awareness. They were also supposed to keep track of the diseases in the villages and bring the ill to the mobile clinic when it visited these villages. This ideal plan had not worked partly because of the formidable social obstacles in its path and partly because of a lack of motivation among the workers. Moreover, since this was a funded project there were heavy reporting responsibilities that kept the workers involved in paper work. What can be more indicative of the lack of effectiveness of the programme than the fact that even after two years the Trust workers had no inkling of the severe reproductive health problems being faced by the women of the area. The supervisors had not even heard of the target free approach and the paradigm shift in maternal and child health care. They expressed surprise that the government had taken what they deemed to be a very rash step of freeing the population control programme from sterilisation targets!

Service delivery work like arranging health camps required an infrastructure, which we neither possessed nor had the intention of setting up. So we had no alternative but to fall back on the Kasturba Trust and the government health department and try and galvanise their functioning. Private gynaecologists in Indore had to be contacted and convinced to give their services free of charge. There are a lot of institutional and specialised human resources in the city of Indore, which were not being properly mobilised by the Trust. Thus just by mobilising this existing infrastructure more efficiently it became possible for us to arrange the health clinics. Despite having spent more than a decade organising adivasis we had never paid much attention to health apart from doing crisis management when epidemics of cholera, gastro-enteritis or scabies spread. The actual rural health scenario and especially the sphere of women's health turned out to be much more complex than we had

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imagined. Our cut and dried prescriptions, which we had thought out beforehand had to be trashed. The inertia against change becomes more evident when deeply ingrained attitudes and habits have to be changed. Mobilising people and especially women on a secondary issue like health as opposed to more pressing livelihood problems we found was a difficult task.

Three reproductive health clinics were held one each month in the winter of 1996-97. Organising the first one at Palsud village required a lot of preparatory work. Inspection tables had to be constructed. The mobile clinic of the Kasturba Trust did not have any obstetric instruments so these and gloves had to be acquired. The gynaecologists from Indore had to be contacted. The PHC in Barwah had to be informed to requisition the services of a pathologist. The school building in Palsud had to be cleaned and temporary inspection rooms with sufficient lighting had to be prepared. Everything turned out very well in the end. Three gynaecologists, one physician and one paediatrician attended to upwards of eighty patients. Thereafter the other two camps at Okhla and Kundia did not pose many problems as we had got the hang of the process. The camp at Okhla was immensely successful with over a hundred patients. The camp at Kundia had only about forty patients because some of the influential but dubious non-adivasis in the nearby villages objected to our not involving them.

The doctors found that most of the women were anaemic but exact estimations were not possible because the pathologist from the PHC at Barwah did not come with the reagents required for haemoglobin testing. He said that there was only a limited supply at the PHC. The doctors found it difficult to communicate properly. This difficulty arose not just because of the language difference but also because of the tendency not to reveal too much to the patient. Thus Subhadra had to both elicit more information from the doctors and also convey it to the women in their own language. There were some medicines that were free having been provided by the doctors from their stocks of physicians' samples but others had to be bought. Consequently there was some confusion among the patients who began demanding free medicine as in other camps of this type. We of course had made it quite clear in our meetings that medicines would have to be bought. Many women who had registered their names for checkups in the preparatory meetings later refused to get them selves physically examined. Some even ran away to their farms rather than be dragged to the examination table!

The real problems arose during the follow up to these camps, which proved to be extremely educative for us. A major revelation was that many women do not take the medicines prescribed to them. Some women had orally taken the vaginal tablets for curing leucorrhea given to them for insertion in their vagina. Another woman had kept the vaginal tablets safely wrapped up in cloth in her private box because the doctor had just told her to keep it 'inside' without mentioning the Hindi word for vagina. So the woman had assumed that the tablets were some kind of totem and kept them in her box instead of inserting them into her vagina. Inquiries revealed that this carelessness or reluctance in taking medicines regularly was quite common. Many of the women had come with the expectation that the big doctors from Indore would give them injections of special miraculous medicines which would immediately cure them of their problems. One woman in Okhla, Suraj, even went to the extent of saying that she did not trust our medicines and us. She had gone for the check-up to see what kind of treatment was being given. She was extremely upset when we repeatedly went to her house every week to see whether she was taking the medicines.

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"Mujhe aise lafde nahin chahiye, mere naam tumhari chopdi se kat do"(I do not want to get into such trouble so please remove my name from your register) she told us irascibly.

The quacks were playing an extremely dangerous role as far as the reproductive health of women was concerned. Initially they gave antibiotic injections and pain-killers to the women who went to them for treatment. When naturally this did not succeed they advised the women to undertake hysterectomies. These quacks acted as touts for gynaecologists in Sanawad and Indore who have private clinics. Kusma of Akya related how on one occasion she was taken along with five other women who were complaining of various kinds of pains to a gynaecologist in Sanawad by a quack in Katkut. All five of them were told to get hysterectomies done. Kusma was extremely relieved when the doctor at the Okhla clinic told her that she suffered from hyperacidity and high blood pressure and so there was no need for her to take the burra operation. These quacks also provided unsafe abortion services, which had led to the death of a woman from Katkut the year before.

Invariably the women continue to suffer from pains and leucorrhea even after undergoing this burra operation. Quite a few such women came to the clinics and some solution to their problems had to be found. While some of the women reported improvements from the insertion of vaginal tablets most did not. Leucorrhea too required more detailed analysis and treatment than that made available in the clinics. We tried homoeopathic and ayurvedic treatment as an alternative and there were better results from this. Another phenomenon was that of women's vaginal opening having become so extended and loose from repeated childbirths that when they get up from a squatting position air is sucked into the vagina which is then ejected with an embarrassingly loud sound when they sit down again. All in all it became clear that a much more comprehensive analysis and treatment programme would have to be undertaken for reproductive health problems. Many women had complained of pains in the stomach and of dizziness. Their problems were diagnosed as being acidity and hypertension. When despite appropriate medication some women reported that there was no improvement we decided to inquire about their food habits. We found that they took a diet, which was heavy in salt and hot chilly. They did not drink much water. Combined with low nutritional levels this was a sure fire recipe for hyperacidity and high blood pressure. When Subhadra suggested to one woman that she drink a litre of water first thing in the morning every day pat came the latter's reply, " Why should I drink so much water when I do not feel thirsty?" Why indeed.

One day while coming back from Katkut to Okhla we decided to veer off from the road to visit a group of dalit bamboo basket weavers just to see how they were doing. We found that one boy had been affected by scabies. We wrote them the name of the medicine, benzyl benzoate, on a piece of paper and told them to get it from Katkut and explained to them how to apply it and what precautions to take. We also told them that in the interim they could apply crushed leaves of the neem tree. When we went back five days later we found that the people had not bought the medicine as it was not available in Katkut and had relied only on the neem leaves which had not been effective and the boy was in a worse condition. The infection had also spread to a few more children. We got the medicine for them from Indore so as to ensure that the disease did not spread any further. Among adivasis scabies assumes epidemic proportions because they do not clean themselves properly and rarely apply the appropriate medicine.

There were some serious cases ranging from piles, stones in the bladder, suspected cervical cancer and the like which require detailed examination and treatment in Indore but the patients are too poor for this. The camps threw up three advanced cases of Tuberculosis.

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These people were getting themselves treated by private practitioners at great expense unaware that the government had a TB eradication programme, which provides free treatment. One of these patients was from Katkut and yet he did not get wind of a TB camp held by the PHC in Katkut in October 1996, which had drawn a blank. When finally he came to know from us he took the trouble of walking twelve kilometres to the Kundia camp for registration and treatment. Thus just medication alone is not a solution to the health problems that women face. The culture of instant treatment through injected medication and intravenous drips introduced by irrational allopathic practice over the years has totally destroyed the people's capacity to seek their own solutions. Consequently, as mentioned earlier, women want immediate medical solutions and are impatient about sitting and understanding the cause of their problems.

Our discussions with them had clearly revealed that the women felt the pressure of work and patriarchy after marriage. This invariably led to their general health deteriorating and most women coming for treatment were diagnosed as being anaemic from the whiteness of their eyes but due to some logistical problems measurement of haemoglobin levels had not been possible. So it was decided to undertake a detailed reproductive health survey. This it was hoped would give us a better idea of the extent of the problems and so help us in devising an appropriate solution. There are, however, some serious practical and ethical problems with conducting surveys that are normally glossed over by academic researchers and policy makers. The numerous surveys that had been conducted by the government and the Kasturba Trust have induced a survey fatigue in the people and they just do not like to respond, a phenomenon that has been noted by other researchers also (Chambers, 2003). So very often the data are fudged as done by the health workers of the PHC in Barwah. Then there is the question of the ethics of collecting data from people ostensibly for their benefit when they are in most cases utilised for serving other dubious ends (Subhadra & Rahul, 1997). Rarely are the respondents of a survey involved in the design of its structure or in the policy decisions taken based on the results.

When, however, surveys are done in a small local population with the intention of providing immediate relief to the respondents based on the information gathered from them about some problem or the other, then the problem of ethicality does not arise. A good example of such a study is the landmark one done by the Search project in Garhchiroli district in Maharashtra (Bang, 1989). Our survey too fell into this category. Nevertheless we took no chances and had detailed discussions with the women to decide on the best possible design of the questionnaires so as to ensure full cooperation before embarking on the survey. The survey was conducted in the first week of April 1997 by adolescent girl students in the 15-18 years age group studying in the high school run by the Kasturba Trust in Indore. An orientation workshop extending over three days was first held for these girls. The first day was spent in bringing home to the girls the extent to which women are oppressed by patriarchy. This was done not in a pedagogical manner but by inducing the girls to analyse various kinds of injustice being suffered by women in their own surroundings. The second day was devoted to explaining the workings of the reproductive system in particular and the human body in general. The third day was utilised to give the girls an idea of the kind of reproductive health problems being faced by women in the survey area and the survey design and schedules were explained to them.

The workshop revealed that even young girls have internalised patriarchy and are not at all sensitive to the ways in which women are continually downgraded in society. There was stiff resistance on the second day to the open discussion that was conducted by

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Subhadra to describe the reproductive system with the aid of overheads. Girls just did not want to discuss sex and the ways in which lack of knowledge about sexual matters could lead to serious reproductive health problems. These girls mostly came from middle and upper middle-class backgrounds and they all had misconceptions about the menstrual discharges. These misconceptions were reinforced by the various taboos that accompany the onset of menses in Hindu society. There is an urgent need for sensitising adolescent girls not only to reproductive health issues but also to the societal factors that contribute to widespread morbidity among women. This lack of information among adolescents and efforts to improve matters is a universal phenomenon (AGI, 1998).

The main aim of the survey was to get a comprehensive idea of the extent of reproductive health morbidity among women in the reproductive age group. Simultaneously the survey was structured so as to test a few hypotheses that we had surmised from our initial fieldwork. One hypothesis was that the high levels of morbidity had a close relationship with the poor general health status as reflected in the anaemic condition of most women. The other more important hypothesis was that this morbidity had more to do with the pernicious effects of patriarchy that were so evident and was not just the result of poverty. A subsidiary to this latter hypothesis was that the effects of patriarchy were more pronounced in married women. The main schedule consisted of a list of various problems and factors that affect reproductive health like the number of childbirths and deaths, the age at marriage and such other related information for women in the 15-45 years age group. There were two subsidiary schedules one for determining the heights and weights of children in the 3-6 years age group and one for determining the educational status of children in the 10-16 years age group. The haemoglobin percentage of the women in the 15-45 years age group was also tested by using haemometers.

Universal sampling was adopted for the survey in thirteen villages of the area, which had been covered by the clinics earlier. Due to various reasons all the women, however, did not respond to the questionnaires. The villages of Limbi and Aronda were chosen because these have upper-caste people who are quite well off economically. Thus the upper-caste women of these villages constituted the control population to test the hypothesis that reproductive health problems were related to patriarchy and not to poverty alone. The other control group was that of unmarried menstruating girls older than 15 years of age to test the hypothesis that the effects of patriarchy were more pronounced on married women than on unmarried women.

On an average each village was surveyed by a team of five girls under the supervision of a teacher. This team stayed with the villagers during the period of the survey. The survey was preceded by a meeting with the men and women in the villages to explain once again to them the rationale behind the survey. The information was gathered through personal interviews. The surveys were carried out over a period of five days. Every evening the survey team held meetings with the men and women explaining to them various aspects of reproductive health. A cultural show was held on the final evening, which included a hand puppet show on the ill effects of alcohol consumption. Subhadra,I and a doctor of the Kasturba Trust handled the logistics of organising the survey. This was a difficult task because the area is a hilly one without proper roads and the haemometers and nurses had to be ferried around on time.

Both the villagers and the team members immensely enjoyed the whole exercise. The only hitch came in the testing of haemoglobin levels. There were just four haemometers, which had to be circulated among the villages. Due to improper use blood

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clotted in the pipette of one of the haemometers and so it went out of order after use in only one village. So haemoglobin testing could be done in only eleven villages. Thus even though a total of 268 ever married women in thirteen villages had been surveyed, the haemoglobin levels of only 163 women in eleven villages could be tested and so the data of only these women were considered for the purposes of analysis. In addition to this 28 unmarried girls above 15 years of age were also surveyed.

The results presented a shocking picture of the reproductive health status of the women of the area. As many as 84.7% of the women suffered from some reproductive health problem or other. 49.1% suffered from vaginal discharges and 45.4% from dizziness arising possibly out of high blood pressure. 65% of the women complained of waist pains. Another disturbing statistic was that 6.8% of the women suffered from STDs, which was quite high for such a remote rural area where there was no prostitution. On an average the number of diseases being suffered simultaneously by a respondent, the morbidity index, was as high as 3.1. This morbidity index for adivasi women was highest at 3.5 while that of the dalit women stood at 2.6 and that of other caste women at 2.1. Thus even though the other caste women who are economically well off are not as badly off as the adivasis and the dalits nevertheless the level of morbidity among them too is very high. Notably the other caste women of Aronda who are Muslims showed a high morbidity level of 3.2 almost at par with the adivasi women. Statistical testing showed that the null hypothesis that the means of the samples of the different caste groups were from the same population could be accepted at a 5% level of significance. Thus our surmise that some other factor in addition to poverty was responsible for the poor reproductive health of the women had been borne out by the results of the survey. Significantly none of the 28 unmarried girls surveyed reported as suffering from any problems. Our detailed observations of the day to day life of the married women in the area described earlier led us to believe that the pernicious effects of patriarchy were mainly to blame for their sorry reproductive health status irrespective of their economic condition.

The survey revealed that the average haemoglobin level of the women was only 7.36 grams per decilitre of blood, which was about 46% of the desired value. Thus our hypothesis that there was a close relationship between the anaemic condition of the women and their poor reproductive health status too was amply borne out. Significantly unmarried girls showed an average of 11.1 grams per decilitre, which was relatively all right further confirming that it was married women who were more subject to the pressures of patriarchy. Furthermore 73.6% of the women had been married before completing 18 years of age, 41.7% had lost at least one child, 17.3% of women had more than 5 children and only 10.4% of the women had been sterilised. These discouraging statistics also pointed toward the pervasiveness of patriarchal values. The survey also revealed that there was no statistically significant difference in the literacy levels of boy and girls and the nutritional levels of girls was slightly better than that of the boys even though the difference was statistically insignificant. These levels, however, were far below that of the upper socio-economic strata in urban areas as was only to be expected. Thus these data too confirmed that the effects of patriarchy begin to make themselves felt on women only after marriage. It was clear therefore that gynaecological solutions alone would not be able to solve the reproductive health problems of women without addressing the problem of patriarchal oppression and so ensuring their reproductive rights also.

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email: rahul.indauri@gmail.com homepage: www.rahulbanerjee.notlong.com

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