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WOMEN & HEALTH

ROOTS OF WOMEN'S ILL HEALTH

Power relations mediate all social life and as such, they not only determine our environment, but also define the way we react to it. Our definitions of health and illness depend on the characteristics of the society we live in and our location in it. In a society where commodity production is predominant as long as an individual can work productively or rather, as long as that labour is productive to the capitalist, the individual is considered healthy. Therefore, health services are directed at maintaining this minimum level of health below which the generation of surplus value would fall off (Schatzkin, 1978). In turn, this defines for the worker, the boundaries of ill health such that real health needs from the point of view of quality of life never get expressed. For, the fulfilment of these health needs would be contradictory to the needs of capital accumulation. The patterns of morbidity and mortality express and reflect this contradiction between real health needs of the worker and the level of health necessary for the generation of surplus value.

How does all this affect women? As a component of the labour force, their needs are subordinated to the needs of capital. Further, a woman's traditional role is to reproduce and sustain labour power. This is the necessary function of women in society--- the maintenance and reproduction of the labour force, which in turn is necessary for the reproduction of capital. For a woman, the definition of health is determined by her ability to perform these functions. Just as in the workplace, the worker's health needs are subordinated to the needs of capital accumulation, women's health needs are subordinated to the need to maintain the work force at that level of health required for the generation of surplus value. Moreover, women as integral units of the family, are necessary not only for the reproduction of the working class, but also for reinforcing the ideological underpinnings of capitalism. Medical and health services are designed to keep women at an optimum level for the performance of these functions. **Thus, the needs of capitalist accumulation mediating through partiarchal relations suppress women's real health needs and their reproductive freedom.**

Medicine legitimates and rationalises social attitudes and notions about women (and men) whether they relate to their physiology or their social role. And since women's oppression is justified by their supposed biological inferiority, medicine obviously plays a very important role, in substantiating this myth. Medicine's 'model' of the normal human being is the upper/middle class male. This makes all women, by definition 'abnormal'! Menstruation becomes a disability, child birth an illness. Female physiology is considered a complication of the basic male physiology especially with reference to the reproductive (Rothman, 1979).

Two of the characteristic features of bourgeois medicine are its clinical paradigm and the dominant mechanistic model of the human body. This locates the cause of all ill-health entirely within the body, either as being due to the intervention of an outside agent or because of the malfunctioning of one or more 'parts' which comprise the human body. This means that women's complaints, if they are not caused by obvious external agents, must lie either in their 'aberrant' reproductive physiology (so different from the male) or in their peculiar female 'psyche'. Moreover, the models of 'normality' in medicine are those that are approved of by dominant ideology and are useful to bourgeois society. For women such a model is the ideal image of wife or mother. Not surprisingly, all health problems of women are seen in terms of how they might affect the fulfilment of that role.

Medicine, which is always articulated within a specific mode of production, contributes to the reproduction of that mode not only at the ideological but also at the economic and political levels. Thus the inappropriateness of medicine for women or its inaccessibility to the poor or to women is a characteristic feature of bourgeois medicine which serves to maintain and perpetuate the current relations of production and reproduction.

Any enquiry, discussion or analysis of health from a radical, marxist perspective must include an analysis of the women - and - health nexus. At the same time, no understanding of the women's status, their oppression and exploitation can be complete without a clear perception of the political and ideological roots of women's ill health.

The Women's Health Movement Abroad

In the '60s, the growing disenchantment of women with institutions and with social norms took the form of women's liberation movement. This

brought women together in consciousness raising groups where women for the first time began to exchange personal experiences and make women-to-women contacts that had been denied them. Among other things, this led to the realisation that their demeaning and dehumanising experience in the health system were not stray and personal incidents but the universal experience of all women. This has over the years generated several analyses of the medical system and has led to specific actions and programmes.

Elizabeth Fee (1970) characterises these in terms of three forms of social criticism, the liberal feminist, radical feminist and marxist feminist. Liberal feminist saw their main challenge as being destroying the 'myth' of a biological basis of women's oppression. They demanded equal pay and equal opportunity for women but did not seriously challenge the social and economic hierarchy. They saw the medical system as reflecting the sexual hierarchy of society with a male monopoly of the upper levels and a predominance of women at the menial jobs at the lower levels. Their solution was centered on demanding a better representation of women at the upper levels, but did not question the hierarchical organisation of health care or of society.

Radical feminism demanded a fundamental, restructuring of society, its institutions and values. Many of these women had participated in student, civil rights and anti-war movements. Some had become disenchanted with left parties and official marxist view of feminism as being a form of bourgeois protest and with marxist analyses which appeared to be insufficient to explain women's situation adequately or provide a satisfactory theoretical understanding of the family, reproduction, sexuality. Radical feminism saw the patriarchal family as the major and most important oppressive force in society and a battle of the sexes as being of more consequence than the class struggle. They saw revolution as leading to an annihilation of sex differences. There was an outpouring of radical feminist analyses of society, of institutions and of politics in the late '60s and the '70s, all of which served to expose the operation of paternalist ideology and the structures of women's oppression in society.

Radical feminists saw the medical profession as imitating patriarchal society and were heavily critical of medical mysticism especially in the area of gynaecology and obstetrics. They worked to disseminate information and knowledge about medicine and specially about women's sexual and reproductive functions which had for so long been a monopoly of the doctors. This led to a strong movement against hospitalised childbirth in the US. Groups in many states of the US and in Britain and Europe set up women's health centres and self-help clinics as 'alternatives' to the dehumanised hospital centred medical systems. They provided for gynaecological examinations, and childbirth facilities as well as abortion services. Inevitably they have come into conflict with power groups professional groups; but have survived and proliferated nevertheless.

It was mainly this current of feminist thought which gave rise to a number of significant books and pamphlets such as *Our Bodies Ourselves* (from the Boston Women's Health Book Collective), *Witches-Midwives and Nurses* and *Complaints and Disorders* (both by Barbara Ehrenreich and Deirdre English) and *Vaginal Politics* (by E Frankfort). This and other similar literature has been very influential in rejuvenating the interest of radical and marxist groups in the history, nature and ideology of science and medicine.

Marxist feminists saw their task as the combining of feminist consciousness with historical dialectical method of analysis. They saw patriarchy as both supporting and strengthening capitalism. At the same time they saw capitalism as providing the material condition for the future abolition of sexual distinction between man's work and women's work, but the realisation of these conditions being limited to the extent necessary for the survival of capitalism. "Capitalism... cannot free itself from dependence on sexism any more than it can transcend class oppression or the pursuit of private profit at the expense of the satisfaction of real human needs" (Fee, 1975).

Marxist feminists believe that no one characteristic of the medical system can be analysed in itself, but must only be seen in relation to the entire social structure and its institutions, and the economic order in which it is rooted. Thus, they see the fragmentation of capitalist medicine as a part and consequence of the ideology of medicine which sees the body in parts. They are also critical of the sexist bias of medicine and the emphasis on 'scientific' base which itself has an inherent class and sex bias. They see medicine as ignoring the social roots of illness.

Women's Health Issues in India

In India, women's health issues have not emerged as a major focus of activity or analyses within the women's movement. Women's groups are of course, aware of women's inaccessibility to health care services, the lack of reproductive freedom, sexual harassment of women patients (and of nurses) and to a lesser extent the operation of the sexist ideology

in medicine. But this has not led to a comprehensive theoretical understanding of women's health as a part of feminist theory. Nor has it generated concerted action programmes. There have been individual campaigns, such as the demand for a ban on estrogen-progesterone drugs for pregnancy testing and amniocentesis for sex determination. But while these, especially the latter, has given rise to significant debate and action, one cannot say that they have led to a better perspective of the role of medical technology in the oppression of women. The reason for this apparent uninterest in health issues perhaps lies in the historical and economic roots of the women's movement in India and needs to be examined.

This apathy towards health issues is even more significant when one recollects that rape was one of the earliest issues taken up by the women's movement. It would have been logical to suppose that this would have led to a discussion of broader questions of female sexuality, a realisation of how little women knew about their bodies and ultimately, to a questioning of the male monopoly of the information about women's bodies, its functioning in health and illness. This did not happen, although there was sporadic discussion about such matters as the 'technical' definition of rape and the relevance of injuries on a woman's body. Nor was there significant and sustained effort to provide 'alternative' medical aid to vicitims. Why did this not happen? Was it because the medical system and the definitions promoted by it hold sway even among those who have little access to it?

Health issues which would be of concern to Indian women are generally different from those which confronted feminists in the West in the late '60s and early'70s. For instance, by then in most countries of the West, the major achievements of medicine which produced visible and noticeable change had already taken place. The life expectancy had levelled out and there appeared to be after all, a maximum limit to human life. Together with this, the hospital-centred medical system had increasingly become dehumanised, authoritarian and expensive. The women's movement could successfully question the ethos of such a system and its value to women.

In the '70s in India, although the state health system was weak and inefficient, it was at least able to bring some relief, especially in acute illness and during crises. Moreover, by this time several groups, frustrated and disgusted with both the state systems and the rapacity of the private practitioners had set up 'alternative' health programmes in the rural areas. And many of these had made maternal and child health programmes their main focus. Undoubtedly, this brought about positive changes in women's (or rather maternal) health status. Therefore the women's movement in India had no immediate and concrete targets in the area of health. The demand for birth control measures and abortion were two major areas of activity of the women's health movement in the West. In India, such measures were, in fact, being forced on women as part of a determined and massive family planning programme.

Further, the sex-wise mortality and morbidity picture in the West was and is quite different from the Indian. In the US, for instance, women show lower mortality and morbidity rates and also a greater frequency of contact with the medical system. Women there were concerned with countering the criticism that women were generally, hypochondriac, and in voicing concern and initiating action about the increasing consumption of tranquilisers and painkillers by women.

What then, are the issues which demand concerte action, research and discussion in India today? It is hardly necessary to point out that women's health status has been steadily declining. In 1901, the sex ratio (number of women to 1000 men) was 972 which declined to 930 in 1971. In almost every age group (except 10 to 14 years) until 34, the age-specific death rates are higher for women. Or in other words more than half the deaths among women occur before they are 35. According to one report, 20 per cent of all deaths among women in the age group 15-34 are because of childbirth and associated causes (SNDT 1981). However, maternal mortality is not the major cause of death among women in that age group. And yet most health programmes are directed only at reducing maternal mortality without any alteration of the accessibility of this group of women to general services.

Women have also been the major focus of family planning programmes. Most of the measures proposed and implemented — sterilisation, abortion, oral contraceptives, copper T, injectables — have affected women's health significantly, and even disastrously.

The changing patterns of economic development have put a heavy burden on women which is reflected in their health status. In a society where women hold a lower social status, any situation of deprivation is bound to affect women adversely. The marginalisation of farmers, landlessness and forced migration, temporary and permanent, have undoubtedly affected women's health and nutritional

status. The growth of the small and the cottage industries sector has depended heavily on female labour. And most of these do not come under the purview of any kind of safety legislation. Therefore, women have, in the last decade become exposed to new kind of health hazards. Added to this is the fact that women risk their lives in the performance of domestic labour. According to Rajni Kothari a woman spends approximately 73,000 hours on an average in the kitchen, most of which are environmentally harmful and unsafe (Raj and Patel, 1982).

The number of 'workers' among women is estimated to be only 20.01 per cent. But the Census definition of 'work' does not include cooking, collecting firewood, fetching water, etc. activities which take up half the energy expenditure of women. At the same time adult women eat consistently less than men and also much less than the recommended calorific allowances, which are themselves based on somewhat questionable assumptions. According to a recent survey carried out by the National Institute of Nutrition, Hyderabad, 60 per cent of the rural population is anaemic, most of this group being women. Malnutrition is not only aggravated by diseases but renders women more prone to illness. Ironically enough, although women suffer from illness more or at least as often as men, they seek help less often.

There is little hard-core data available to support any analysis of women's health status. And this itself is a telling comment on how unimportant women's health is. Nevertheless, there is sufficient evidence — experiences, personal observations—that women's health status presents an apalling, dismaying and deteriorating picture. In this, the second issue of SHR, we examine a few facets of this picture.

Sathyamala discusses the sexist ideology of medicine and its operation in the past and currently. She convincingly shows that the sexist ideology is so closely integrated with the theory and practice of medicine that it is difficult even to identify it, let alone accept it.

Our next offering is an article by Barbara Katz Rothman, reproduced from the book *Women: A feminist perspective* edited by Jo Freeman (1979) giving a slightly different theoretical explanation of the sexist bias. She sees sexism in medicine as a component of the mechanistic, positivist bourgeois medicine and calls for a critical examination of the medical mode of women's bodies and health.

Nirmala Sathe provides an overview of health issues in the women's movement in India.

Srilatha Batliwala writes on the energy-health-nutrition nexus with reference to women. This paper gives credence to the fact that the gap between expenditure for energy and intake of calories is larger for women than for men. These data and the accompanying analyses gave for the first time, (when it was first presented) hard-core information and statistics about some aspects of women's health status.

Meredeth Turshen's article is an extract from a book *Third World Medicine and Social Change* (editied by John Morgan and published by Lanham) which is just out. It analyses the nutrition-health complex with reference to women in Africa. It looks at the health situation of women from the perspective of Africa's changing economy. It seeks to show the linkages between political and economic measures, changes in cropping patterns, food imports, international loans and changes in land tenure, women's nutritional and health status.

Misuse of medical technology is at times, a sore topic of discussion. The use of amniocentesis for sex determination, aroused great deal of discussion a year ago. It was in fact, one of the few issues that women's groups took up all over the country and pressed for a ban on such tests being used indiscriminately. Vibhuti Patel concisely traces the major features of this debate and highlights the misuse of such medical technology which more often than not leads to female foeticide.

How healthy are workers in the drug industry? A large number of women are employed in the pharmaceutical industry , but there are few studies of their health status. Sujata Gotoskar, Rohini Banaji and Vijay Kanhere report a case-study of women workers manufacturing vasodilators. A drug such as this is prescribed to produce a definite physiological change in those who need it. What happens to normal women who have to breath in the powder day-in and day-out? This study, highlights the need to gather more information of the hazards women face at work places.

We wind up this issue with a review and report of 'health' problem which is currently facing the Kashtakari Sanghatana working among the adivasis in Dahanu in Maharashtra. And this is the torture of women 'bhutalis' (witches). The Sanghatana has attempted in this paper to locate the issue in a socio-economic perspective. Who is the witch? Why

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led to a hysterical state. Modern thinking has reversed this understanding. It is believed now that emotions acting through hypothalamus effect menstrual function considerably.

The process of professionalisation includes learning attitudes about work, about relations with colleagues and about patients or clients. In medicne these attituides are strongly coloured by a demeaning regard for women. For, after all, such attitudes about women are pervasive in society and moreover the medical profession has been virtually a male monopoly. This may be disputed in India since the majority of gynaecologists here are women. Unfortunately, they too have imbibed the sexist values in society. We are all products of our cultural expectations---- and our culture devalues women.

The answer does not lie in doing away with gynaecologists. The more mature way would be : (i) to recognise inadequacies that exist in our knowledge and be more open and receptive to women's personal experiences; (ii) to redirect research priorities and focus on problems that women consider as important; (iii) to end the medical monopoly of knowledge about women's physiology, their illnesses. Only then can we hope that medicine will serve those who need it most.

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does witch-hunting take place with greater frequency during certain seasons? There are no simple answers. This article looks at the entire complex fabric of the adivasi's way of life, the status of women, and how factors such as deforestation, modern diseases, increasing unemployment and impoverishment and a deterioration and disappearance of trbial knowledge of medicine may be generating a set of circumstances which could perpetuate and strengthen the belief in the bhutalis and thus lead to increasing persecution of women. We especially ask readers to respond to this article.

Our focus throughout the issue is on women as consumers of health care. Women also comprise a large proportion of the providers of health care and we hope to devote a seperate issue to the topic sometime. We hope you find this glimpse of the many health issues which concern women, insteresting.

padma prakash

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IS MEDICINE INHERENTLY SEXIST ?

c sathyamala

During the last twenty years, many feminists, activists and researchers have been taking a closer look at medicine. There is voluminous and irrefutable evidence that the medicine of the 19th and early 20th centuries incorporated and reinforced the sexist ideology in society. But does sexism operate in and through current medical practice in India? The author argues, that the teaching and practice of medicine here is strongly influenced by what happens in the West With extensive illustrations from popular textbooks and journals she shows how sexism in medicine operates just as strongly now as it did a hundred years ago. Additionally, campaigns such as the one promoting breast feeding continue to use outmoded and demeaning stereotype for women. This article is based on a paper written for the Medico Friend Circle's Annual Conference held in 1983, which focussed on 'Prejudice against women in the medical system.'

Medicine has played and continues to play a powerful role as a reinforcer and perpetuator of sexist ideology. It has the dubious distinction of shifting justification for sexism from religion to bio-medicine, thereby taking it out of the realm of prejudice and putting it within the confines of 'scientific' objectivity. The interpretations medicine offers are basically to legitimise the discrimination of women and their continued oppression under the guise of biological determinism.

The period of rapid industrialisation in the West witnessed the growth of the monopoly of the white middle-class male over medicine. This period also saw the emergence of new social norms which specified roles on the basis of sex and class. The upper-class women were expected to lead a sedentary life of enforced leisure with nothing more taxing than embroidery to keep them occupied, whereas the working-class women were forced to lead a life of hard physical labour. Although it was the working class women who were subjected to a host of illnesses, (a result of nutritional deficiencies and poor working and living conditions,) it was the upper-class women whom medicine considered as inherently sick. "It was the wealth extracted in that harsh outside world that enabled a man to afford a totally leisured wife. She was the social ornament that proved a man's success, her idleness, her delicacy, her child-like ignorance of 'reality' gave a man the 'class' that money alone could not provide". (Ehrenreich and English, 1973).

The combined effects of enforced leisure, confinement and boredom led to the emergence of the cult of 'female invalidism' among the upper class women. To the medical men the 'sick' women of the upper classes were a godsend. Here was a patient, who was ill without being 'diseased', in obvious need of the ministrations of a medical man (like himself), compliant enough to obey every one of the doctor's demands, and wealthy enough to afford the prolonged treatment --- an ideal patient as it were. "As a businessman, the doctor had a direct interest in a social role for women that encouraged them to be sick; as a doctor he had an obligation to find the causes of female complaints. The result was that as a scientist he ended up proposing medical theories that were actually justifications of women's social roles". (Ehrenreich and English, 1973). The popular medical theory proposed was that women's inherent weakness rested on the physiological law of 'conservation of energy'. Each person had a fixed supply of vital energy and the different organs had to compete with each other for their share. Since a woman's life was centred around her reproductive organs it meant that these organs developed at the expense of all the other organs. The result of such distribution of energy left the woman strong enough to bear children, but weak in every other way. This theory implied that the woman could never be physically or intellectually superior to a man who did not lose out his energy on reproductive functions. As a further development of the theory, it was postulated that the ovaries were central to the woman's being. The ovaries determined the personality traits of the woman and these could range from irritability to insanity. In textbooks and in actual medical practice, doctors found uterine and ovarian problems behind every female complaint be they headaches, sore throat or tuberculosis.

Although all these could be dismissed as part of the deep medical ignorance of the times, it did not prevent the medical profession from carrying out treatment which were specifically designed to alter female behaviour. Treatment for female invalidism included isolation, prolonged rest, clitorectomy and ovariotomy. Ehrenreich and English point out that this was in effect a surveillance system through

which the doctors could detect the first signs of rebelliousness and could interpret them as symptoms of disease, and hence, curable.

But the theories and medications could not be applied to working-class women. They had neither the time nor the money to indulge in female invalidism and their labour was essential for the growth of capital. Medical theory came up with an explanation based on racial differences : These women (mostly blacks and immigrants from Europe) were congenitally inferior to the white Anglo-Saxon protestants in that they had smaller brains, larger muscles and a host of inherited social traits. They were considered to be free from uterine diseases and were supposed to have robust healthy babies. Although these working-class women were not 'sick' they were 'sickening' to other classes. They bred disease and were the reservoir of infection. The danger of coming in contact with working-class women was especially great for upper classes for they often worked as maids in the homes of the upper class and as prostitutes. Thus medical theory proposed two seperate biological reasons to explain and justify the social roles of these two classes.

Sexism in Current Medical Practice

It could be argued that all this took place in the distant past at a time when the scientific foundation of medicine was still being laid and that the content of medicine itself has changed since then. Such an argument would be valid only if it was possible to prove that the later devlopments in medicine were not influenced by sexist prejudices. But a review of medical literature reveals that sexism is still dominant in the interaction between 'medicine' women, and medicine still continues to rationalise and to dictate social norms to women.

It would have been difficult to substantiate these statements had they been made say, twenty years ago, because then the ultimate pronouncements on woman's 'nature' still came from the doctors. But the militant feminist movement in the west has been powerful enough to draw the attention of academicians to provide the much-needed data. The following quotes are taken from studies conducted in US and in England and are relevant to India as well. for the teaching and practice of medicine is not very different and students follow the same textbooks. Doctors continue to view women patients as hysterical, irrational and incapable of making decisions. ". . . . . women's illnesses are psychosomatic until proven otherwise".

"Following traditional linguistic convention, patients in most medical school lectures are referred

> *"Primary dysmenorrhoea is dismissed as being psychogenic, although it affects 50 percent of women"*

to exclusively by the male pronoun 'he'. There is, however a notable exception: in discussing a hypothetical patient whose disease is of psychogenic origin, the lecturer often automatically uses 'she'. For it is widely taught, both explicitly and implicitly, that women patients (when they receive notice at all) have uninteresting illnesses are unreliable historians and are beset by such emotionality that their symptoms are unlikely to reflect 'real' disease."

" Woman as compared to men are more likely to have their depression treated by drugs than to be helped to overcome the causes of their distress". (Howell, 1974)

Work up by physicians in response to five common complaints in a sample of 104 men and women - 52 married couples— were evaluated by chart audit. For the total group of complaints, back pain, headache, dizziness, chest pain and fatigue, the physicians' work ups were significantly more extensive for men than they were for women. These data tend to support the argument that male physicians take medical illness more seriously in men than in women. (Armitage et al, 1979-)

Most complaints which are termed women's complaints (because they refer to their reproductive tracts) are often dismissed as being of purely psychogenic origin. Primary dysmenorrhoea is one such gynaecological complaint which though it affects about 50 per cent of women, is considered partly or wholly psychogenic. This is inspite of the fact that the origin of pain is still unknown.

"One gains little conviction in relation to most of the literature (regarding dysmenorrhoea) especially in respect of management. To illustrate an extreme, one recent study advises physicians not to trust empiric diagnoses of dysfunctional dysmenorrhoea, but to inspect the peritoneal cavity by culdoscope and to expect often to find free (menstrual ?) blood as the cause of the pain. Actually, one is finally driven to the conclusion that theories concerning intrinsic dysmenorrhoea in early menstruation are as conflicting as are countless methods and medications which are claimed as being helpful. Hardly, a day or a medical journal, goes by which does not offer a new near-panacea whose rationale conflicts with many

others. It reflects more essentially the psychosomatic ineffectiveness of the proscribing physician, and in general the results are not superior to our sage advices at the beginning of the century" (Jones).

The psychogenic theory of primary dysmenorrhoea however is very definite : "It is generally acknowledged that this condition, is much more frequent in the highstrung, nervous or neurotic female than in her stabler sister." (Lennane and Lennane 1973).

"Faulty outlook leading to an exaggeration of minor discomfort.... may even be an excuse to avoid doing something that is disliked". Or more simply, "The pain is always secondary to an emotional problem." (Lennane and Lennane 1973).

In refuting these theories Jean Lennane and John Lennane have this to say : "There is no valid basis for this attitude. These authors are not referring merely to the effect that the personality of the patient may have on the amount of suffering or complaints occurring in any organic illness, but are implying or directly stating, that the patients' faulty outlook is causing the condition.

"If the pain is the result of 'faulty outlook' one would expect it to start at the time of the initial psychic shock (menarche), and not two to four years later. The pain is dependent on the occurrence of ovulation and is reliably and usually completely removed by suppression of ovulation (92 per cent of severe cases in one study) Perhaps the few who do not respond to ovulation suppression might be psychologically disturbed, but in practice, psychosomatic study and psychometric tests do not confirm this hypothesis. Scientific supporting evidence is completely absent e. g. a prospective study of pubescent girls, or of menstruating girls who were not yet ovulating. Evidence when offered, is scanty. **'A dysmenorrhoic mother usually has a dysmenorrhoic daughter'** which, if true (no statistical confirmation is offered), would more usually be taken to indicate a hereditary factor.

"The attitude to treatment may also be unusual.. 'very little can be done for the patient who prefers to use menstrual symptoms as a monthly refuge from responsibility and effort'. The patient with visceral colic is treated with rest and relief of pain; the patient who persists in having severe dysmenorrhoea may be denied both." (Lennane and Lennane, 1973).

The following quote also shows how women's gynaecological complaints are seen as unimportant and not worthy of medical attention. "Majority of the women in our country are housewives. In most

"Mistaken and misleading beliefs about female sexuality continued to dominate medical theories until the late 70s."

of the other countries women do as much office work as men and in addition do the duties of housewives. Thus Indian women have more 'spare time'. Since majority of them have no other activities or hobbies and do not do any reading (being uneducated) **they spend most of their spare time concentrating on their vaginal discharge".** (emphasis ours) (Kapoor, 1976). The underlying attitude that will be encouraged in general practitioners is self-evident. It is also significant that leucorrhoea (vaginal white discharge) is the only common gynec problem discussed in the book.

In fact, it is not too farfetched to say that almost every second gynaecological complaint is viewed with suspicion as being fictitious and just a figment of the imagination. Here is what Lennane and Lennane say with regard to nausea of pregnancy : "A well-defined clinical entity occurring in 75 to 88 per cent of pregnant women. The exact cause remains unknown. The condition is nevertheless commonly held to be partly or wholly psychogenic again without any scientific supporting evidence. Few will deny that the psychogenic factor is of prime importance, and it is probable that many adjustments demanded of the newly-pregnant woman impose a mild condition of stress coupled with an irrationally exaggerated fear of the obstetric hazards confronting her, especially that of producing an abnormal child. Classified with the neuroses, (nausea of pregnancy) may indicate resentment, ambivalence and inadequacy in women ill-prepared for motherhood" ..... " Nearly all pregnant women see a doctor and to classify up to 88 per cent of patients with a particular organic condition (pregnancy) as neurotic is unusual in the extreme" ... "its severity in multiple pregnancy and hydatidiform mole contradict the neurosis theory. unless it is postulated that the patient can subconsciously and definitely diagnose these conditions as early as the fourth week" (Lennane and Lennane, 1973).

Female sexuality has always been a source of concern in all patriarchal societies. Medical theories of the late 19th and early 20th century drew a rigid distinction between reproductivity and sexuality. It was believed that the development of reproductive powers and of the maternal instincts could only take place when sexuality itself was suppressed. Women

were told (by medical theoreticians) that sexual feelings were 'unnatural, unwomanly pathological and probably detrimental to the supreme function of reproduction". These beliefs continued to dominate medical theories till as late as the 'seventies, even after Master's and Johnson's findings had revolutionised the understanding of female sexuality. According to Scully and Bart (1973) who reviewed 27 general gynaecological textbooks published in the US from 1943 to 1972: "... examination of gynaecological textbooks, one of the primary professional socialisation agents for practitioners in the field, revealed a persistent bias towards a greater concern with the patient's husband than with the patient herself. Women are consistently described as anatomically destined to be happy. So gynaecology appears to be another of the forces committed to maintaining traditional sex role stereotypes, in the interest of men and from a male perspective."

In the textbooks published between 1963-72: " Eight (of the textbooks) continued to state, contrary to Master's and Johnson's findings, that the male sex drive was stronger and six still maintained that procreation was the major function of sex for the female. Two said that most women were 'frigid' and another stated that one-third were sexually unresponsive. ..... when they (the book) deal with the subject (sex role) the traditional female sex role is preferred. Thus Jeffcoate states 'An important feature of sex desire in the man is the urge to dominate the women and subjugate her to his will; in the women, acquiescence to the masterful takes a high place'. In 1971 we read: 'the traits that compose the core of the female personality are feminine narcissism, masochism and passivity' ... A 1970 text states, 'The frequency of intercourse depends entirely upon the male sex drive. The bride should be advised to allow her husband's sex drive to set their pace and she should attempt to gear hers satisfactorily to his. If she finds, after several months or years that this is not possible, she be advised to consult her physician as soon as she realises there is a real problem'. The gynaecologist's self-image as helpful to women combined with unbelievable condescension is epitomised in this remark: "If like all human beings he (the gynaecologist) is made in the image of the Almighty and if he is kind, then his kindness and concern for his patient may provide her with a glimpse of God's image."

Medical attitudes have changed little in spite of the criticisms which have been the outcome of the feminist movement. A recent example is the breast feeding campaign which has merely incorporated the new attitude of society towards women,

"The advocates of the breast feeding campaign reinforce the idea of the main role of women being to reproduce and nourish at the cost of self"

but has not changed its fundamental sexist ideology.

For many years the infant formula companies had peddled breast milk substitutes as an expression of mother's love. They had played upon the image of women as sex objects who in order to be desirable had to be depilated, deodorised, and have well-shaped and firm breasts. The counter propoganda (of the breast feeding campaign) tries to allay the fears of the mother about the shape of her breast by reassuring her that breast feeding will, in fact, make her more shapely.

"Contrary to the old wives's tales that nursing makes breasts sag (age and gravity do that), breast feeding actually helps women to get their bodies back in shape after childbirth. It helps the uterus return to its pre-pregnancy condition and facilitates loss of excess weight gained during pregnancy. It promotes a deep feeling of warmth and attachment between mother and baby. and many women report the physical sensations of breast feeding are pleasurable" (UNICEF, 1981). The issue is not whether the technical content of the quote is correct or not, but that the images it uses and reinforces are as sexist as 'organised' commercial advertisement. The advocates of this campaign also reinforce the idea of the main role of women as being to reproduce and to nourish at the cost of self.

' Lactation offers the opportunity of giving 'self.' to feed an infant, instead of feeding through the medium of the substitute glass bottle, rubber nipple and compounded baby formula. To this end successful lactation is indeed, a worthy and noble goal for the physician to inspire" (Applebaum, 1970). And further,

"The remarkable ability of poor women to breast feed their babies for prolonged periods is the most redeeming feature in an otherwise bleak nutritional status of many developing countries" (Gopalan, quoted UNICEF)

Conclusions

A woman is by definition 'emotional'. For long it was believed that a woman's emotions were controlled by her womb and a disturbance in the womb

led to a hysterical state. Modern thinking has reversed this understanding. It is believed now that emotions acting through hypothalamus effect menstrual function considerably.

The process of professionalisation includes learning attitudes about work, about relations with colleagues and about patients or clients. In medicne these attituides are strongly coloured by a demeaning regard for women. For, after all, such attitudes about women are pervasive in society and moreover the medical profession has been virtually a male monopoly. This may be disputed in India since the majority of gynaecologists here are women. Unfortunately, they too have imbibed the sexist values in society. We are all products of our cultural expectations---- and our culture devalues women.

The answer does not lie in doing away with gynaecologists. The more mature way would be : (i) to recognise inadequacies that exist in our knowledge and be more open and receptive to women's personal experiences; (ii) to redirect research priorities and focus on problems that women consider as important; (iii) to end the medical monopoly of knowledge about women's physiology, their illnesses. Only then can we hope that medicine will serve those who need it most.

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(Contd from Page 52)

does witch-hunting take place with greater frequency during certain seasons? There are no simple answers. This article looks at the entire complex fabric of the adivasi's way of life, the status of women, and how factors such as deforestation, modern diseases, increasing unemployment and impoverishment and a deterioration and disappearance of trbial knowledge of medicine may be generating a set of circumstances which could perpetuate and strengthen the belief in the bhutalis and thus lead to increasing persecution of women. We especially ask readers to respond to this article.

Our focus throughout the issue is on women as consumers of health care. Women also comprise a large proportion of the providers of health care and we hope to devote a seperate issue to the topic sometime. We hope you find this glimpse of the many health issues which concern women, insteresting.

padma prakash

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WOMEN, HEALTH AND MEDICINE

barbara katz rothman

Until pregnancy and childbirth were defined as medical events, midwifery was in no sense a branch, area or interest of medicine as a profession. The expansion of scientific medicine converted normal physical changes of pregnancy and others into medical problems devoid of their larger socio-emotional content. The displacement of the midwife by the male obstetrician resulted not from any ideological struggle or 'scientific' advancement but from the control that physicians exercised through their professional associations. The treatment of the body as a machine and the lesser functional importance assigned to women constituted a basis for exercising the overt social control over women through the surgical removal of her various sexual organs and by creating physical deformities in her. The author argues that the alternative to the mechanical model of taking the female system as a complication of so-called biological stability of the non-cycling male, is to take the female as working norm for the female system.

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Women are not only people : *woman* is a subject one can study, even specialize in within medicine. Obstetricians and gynecologists are medicine's and perhaps society's generally recognized "experts" on the subject of women, especially women's bodies: our health, reproductive functioning, and sexuality.[1] Obstetrics is the branch of medicine concerning the care of women during pregnancy, labor, and the time surrounding childbirth,[2] similar in some ways to midwifery. Gynecology is the "science of the diseases of women, especially those affecting the sex organs."[3] There is no comparable "science" of the study of men, *their* diseases and/or reproductive functions. An attempt by urologists in 1819 to develop an "andrology" specialty came to nothing.[4]

At its simplest, we can think of a medical specialty as arising out of pre-existing needs. People have heart attacks : the medical specialty of cardiology develops. Or the amount of knowledge generated in a field grows so enormously that no one person can hope to master it all: physicians "carve out" their own areas of specialization. Increasing knowledge about cancer thus led to the specialty of oncology, and subspecialities within oncology.

But the development of a medical specialty is not necessarily the creation of a key for an already existing lock. Medical "needs" do not necessarily predate the specialty, even though the specialty is presumably organized to meet those needs. This has been made quite clear in the work of Thomas Szaz on the relatively recent expansion of medicine into such "social problem" areas as alcoholism, gambling and suicide.[5] Medicine doesn't have the "cures" for these problems but by defining them in medical terms, as sickness, the physician gains political control over the societal response: punishment becomes "treatment ', desired or not, successful or not. Similarly, medical control over childbirth, lactation, menopause, and other women's health issues was not based on superior ability to deal with these concerns.

The case of Jacoba Felice de Almania, a woman tried for the illegal practice of medicine in 1322 illustrates this point. In her defense Jacoba Felice de Almania had witnesses who testified that she never charged unless she cured, and that her cures were successful where other "legal" (male) practitioners had failed. However, since she had not attended a medical school (medical schools being closed to women) she was not licensed to practice medicine. That she saw women who did not want to go to a male practitioner, that she was successful did not matter. "Efficacy of treatment was not the criteria for determining who was or was not a legitimate medical practitioner, but the educational requirements and membership in the faculty of an organized group were the most important factors."[6] In essence, what professional control over medicine says is, "We may not be able to help you, but we are the only ones qualified to try."

Vern Bullough, in his analysis of the development of medicine as a profession, writes that during the middle ages, "One obvious group outside of the control of the university physician was the midwife, but during the period under study the university physician generally ignored this whole *area of medicine*. Midwives might or might not be qualified, but this *was not a matter of public concern*. (emphasis added)".[7] More accurately, one might state not that physicians ignored this "area of medicine," but that midwifery and its concerns were outside of medicine, just as matters that were

undoubtedly of concern *to women* existed outside of the "public" concern. Until pregnancy and childbirth were defined as medical events, midwifery was in no sense a branch, area, or interest of medicine as a profession.

Medical expansion into the area of childbirth began before the development of asepsis, surgical techniques, anesthesia; any of what we now consider the contributions of obstetrics. And yet, even without the technology, by the beginning of the nineteenth century medicine had begun the redefinition of childbirth from a family or religous event to a medical one, needing medical presence for its safe conduct.[8]

Midwives treated childbirth in the larger context of women's lives. Midwives did not and do not deliver babies. They teach women how to give birth. Brack has called the role of midwife "total" —she helped in the socialization of the mother to her new status, both as teacher and as role model. "The midwife's relation to the woman was both diffuse and affective, while the physician role demanded specificity and affective neutrality".[9] Midwives taught how to birth babies, how to nurse them, how to care for the babies and for the mother's own body. Physicians deliver babies and move on. The physician "isolated the laboring woman and her delivery of the infant from the rest of the childbearing experience, and defined it as a medical and surgical event which required specialized knowledge."[10] As one modern nurse—midwife has said of obstetrics residents : "They want us to stay with the woman in labor and just call them when she's ready to deliver. To them, that's the whole thing."

At the time that physicians were taking over control of childbirth, it is virtually unarguable that the non-interventionist, supportive techniques of the midwives were safer for both the birthing woman and her baby. The physicians' approaches included bleeding to "syncope" (until the woman fainted), tobacco infusion enemas, frequent non-sterile examinations, and other surgical and chemical interventions.[11] In the 1910's and 20's, as American physicians successfully ousted midwives, the midwives' safety records remained better than the physicians. In Newark a midwifery program in 1914-16 achieved maternal mortality rates as low as 1.7 per thousand, while in Boston, where midwives were banned, the rates were 6.5 per 1000. Similarly, infant mortality rates in Newark were 8.5 per 1000 contrasted with 37.4 in Boston.[12] In Washington, as the percentage of births reported by midwives shrank from 50 percent in 1903 to 15 percent in

"... midwifery and its concerns were outside of medicine, just as matters that were undoubtedly of concern to women existed outside of the public concern".

1912, infant mortality in the first day, first week, and first month of life all increased. New York's dwindling corps of midwives did significantly better than did New York doctors in preventing both stillbirths and post—partum infection.[13]

The physician's separation of the "delivery" of the baby from its larger socio-emotional context has its roots as far back as Rene Descartes concept of mind-body dualism. To Descartes, the body was a machine whose structure and operation falls within the province of human knowledge, as distinguished from the mind which God alone can know. Though even the Hippocratic principles state that the mind and body should be considered together, "Experience shows that most physicians . . . irrespective of their professional activites and philosophical views on the nature of the mind, behave in practice as if they were still Cartesian dualists. Their conservative attitudes are largely a matter of practical convenience."[14]

The medical models used for convenience are that diseases are the bad-guys which the good-guy medications can take care of; that the body breaks down and needs repair; that repair can be done in the hospital like a car in the shop; and that once "fixed," the person can be returned to the community. The earliest models were largely mechanical; later models worked more with chemistry; and newer, more sophisticated medical writing describes computer-like programming; but the basic points remain the same. It was a useful model when dealing with the problems facing medicine at the turn of the century : primarily bacterial and viral disease-causing agents and simple accidents and trauma. It has never worked well for understanding the problems that women face in dealing with doctors, including the experience of childbirth. While midwifery was learned by apprentice, doctors were instructed in the use of forceps, as well as techniques of normal delivery, by "book learning," by discussion, the use of wooden models, and infrequently by watching another doctor at work. Wertz, in her study of the development of obstetrics, has pointed out that "By regarding the female body as a machine, European doctors found that they could measure the birth canal and predict whether or not the child could pass through."[15] Stories of women delivering while their doctors scrubbed for a Caesarian section were told, probably

... the female gonads were removed not when women were «too female» that is, too passive or dependent, but when women were too masculine-assertive' aggressive, unruly...»

with much relish, and similar stories continue to be part of the lore of midwifery. Among the stories midwives tell each other are the tales of women who were told that they could never deliver vaginally, and then went on to have normal births of oversized babies.

In the nineteenth and early twentieth centuries midwives and physicians were in direct competition for patients, and not only for their fees. Newer, more clinically oriented medical training demanded "teaching material," so that even the immigrant and poor women were desired as patients.[16] The displacement of the midwife by the male obstetrician can be better understood in terms of this competition than as an ideological struggle or as "scientific advancement." Physicians, unlike the unorganized, disenfranchised midwives, had access to the power of the state through their professional associations. They were thus able to control licensing legislation, in state after state restricting the midwife's sphere of activity and imposing legal sanctions against her.[17]

The legislative changes were backed up by the attempt to win public disapproval for midwifery and support for obstetrics. Physicians accused midwives of ignorance and incompetence, and attacked midwifery practices as "meddlesome." Rather than upgrading the midwives and teaching the skills physicians thought necessary, the profession of medicine refused to train women either as midwives or as physicians.[18] Physicians argued repeatedly that medicine was the appropriate profession to handle birth because "normal pregnancy and parturition are exceptions and to consider them to be normal physiologic conditions was a fallacy."[19] Childbirth became redefined as a medical rather than a social event, and the roles and care surrounding it were reorganized to suit medical needs.[20]

Once professional dominance was established in the area of childbirth, obstetrics rapidly expanded into the relatively more sophisticated area of gynecology. The great obstetricians of the nineteenth century were invariably gynecologists[21] (and of course all men). Among other effects, this linking of obstetrics and gynecology further reinforced the obstetrical orientation toward pathology.

One of the earliest uses of the developing field of gynecology was the overt social control of women through surgical removal of various of her sexual organs. Surgical removal of the clitoris (clitoridectomy) or less dramatically, its foreskin (circumcision) and removal of the ovaries (oopherectomy or castration) were used to check women's "mental disorders." The first gynecologist to do a clitoridectomy was an Englishman, in 1858.[22] In England, the procedure was harshly criticised, and not repeated by others after the death of the originator in 1860. In America, however, clitoridectomies were done regularly from the late 1960's through till at least 1904[23] and then sporadically until as recently as the late 1940's.[24] The procedure was used to terminate sexual desire or sexual behavior something deemed pathological in women. Circumcisions were done on women of all ages to stop masturbation up until at least 1937.[25]

More widespread than clitoridectomies or circumcisions were oopherectomies for psychological "disorders". Interestingly the female gonads were removed not when women were "too female" — i.e., too passive or dependent, but when women were too masculine—assertive, aggressive, "unruly." Oopherectomies for "psychiatric" reasons were done in America between 1872 and 1946.[26] (By the 1940's perfrontal lobotomies were gaining acceptance as psychosurgery.)

The developing medical control of women was not limited to extreme cures for psychiatric problems. The physical health and stability of even the most well-adjusted, lady-like women was questioned. Simply by virtue of gender, women were (and are) subject to illness labeling.

One explanation for women's vulnerability to illness labeling lies in the functionalist approach to the sociology of health. Talcott Parsons has pointed out that it is a functional requirement of any social system that there be a basic level of health of its members.[27] Any definition of illness that is too lenient would disqualify too many people from fulfilling their functions and would impose severe strains on the social system. System changes, such as war, can make changes in standards of health and illness generally set for members. This works on an individual level as well, standards of health and illness being related to social demands, a mild headache will excuse a student from attending class, but not from taking final exams. A logical extension of this is that the less valued a person or group's contribution to society, the more easily they are labeled ill.

Women are not always seen as functional members of society, as people doing important

things. This has historically and cross—culturally been especially true of the women of the upper classes in patriarchal societies, where it is a mark of status for a man to be able to afford to keep a wife who is not performing any useful function. A clear, if horrifying example of this is the traditional Chinese practice of foot-binding. By crippling girls, men were able to show that they could afford to have wives and daughters who do nothing. It is a particularly disturbing example of conspicuous consumption. But we do not have to turn to faraway places to see women defined as useless. In Ehrenreich and English's historical analysis of the woman patient *Complaints and Disorders*, they speak of the late nineteenth and early twentieth century "lady of leisure." "She was the social ornament that proved a man's success; her idleness, her delicacy, her childlike ignorance of 'reality' gave a man the 'class' that money alone could not provide."[28]

The practice of creating physical deformity in women can be seen in our history as well. A woman researcher who studied menstrual problems among college women between 1890 and 1920 found that women in the earlier period probably were somewhat incapacitated by menstruation, just as the gynecologists of the day were claiming. However, she did not attribute the menstrual problems to women's "inherent disabilities" or "overgrowth of the intellect" as did the male physicians. She related it to dress styles. Women in the 1890's carried some fifteen pounds of skirts and petticoats, hanging from a tightly corseted waist. As skirts got lighter and waists were allowed to be larger, menstruation ceased to be the problem it had been.[29] In the interest of science, women might try the experiment of buckling themselves into a painfully small belt and hanging a fifteen pound weight from it. One might expect weakness, fatigue, shortness of breath, even fainting: all the physical symptoms of women's "inherent" disability. And consider further the effects of bleeding as a treatment for the problem.

It follows from Parson's analysis that in addition to actually creating physical disability (the bound feet of the Chinese, the deforming corsetry of our own history), women were more easily *defined* as sick when they were not seen as functional social members. At the same time in our history that the upper class women were "delicate", "sickly" and "frail," the working class women were well enough to perform the physical labor of housework, both their own and the upper classes as well as to work in the factories and fields. Because "...however sick or tired working class women might have been, they certainly did not have the time or money to support a cult of invalidism. Employers gave no time off for pregnancy or recovery from childbirth, much less for menstrual periods, though the wives of these same employers often retired to bed on all these occasions."[30] The working class women were seen as strong and healthy, and for them, pregnancy, menstruation, and menopause were not allowed to be incapacitating.

These two themes: the treatment of the body as a machine, and the lesser functional importance assigned to women, still account for much of the medical treatment of women.

Contemporary physicians do not usually speak of the normal female reproductive function as diseases. The exception, to be discussed below, is menopause. The other specifically female reproductive functions—menstruation, pregnancy, childbirth, and lactation—are regularly asserted in medical texts to be normal and healthy phenomena. However, these statements are made within the context of teaching the medical "management," "care," "supervision," and "treatment" of each of these "conditions."

Understood in limited mechanical terms, each of these normal female conditions or happenings is a complication, stress on an otherwise normal system. Medicine has fared no better than any other discipline in arriving at a working model of women that does not take men as the comparative norm.

For example, while menstruation is no longer viewed as a disease, it is seen as a complication in the female system, contrasted to the reputed biologic stability of the supposedly noncycling male.[31] As recently as 1961 the American Journal of Obstetrics and Gynecology was still referring to women's "inherent disabilities" in explanations of menstruation:

> Women are known to suffer at least some inconvenience during certain phases of the reproductive cycle, and often with considerable mental and physical distress. Woman's awareness of her inherent disabilities is thought to create added mental and in turn physical changes in the total body response, and there result problems that concern the physician who must deal with them.[32]

Research on contraception displays the same mechanistic biases. The claim has been made that contraceptive research has concentrated on the female rather than the male because of the sheer number of potentially vulnerable links in the female chain of reproductive events.[33] Reproduction is

"Reproduction is dealt with not as a complicated organic process, but as a series of discrete points, like stations on an assembly line, with more for female than for male".

clearly a more complicated process for the female than the male. While we might claim that it is safer to intefrere in a simpler process, medicine has tended to view the number of points in the female reproductive process as distinct entities. Reproduction is dealt with not as a complicated organic process but as a series of discrete points, like stations on an assembly line, with more for female than for male.

The alternative to taking the female system as a complication of the "basic" or "simpler" male system is of course to take female as the working norm. In this approach, a pregnant woman is compared only to pregnant women, a lactating breast compared only to other lactating breasts. Pregnancy, lactation, etc. are accepted not only as nominally healthy variations, but as truly normal states. To take the example of pregnancy, women *are* pregnant; it's not something they "have" or "catch" or even "contain". Pregnancy involves physical change; they are not, as medical texts frequently call them, "symptoms" of pregnancy. Pregnancy is not a disease; its changes are no more "symptoms" than the growth spurt or development of pubic hair are "symptomatic" of puberty. There may be diseases or complications of pregnancy, but the pregnancy itself is neither disease nor complication.

In contrast, the working model of pregnancy that medicine has arrived at is that a pregnant woman is a woman with an insulated parasitic capsule growing inside. The pregnancy, while physically located within the woman, is still seen as "external" to her, not a part of her. The capsule within has been seen as virtually omniscient and omnipotent, reaching out and taking what it needs from the mother-host, at her expense if necessary while protected from all that is bad or harmful.

The pregnancy, in this medical model, is almost entirely a mechanical event in the mother. She differs from the nonpregnant only in the presence of this thing growing inside her. Difference other than the mechanical are accordingly seen as symptoms to be treated, so that the woman can be kept as "normal" as possible through the "stress" of the pregnancy. Pregnancy is not necessarily inherently unhealthy in this model, but it is frequently associated with changes other than the growth of the uterus and its contents, and these changes are seen as unhealthy. For example, haemoglobin (iron) is lower in pregnant women than nonpregnant, making pregnant women appear (by non-pregnant standards) anemic. They are then treated for this anemia with iron supplements. Water retention, oedema, is greater in pregnant women than non-pregnant, and they are treated with limits placed on their salt intake and with diuretics. Pregnant women tend to gain weight over that accounted for by the fetus, placenta and amniotic fluid. They are treated for this weight gain with strict diets, sometimes even with "diet pills". And knowing that these changes are likely to occur in pregnant women, American doctors have tried to treat all pregnant women with iron supplements, limits on salt and calorie intake, and many with diuretics, in the name of "preventive medicine".

What is particularly important to note is that these "treatments" of entirely normal phenomena are frequently not perceived by the medical profession as interventions or disruptions. Rather, the physician sees himself as assisting nature, restoring the woman to normality. Bogden, in her study of the development of obstetrics, reports that an 1800's non-interventionist physician, as opposed to a "regular" physician, would give a laboring woman a catheter, some castor oil or milk of magnesia, bleed her a pint or so, administer ergot, use poultices to blister her, and "Any of these therapies would be administered in the interests of setting the parturient up for an easier, less painful labor and delivery, while still holding to the belief that the physician was letting nature take its course." [34] Wertz says that currently medicine has redefined "natural childbirth" in response to consumer demand for it to include any of the following techniques : spinal or epidural anesthesia, inhalation anesthesia in the second stage of labor, forceps, epesiotomy, induced labor. [35] Each of these techniques increases the risk of childbirth for mothers and babies. [36] Under the title "Normal Delivery," an obstetric teaching film purports to show "the use of various drugs and procedures used to facilitate normal delivery." Another "Normal Delivery" film is "a demonstration of a normal, spontaneous delivery: including a paracervical block, epesiotomy . . . ."

The use of estrogens provides an even better example of how medicine views the body as a machine that can be "run" or "managed" without being changed. Estrogens are female hormones; in medicine they are seen as femininty in a jar. In the widely selling *Feminin Forever*, Dr. Robert A. Wilson,

"The model of the body as a machine, which can be regulated, controlled, and "managed" by medical treatments, is not working. "Femininity" or physical "femaleness" is not something that comes in a jar and can be manipulated".

pushing "estrogen replacement the rapy" for all menopausal women, calls estrogen levels as detected by examination of cells from the vagina, a woman's "femininity index." As estrogen levels naturally drop off after menopause a women is according to Dr. Wilson, losing her "femininity. Interestingly, estrogen levels are also quite low while a woman is breast-feeding, something not usually socially linked to a "loss of femininity."

Menopause remains the one normal female process that is so overtly referred to as a "disease', in the medical literature. To some physicians, menopause is a *deficiency disease*, and the use of estrogen restoring the woman to her "normal" condition. Here we must reconsider the question of women's functional importance in the social system. Middle-aged housewives have been called the last of the "lady of leisure," having outlived their social usefulness as wife-mothers, and having been allowed no alternatives. While oopherectomies and clitorectomies are no longer being done on upper class women as they were a hundred years ago, to "cure" all kinds of dubious "ills," older women are having hysterectomies, (surgical removal of the uterus) at alarming rates. [31] Much more typical of modern medicine, however, is the use of chemical rather than surgical "therapy." Because the social changes and demands for readjustment of middle age roughly coincide with the time of menopause, menopause becomes the "illness" for which women can be treated.

Estrogens have been used in virtually every stage of the female reproductive cycle, and usually with the argument that they return the woman to normal. or are a "natural" treatment. Estrogens are used in puberty, to keep girls from getting "unnaturally" tall; to treat painful menstruation; as contraception, supposedly mimicing pregnancy; as a chemical abortion in the "morning after" pill; to replace supposedly missing hormones and thus to prevent miscarriages; to dry up milk and return women to "normal" nonlactating state and in menopause to return women to the "normal" cycling state. For all the claims of normality and "natural" treatment, at this writing approximately half of these uses of estrogens have been shown to cause cancer. The use of estrogens in pregnancy was the first to be proven carcinogenic: daughters of women who had taken estrogens (notably DES, a particular synthetic estrogen) are at risk for the development of a rare cancer of the vagina [30] The sequential birth control pill was taken off the market as the danger of cancer of the lining of the uterus (endometrial cancer) become known, and similarly estrogens taken in menopause have been shown to increase the risk of endometrial cancer by as much as fourteen times after seven years of use. [31]

The model of the body as a machine, which can be regulated, controlled, and "managed" by medical treatments, is not working. "Femininity" or physical "femaleness" is not something that comes in a jar and can be manipulated.

Nor are women accepting the relegation to secondary functional importance, as wives and mothers of men. In rejecting the viewpoint that we bear men's children for them, we are reclaiming our bodies. When pregnancy is seen not as the presence of a (man's) fetus in a woman, but as a condition of the woman herself, attitudes toward contraception, infertility, abortion, and childbirth all change. When pregnancy is perceived as a condition of the woman then abortion, for example, is primarily a response to that condition.

The women's health movement has grown as an important part of the women's liberation movement. In some of its work, the movement has been geared toward consumerism within medicine, seeking better medical care and a wide range of services for women. While better trained, more knowledgeable and more *humane* physicians are a high priority, what the self-help and lay midwifery groups are doing goes much deeper than that. I believe that these women are reconstructing the pre-obstetrics and gynecology model of women's health. They are redefining women's health in fundamentally women's terms.

Women's self-help groups and clinics are teaching women how to examine their own bodies, not in the never-ending search for pathology in which physicians are trained, but to learn more about health. Medical technology and physicians are clearly useful in treating illness, but do we really want physicians to be "treating" health? It is entirely possible for a woman to fit herself for a diaphragm, do a pap smear and a breast examination (all with help and instruction if she needs it) and never adopt the "patient" role. It is also possible for a woman to go through a pregnancy and birth her

baby with good, knowledgeable, *caring* help, but without becoming a "patient" under the "supervision" of a physician.

Redefining normality within the context of the female. reproductive sytstem will take time. We have all been imbued with the medical model of women's bodies and health and it is hard to work past that. Redefining women in women's terms is not a problem unique to health. it is an esential feminist issue.

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Books in Print

Rational Drug Therapy : The Arogya Dakshata Mandal, 1913 Sadashiv Peth, Pune 411 030 is to publish in August, 1984 a booklet highlighting recent advances in the treatment of common dieases, rational approach to treatment, side effects of drugs, clinical diagnosis of common diseases etc. This is meant to act as a physician's desk reference for day-to-day practice. For further information write to Dr. A R. Patwardhan at the above address.

The Mandal also publishes a monthly information sheet the *Pune Journal of Continuing Health Education which* is designed to present scientific information and opinion to the medical profession to stimulate thought and further invistigation. Subscription rate : Rs. 10 a year.

Book News

Our Jobs, Our Health : A woman's guide to occupational health and safety, Boston Women's Health Book Collective, Boston USA: The book shows how to recognise hazards in the work place It provides basic information about toxic chemical stress, job design, cancer and hazard control. The section of reproductive issues in the work place describes how workplace conditions can damage the reproductive health of both men and women. Finally it discusses legal rights and some strategies that can be used to win health and safety improvements in the work place. Available for reference at the Centre for Education and Documentation, 3 Suleman Chambers, 4 Battery Street, Behind Regal Cinema, Bombay 400 039

"WOMEN'S HEALTH IS WOMEN'S CONCERN"
A Brief Overview of Health Issues in the Women's Movement

nirmala sathe

Women's health status is closely linked to their social status. Even though the 'ideal' woman is supposed to look weak and delicate, she has to be able to perform all the domestic tasks necessary for the sustenance of the family. Her major role in society is that of a reproductive machine. The feminist movement aims at uniting women to raise their voices against the oppression of these stereotypes. Logically then, health issues concerning women must form an integral part of the women's movement. Why has the movement been generally apathetic to health issues? The author, a feminist-activist, briefly reviews the sporadic activities concerning women's health and strongly urges that women's health issues should preferably be taken up by women's groups.

All of us have a right to good health. The right to health means not only the right to be free from disease, but also to enjoy physical, mental and emotional well-being. Health cannot be separated from political, cultural or economic systems in which we are living. It cannot be isolated from the roles we are playing and the status we have in society.

My grandmother often used to tell us "Beti, a woman cannot afford sickness. If she does fall sick then she can't complain, but has to bear her illness silently; for who will tolerate a sick-slave?". Many of us have experienced this truth in our own lives or through those of our mothers, grandmothers.

Although it is true that in economically poor classes even the men do not get proper medical aid in sickness, it is the women who are the more neglected group. In fact, even among the economically better off, where it is possible for women to afford good care and proper food, they are found to be weak, or rather not as healthy as they could be. This is because of cultural influences. According to the ideal image of women perpetuated in society, a woman is supposed to be weak and delicate. A 'strong' woman thus becomes, in a sense, the victim of cultural norms. Women are traditionally supposed to eat only after the rest of the family members have eaten and then only what has been left over, even though in poor families it is hardly ever sufficient to keep body and soul together. It will not be an exaggeration to say that she ever gets sufficient rest only on her deathbed.

Menstruation, pregnancy, childbirth, breast-feeding, menopause, all these are considered to be 'women's issues'. In a way society at large has nothing to do with them, because women are not equal members of the society and therefore, complaints about these are treated as, 'psychological' or as 'women's sickness' and are not given the serious consideration they deserve. Doctors and medical professionals produced in this male-dominated society are taught to either close their eyes and ears to such complaints or to immediately connect all women's complaints to their reproductive system. A woman is looked upon as a mere reproductive machine rather than as a human being. Politically also, it is the world-wide phenomenon, that all drives for population control or population increase, breast-feeding or the baby foods campaign have treated women as reproductive machines. Nowhere have these issues been treated in a manner where women's 'health' is given central importance.

In order to understand the location of women's health-issues in the context of feminist movements, it is necessary to broadly define feminism and the feminist movement. Feminism is a new concept in India, a concept not yet well-accepted or understood by the people at large. Broadly speaking one can say that feminism deals with all the aspects of a woman's life and her role in society -- male dominated society. Feminists are interested in changing a hierarchical society and in creating a society where everybody is equal. In today's society, women are at the bottom of the hierarchical structure. In any class, caste or race, whatever their status, women among them are always at the bottom.

No doubt women of the upper classes have more facilities and opportunities than the lower class males, but in their own class they are the least important. Not only that, but because they are women any man from any class can express his superiority as a male member of the patriarchal society. One example is rape.

So the main role of the feminist movement is to unite women to raise their voices against their oppression in a male-dominated society. In her family life, work place, place of education and in all

"Irrespective of educational status, caste or class background, women share the same (health) experience and feelings of inferiority because of their physiology."

the aspects of her life, women have a lower status than men. In our health systems too, the status of women is only as a reproductive machine.

In India, we cannot say that there exists any mass feminist movement. But at the same time it is a fact that there are several women's groups -- feminist groups--who are involved in activities in various areas of women's oppression such as rape, wife-beating, legal reforms and so on. Their activities range from cultural activities to agitational morchas and 'helping' individual women in distress to fight for their rights and the common cause.

But none of these groups have as yet taken 'health' as the prime issue and worked on it. Many of them have touched on one or the other aspect of the issue at some point of time. But there has been no consistency shown regarding the health issues of women. This is because of various reasons which are rooted in our outlook (such as the cultural and social stigma attached to the discussion of women's problems about their bodies.) Many feminists have inhibitions which do not allow them to freely discuss these issues among themselves.

Some groups have made an attempt to raise their voices against oppression through medical systems. For instance, the Women's Centre in Bombay held a meeting with other feminist groups to discuss the effects of "amniocentesis" as a sex-determination test, which gave rise to demands and concerted action in Bombay. Two of these demands were : (1) Amniocentesis facilities should be allowed only in research instituions with proper machinery and control; (2) The government and the medical profession should be brought under pressure to abolish pre-natal sex-determination. It was pointed out that unless and until major social upheaval takes place regarding the status of women in society, female babies will continue to be murdered. *(See article on Amniocentesis.)*

Recently, another meeting was held by the Women's Centre to discuss the issue of Depo-provera, the controversial injectable contraceptive. Womens magazines - feminist ones such as *Baija* (in Marathi) and *Manushi* (in Hindi and English) have given importance to the health and reproductive activity of women by bringing out special issues on the subject. Baija's special issue was on women and health in which the whole proplem had been discussed from the feminist point of view.

Organisations which are working in health such the People's Science Movement, Medico Friend Circle, (MFC) have also touched on the women's health problems. The Lok Vidnyan Sanghatana, Maharashtra, had prepared an exhibition on women and health which received a tremendous response from various women's groups as well as others working among the toiling masses. This was the first attempt made to discuss the woman's body and her health, reproduction and social biases about it. The exhibition was taken to many villages and it was a thrilling experience to find that women are able to relate to one another while discussing their experiences about their bodies from menstruation to menopause. They were all encouraged by the fact that as women, irrespective of educational status, caste or class background, they have gone through the same experiences and feelings of inferiority because of their physiology. The explanations we had received were shrouded in myth and the actual scientific explanation of the various functions that a woman's body has to perform had been denied us.

The exhibition criticises the social outlook and stigmas attached to the female sex in society and superstitions about women's bodies and child bearing especially with regard to producing male children. Mainly the posters about sex-determination and about fertility, entitled "Who is responsible for not getting a child ?" have made a great impact and have very positively put forward the view that a woman is not wholly, nor mainly responsible. The exhibition emphatically argues that a woman is not merely a reproductive machine. In adivasi areas as well as urban areas like Bombay, Nasik, Pune, Miraj the exhibition attracted large numbers of women.

This exhibition was shown *by* women and *only to* women. It is only in this situation that women can become vocal about their problems. It is very important to realise that women can relate only to other women when it comes to health and their bodies because only women can truly understand one another's problems. I feel very strongly that **women's organisation mainly should handle the issue of women and health, as male activists, although sincerely interested in understanding the problems, are not able to evolve a movement or even a group around the subject.**

"Women's groups should take prime responsibility about women's health issues. Other organisations in health can help in a number of ways....."

At Anand the MFC held an annual meeting in 1983 where many women were called from various groups which were interested in women and health. Majority of the women, who were educated and were working in one or other organisation found it difficult to discuss their problems in the meeting when men were present as even with the desire and sincerity to understand the problems, male participants were unable to understand the intense emotional severity of the problem. At the session where only women were present, there was a live discussion and a free exchange of experiences.

Here I do not intend to devalue the male-activists, who are really helping to raise the voice of women against the medical oppression of women. MFC activists have brought out various articles and debates on the problem. Peoples Science Movement groups have made attempts to make people aware through health exhibitions, the posters and pamphlets on Anaemia. In both the organisations, it is mainly women activists with the help of male activists who have worked very hard for it.

We can conclude that women's organisations should take prime responsibility about the women's health issues, and other organisations in the health area can help them in a number of ways. With this mutual co-operation, one can hope for a strong women's health movement.

The Women's Centre in Bombay is planning to start some health activities. They will be mainly (1) Educational - making women aware of their body and its functions, to help them to tackle the social prejudices and superstitions and to create a healthy outlook about themselves; (2) Preventive ; and (3) Curative - With the help of sympathetic medical proffesionals to help women in preventing and curing health disorders.

Most of us have very little control over the health care system, very little say in the decisions as to what kind of health care is available to us. Women perhaps, are most affected by the health care system or the lack of it. In all phases of our lives, we face difficulties and become the victims of health care system. As potential mothers, as mothers, as housewives, as consumers in order to keep ourselves in accordance with the beauty norms of the society, women are either neglected or misguided by the health care system. To raise our voices against this, women's groups should start (and are actually starting) to organise around health issues. Only this can lead to a strong and united fight against all sorts of oppression in male-dominated society.

RESPONSE

Why Don't We Organise

Sir : It is a happy development that a forum for debating and defending a radical perspective on health care has come into existence. If the first issue is any guide I have no doubt that the forum is going to be an instrument of immense value to socialist activism in the health sphere. Wish you all success !

May I share an idea here regarding what I think is an essential requisite for continuity and accountability in this effort. If the persons interested organise themselves into a society (maybe, Indian society for Socialist Health Care - ISSHC) it gives us an identity, a shared cause for loyalty, and, no less important, a firm ground from which to influence, to bargain, and to relate to other organisations, agencies and governments. Further if the society has at least one Annual Conference it will provide us the much needed person-to-person interaction for enhancing enthusiasm and exchanging ideas.

I would suggest two streams of membership :

Members—All persons qualified and directly engaged in health care, irrespective of their position in the health personnel hierarchy. This includes health visitors, nurses, auxiliary health workers, dentists, pharmacists, physicians, surgeons etc. The other stream of membership will be that of *Associate Members* for all those interested in socialist health care but not directly engaged in health care. This includes teachers, lawyers, politicians, engineers etc., practically anybody from the public.

Dr. N. Janakiramaiah

Asst. Professor of Psychiatry, National Institute of Mental Health & Neuro Sciences, Bangalore 560029

WORKING EDITOR'S REPLY : We share your viewpoint that radical activists working in the field of health or interested in it, need person-to-person interaction for enhancing enthusiasm and exchanging ideas.

But we feel that it would be a terrible mistake to form a separate organisation of socialists interested in health issues. That will be the best way to isolate socialists from the wider movement on health issues. In fact, not marxists but other radicals were the people who gave meaning to radical medical practice while some socialists have only very recently started questioning the official communist view of health i.e. (i) merely more equitable distribution of medical care and (ii) the content of medicine and medical practice as being value free. Therefore no comprehensive marxist understanding of health and health care exists. Genuine (undogmatic and scientific) marxist theory and practice in health can develop only as an outcome of our interaction and work with wider stratas of radical activists.

Fortunately in India, a broad radical thought current does exist — the Medico Friend Circle, and many of us are part of it. Many of us have been and are, actively involved in its activities including its journal the MFC bulletin. The idea of a journal like SHR came from these MFC members not with a sectarian motivation of providing any 'alternative' to the MFC and its bulletin, but to help focus and sharpen the debate amongst the radicals working in health and in turn, widen the basis of radical medical work and of marxist political praxis.

The MFC is a decade old and has helped to radicalise many health workers. We feel it is still relevant and all radical activists experiencing a need for such organisation should join the MFC and be part of the process of radicalisation started by it.

For further information about MFC contact :
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326, Vth Main, Ist Block
Koramangala, Bangalore-560 034

Protest Against Marxist Male Chauvinism

Dear comrades : I am writing to lodge a strong protest against Dhruv Mankad's reference to our joint article (Health Care in a Revolutionary Framework : Possibilities for an Alternative Praxis, SHR 11) as 'Binayak Sen's article' in his editorial perspective (page 3, SHR 1 : 1). *(Contd. on page 71)*

the fear of society. It is true that feminists all over the world have always demanded "the right of women to control their own bodies/fertility and choose whether or not to have child/children and have facilities for free, legal and safer abortions." While understanding these issues in the third world context we must see it in the background of the role of imperialism and racism that aims at the control of "coloured populations". Thus : "It is all too easy for population control advocates to heartily endorse women's rights at the same time diverting attention from the real causes of the population problem. Lack of food, economic security, clean drinking water and safe clinical facilities, have led to a situation where a woman has to have 6.2 children to have at least one surviving male child. These are the roots of the population problem, not merely the 'desire to have a male child' " (Chhachhi, and Sathyamala, 1983).

Meetings called by Women's Centre (Bombay) and various women's organisations in Delhi, discussed this problem at length and three positions emerged. 1. Total ban on amniocentesis tests; 2. Support to amniocentesis tests; and 3. Amniocentesis tests to be allowed under strict governmental control and only for detecting genetic abnormalities.

Most of the women's organisations feel that the 3rd position is most advantageous even if one accepts the fact that illegally, the tests will be conducted by unscrupulous people. To avoid this, women's organisations and other socially conscious groups will have to act as watch dogs.

The issue of amniocentesis once again shatters the myth of neutrality of science and technology. Hence, the necessity of linking science technology with socio-economic and cultural reality. Class, racist and sexist biases of the ruling elites have crossed all boundaries of human dignity and decency by making savage use of science. Even in China after 10 years of 'cultural revolution' and 'socialist thinking' sex determination test for female extermination are largely prevalent after the government's campaign for one-child-family began (Sunday, 1983). Chinese couples willy-nilly accept a system of one-child-family but the child has to be a male. This shows how adaptive the system of patriarchy, male supremacy is. It can establish and strengthen its roots in all kinds of social structures, pre-capitalist and even post-capitalists, if not challenged consistently.

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(Contd. from page 68)

I am unable to understand the thought process behind the omission of my name. Does Dhruv Mankad assume that because I am married to Binayak Sen, my contribution to a joint production is subsistence (= negligible = zero)? I would be grateful if he could clarify what lies behind this e.g. of marxist male chauvinism - for we can only begin to advance towards correct action from correct analysis.

May I congratulate you on an excellently produced first issue?

Ilina Sen
Dalli Rajhara

DHRUV MANKAD REPLIES :

I tender my sincere apology to Ilina Sen for not mentioning her name in the editorial perspective while referring to a joint article by her and Binayak Sen. The error occurred due to the fact that before writing the perspective, I had not seen the actual article referred to above. I knew about the contents only from discussions with Binayak at Calcutta and later with Anant Phadke, Manisha Gupte Awasthi, Padma Prakash, Amar Jesani at Pune. Till I saw the article in print in SHR, I was under the honest impression that it was indeed written by Binayak only. This is what lies behind " this e.g. of Marxist Male chauvinism".

Despite this apology, I do wish to state that Ilina Sen's 'protest' is petty and unprincipled. She has thrown wild allegations 'of Marxist male chauvinism' on my part without first giving me a chance to explain. This kind of immature reasoning based on mere presumptions - that too, incorrect ones, would lead us neither to correct analysis nor to correct action but only to bickerings and quarrels.

I am restraining myself in my reply with the intention not to extend this issue any further. I hope in future, such errors are avoided and if and when they do occur the reactions thereto are more responsible.

WORKING EDITORS' REPLY : The omission was our fault rather than Dhruv's, because we were responsible for checking the final proofs and were of course aware of the joint authorship. We regret the inadvertant slip.

AMNIOCENTESIS AND FEMALE FOETICIDE
Misuse of Medical Technology

vibhuti patel

Murder of the female child is not new in India. This practice still continues, only the methods of committing such murder have changed. Such practices reflect society's attitude towards the female sex. The patriarchal male-dominated system has evolved modern methods to perpetuate women's oppression in today's socio-economic system. The author analyses the reasons for the popularity of one such modern medical method, amniocentesis, as a pre-natal sex determination test and argues that it is meant to exterminate women and perpetuate their oppression; she also emphasises the need to fight sexist abuse of this medical technique.

Amniocentesis, a scientific technique that was supposed to be used mainly to detect genetic deformities has become very popular in India for detection of the sex of a foetus. For that 15-20 ml of amniotic fluid is taken from the womb by pricking foetus membrane with the help of a special kind of needle. After seperating foetal cell from the amniotic fluid, a chromosomal analysis is conducted on it. This test helps in detecting several genetic disorders like mongolism, defects of neurotube in the foetus, retarded muscular growth, 'Rh' incompatibility, haemophilia and other types of abnormal babies. This test should be conducted on women above 40 years because there are higher chances of mongoloid children produced by such women. In some cases, a sex determination test is required to identify sex-specific deformities such as haemophilia, retarded muscular growth which mainly affect males.

Limitations of Amniocentesis

This test can give 95-97% accurate results. Thus it is not totally reliable. In Harkisandas Hospital and Pearl Centre, Bombay, where this test is conducted on thousands of women, it was noted that the test had affected foetus adversely to 1% of the total number of cases. Thus the test may lead to spontaneous abortions or premature delivery, dislocation of the hips, respiratory complications, needle puncture marks on the baby (Chhachhi & Sathyamala, 1983).

The test is conducted after completion of 16 weeks of pregnancy and within a week the findings are available. In our country, the facility of amniocentesis is available only in big cities like Bombay, Delhi, Chandigarh etc., hence patients from villages and small towns get the results by post; that takes one more week. By the time they decide to abort the foetus, it is over 18 weeks old. Abortion at such a late stage is quite harmful for the mother.

Popularity of the Test

The amniocentesis tests became popular in the last three years though earlier they were conducted in the government hospitals on an experimental basis. Now these tests are conducted for sex determination and thereafter extermination of female foetus through abortions, in private clinics and hospitals and government hospitals in many cities of India like Bombay, Delhi, Amritsar, Chandigarh, Baroda, Ahmedabad, Kanpur, Meerut etc. This perverse use of modern technology is encouraged and boosted by money-minded private practitioners who are out to make a woman, "a male-child-producing machine". As per the most conservative estimate made by a research team of Women's Centre, Bombay, based on their survey of six hospitals and clinics, in Bombay alone 10 women per day undergo test. This survey also revealed the hypocrisy of "non-violent", "vegetarian", "anti-abortion" management of the city's reputed hospital - Harkisandas Hospital, that conducts ante-natal sex-determination test. Their handout declares the test as "humane and beneficial". The hospital has out-patient facilities and there is such a great rush for the test that one has to book one month in advance. As the management does not support abortion, they recommend women to various other hospitals and clinics and ask them to bring back the female foetuses after abortion to them for further "RESEARCH". (Abraham & Sonal, 1983).

In other countries, this test is very expensive and is under strict governmental control, while in our country this test can be done at between Rs. 80 to Rs. 500, Hence not only upper class people, but even working class people can easily avail this facility. A survey of several slums in Bombay showed that many women had undergone the test and after knowing that the sex of foetus was female, had undergone abortion in the 18th or 19th week of pregnancy. Their argument was it is better to spend Rs. 80 or even Rs 800 now than give birth to a female baby and spend thousands of rupees for her marriage when she grows up.

Controversy Around Amniocentesis

Three years back a controversy around Amniocentesis started as a result of several investigative

reports published in popular magazines like *India Today*, *Eve's Weekly*, *Sunday* and other regional -language journals. One estimate that shocked every-body [illegible] academicians and activists was : Between 1978 and 1983, around 78000 female foetuses were aborted after sex determination test in our country. (TOI June, 1982).

The government and private practitioners involved in this lucrative trade, justify the sex determination test as measure for population control. Women have always been worst target for family planning policies. Harmful effects of pregnancy test, contraceptive pills, anti-pregnancy injections, camps for mass-sterilisation of women with their unhygenic atmosphere are always overlooked by the enthusiasts of family planning policy. Most of population control research is conducted on women without giving any consideration to the harm caused by the research to the women concerned. Advocates for population control will continue cashing in on socio-cultural values that treat the birth of a daughter in the family as a great calamity and perpetuate modern method of massacaring female foetuses on a massive scale.

India has a legacy of killing female children *(dudhapiti)* by putting opium on the mother's nipple or by putting the afterbirth over the child's face or by illtreating daughters. (Clark, 1983). These days also female members of the family get inferior treatment as far as food, medication and education is concerned (Research unit on Women's Studies, 1981). When they grow up, there is further harassment for dowry. "Then, is it not desirable that she dies rather than be illtreated?" ask many social scientists. In Dharma Kumar's (EPW, June, 1983) words : "Is it really better to be born and 'left to die' than to be killed as foetus? Does the birth of lakhs or even millions of unwanted girls improve the status of women?".

But what can be the long-term implications if such a trend continues ? Will it not aggravate the already disturbed sex-ratio ? There has been continuous decline in female/male sex-ratio between 1901 and 1971. Between 1971 and 1981 there was slight increase, but it still continues to be adverse for women.

Demographic Profile of India (in millions) 1901-1981

Year	Total Population	Male Population	Female Population	Total No. of women per 1000 men i e. sex ratio.
1901	238	121	117	972
1911	252	128	124	964
1921	251	128	123	955
1931	279	143	136	950
1941	319	164	155	945
1951	361	186	175	946
1961	439	226	213	941
[illegible]	[illegible]	[illegible]	264	930
1981	684	353	331	935

Source : *Census Report*, 1981, Series 1, Paper 1.

Here too, economists have their reply ready i.e. law of demand and supply. If supply of women is reduce, their status will be enhanced. Scarcity of women will increase their value (Bardhan, 1982). According to this logic, women will not be burnt alive because of dowry problem as they will not be easily replaceable commodity. But here the economists forget the socio-cultural milieu in which women have to live. The society that treats a woman as a mere sex-object will not treat women in a more 'humane' way if they are scarce in supply. On the contrary there will be increased incidences of rape, abduction and forced polyandry. In U. P, Haryana, Rajasthan and Punjab among certain communities, sex-ratio is extremely adverse for women. There a wife is shared by 'a set of brothers' (or some times even by patrilateral parallel cousins) (Oube, 1983).

To think that it is better to kill female foetuses than giving birth to unwanted female children, is very fatalistic. By this logic it is better to kill the poor rather than let them suffer poverty and deprivation. How horrifying !

Another argument is that in cases where women have one or more daughters, they should be allowed to have amniocentesis done so that they can plan a 'balanced family' by having sons. Instead of going on producing female children in the hope of getting a male child, it is better for the family's and the country's welfare that they abort the female foetus and have small and balanced families with daughters and sons. This concept of 'balanced family' also has a sexist bias. Would a couple with one or more sons undergo amniocentesis to get rid of male foetus and have a daughter for balancing their family ? No, never !

This frenzy of having a 'balanced family' !-At what cost ? How many abortions (between 16 to 18 weeks) can a woman bear without jeopardising her health ?

Time and again it is stated that women themselves enthusiastically go for the test out of their free will. It is a question of women's own choice. But are these choices made in a social vaccum ? These women are socially conditioned to accept that unless they produce one or more male child they have no social worth. They can be harassed, taunted, even deserted by their husbands and in-laws if they fail to do so. Thus their 'choices' depend on

the fear of society. It is true that feminists all over the world have always demanded "the right of women to control their own bodies/fertility and choose whether or not to have child/children and have facilities for free, legal and safer abortions." While understanding these issues in the third world context we must see it in the background of the role of imperialism and racism that aims at the control of "coloured populations". Thus : "It is all too easy for population control advocates to heartily endorse women's rights at the same time diverting attention from the real causes of the population problem. Lack of food, economic security, clean drinking water and safe clinical facilities, have led to a situation where a woman has to have 6.2 children to have at least one surviving male child. These are the roots of the population problem, not merely the 'desire to have a male child' " (Chhachhi, and Sathyamala, 1983).

Meetings called by Women's Centre (Bombay) and various women's organisations in Delhi, discussed this problem at length and three positions emerged. 1. Total ban on amniocentesis tests; 2. Support to amniocentesis tests; and 3. Amniocentesis tests to be allowed under strict governmental control and only for detecting genetic abnormalities.

Most of the women's organisations feel that the 3rd position is most advantageous even if one accepts the fact that illegally, the tests will be conducted by unscrupulous people. To avoid this, women's organisations and other socially conscious groups will have to act as watch dogs.

The issue of amniocentesis once again shatters the myth of neutrality of science and technology. Hence, the necessity of linking science technology with socio-economic and cultural reality. Class, racist and sexist biases of the ruling elites have crossed all boundaries of human dignity and decency by making savage use of science. Even in China after 10 years of 'cultural revolution' and 'socialist thinking' sex determination test for female extermination are largely prevalent after the government's campaign for one-child-family began (Sunday, 1983). Chinese couples willy-nilly accept a system of one-child-family but the child has to be a male. This shows how adaptive the system of patriarchy, male supremacy is. It can establish and strengthen its roots in all kinds of social structures, pre-capitalist and even post-capitalists, if not challenged consistently.

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(Contd. from page 68)

I am unable to understand the thought process behind the omission of my name. Does Dhruv Mankad assume that because I am married to Binayak Sen, my contribution to a joint production is subsistence (= negligible = zero)? I would be grateful if he could clarify what lies behind this e.g. of marxist male chauvinism - for we can only begin to advance towards correct action from correct analysis.

May I congratulate you on an excellently produced first issue?

Ilina Sen
Dalli Rajhara

DHRUV MANKAD REPLIES :

I tender my sincere apology to Ilina Sen for not mentioning her name in the editorial perspective while referring to a joint article by her and Binayak Sen. The error occurred due to the fact that before writing the perspective, I had not seen the actual article referred to above. I knew about the contents only from discussions with Binayak at Calcutta and later with Anant Phadke, Manisha Gupte Awasthi, Padma Prakash, Amar Jesani at Pune. Till I saw the article in print in SHR, I was under the honest impression that it was indeed written by Binayak only. This is what lies behind " this e.g. of Marxist Male chauvinism".

Despite this apology, I do wish to state that Ilina Sen's 'protest' is petty and unprincipled. She has thrown wild allegations 'of Marxist male chauvinism' on my part without first giving me a chance to explain. This kind of immature reasoning based on mere presumptions - that too, incorrect ones, would lead us neither to correct analysis nor to correct action but only to bickerings and quarrels.

I am restraining myself in my reply with the intention not to extend this issue any further. I hope in future, such errors are avoided and if and when they do occur the reactions thereto are more responsible.

WORKING EDITORS' REPLY : The omission was our fault rather than Dhruv's, because we were responsible for checking the final proofs and were of course aware of the joint authorship. We regret the inadvertant slip.

RURAL ENERGY SITUATION
Consequences for Women's Health

srilatha batliwala

This article examines the interrelationship between women's work, the growing scarcity of energy resources for survival, and its impact on women's health and nutrition. Women contribute 53 per cent of the human energy required for survival tasks. And yet they eat far less than they require. Women's calorific intake is about 100 calories (per woman per day) less than they expend, whereas men show an 800-calorie intake surplus. The article raises some very important questions with regard to women's work, their food intake, access to health care and women's morbidity patterns and examines the energy - health - nutrition syndrone. This is based on a paper presented at the Conference on 'Women and Poverty' in Calcutta, 1983.

Dorland's Medical Dictionary defines the word syndrome as "a combination of symptoms result-from a single cause or so commonly occurring together as to constitute a distinct . . . . . entity". It is hard to find a more apt definition of energy, health and nutrition and their relationship to poverty.

It may be felt that poverty has an impact on the health and nutrition of all the poor, regardless of age and sex. Is there something unique about its impact on women ? Or inversely, do women bear an additional burden - in terms of their health, nutrition, or anything else - in a poverty situation ? This paper attempts to show that they do - and also why strategies for women's health and nutrition need to be emphasised within strategies for general development.

In the field of nutrition, most strategies have been aimed at increasing food intake indirectly or directly (Natarajan, 1974; and NIPCD, 1976: Batliwala, 1978). Women are targets of the latter programmes only during pregnancy and lactation. On the other hand, there has been little or no study of the possible effects of reducing energy expenditure - or to put it simply, reducing the overwhelming drudgery of the poor, and especially of poor women. This is not proposed as an alternative to raising food intake, but as an additional (and possibly critical) facet of improving women's nutrition and health. Such energy saving, as we shall see, is not only a nutritional asset, but may also release a significant amount of women's time.

The greater work load on women has been observed for centuries and rather embarassedly reduced to a sheephish joke by men. But until recently, there was no detailed study of the relative work outputs of women and the nature of such work. In 1981, however, the Application of Science and Technology to Rural Areas (ASTRA) (a cell of the Indian Institute of Science, Bangalore) published the report of their three-year field study of rural energy consumption patterns (ASTRA, 1981). The study was conducted in rural, Karnataka with a sample of six villages comprising 560 households and a population of 3,452.

One of the most significant results of ASTRA's study, was the role of human energy - and specifically women's energy - in the rural energy matrix. Table 1 summarises the findings :

Table 1 : Pattern of Village Energy Supply & Consumption

Source-wise contribution		Sector-wise consumption	
Source	Per cent	Activity	Per cent
Human	7.7	Agriculture	4.3
(Men)	(3.1)	Domestic	88.3
(Women)	(3.8)	Lighting	2.2
(Children)	(0.8)	Transport	0.5
Animal	2.7	Industry	4.7
Firewood	81.6		
Kerosene	2.1		
Electricity	0.6		
Other	5.3		

Source : ASTRA, 1981, "Rural Energy Consumption Patterns - A Field Study", Bangalore, Indian Institute of Science, p. 80.

If we exclude firewood, we find that human beings were the most significant energy contributors - even more than animals. Moreover, if we disaggregate human energy, men, women and children contribute 31%, 53% and 16% of human energy, respectively. The ASTRA study also showed that most human energy was spent not so much on economically productive activities but on survival tasks such as gathering firewood, fetching water, and cooking.

What is the role of women in these activities, and what is the magnitude of the burden on them

Table 2 :

Time and calorie expenditure on domestic and agricultural activities and their calorie cost (for man, woman and child)

Activity	I Hours/day M	W	C	II Calorie cost (cals/minute) M	W	C	III Calorie/day M	W	C
(A) Domestic									
(1) Gathering firewood	0.33	0.41	0.24				115	122	74
(a) Walking to source				5.2	4.4*	4.6*			
(b) Return trip with load				6.4	5.5*	5.7*			
(2) Fetching water	0.02	0.78	0.13				7	232	40
(a) Walking to source				5.2	4.4*	4.6*			
(b) Return trip with load				6.4	5.5*	5.7*			
(3) Cooking	0.02	2.28	0.18	2.5*	2.1*	2.2*	3	287	24
(4) Carrying food/walking to farm	1.00	1.14		5.2	4.4*	4.6*	312	301	—
(5) Livestock grazing	1.63	0.47	1.03	2.8	2.4*	2.5*	274	68	155
Sub-Total	—	—	—	—	—	—	711	1010	293
(B) Agricultural									
(1) Ploughing	0.18	—	—	5.5	4.7*	—			
(2) Irrigation	0.30	—	—	3.3	2.8*	—	59	—	—
(3) Transplanting	0.08	0.33	—	5.1*	4.3*	—	59	—	—
(4) Weeding	0.08	0.33	—	5.1*	4.3*	—	25	85	—
(5) Harvesting	0.18	0.19	—	5.3*	4.5* (Manual)		25	85	—
(6) Winnowing	..	0.09	—				57	51	—
(7) Threshing	0.14)			5.3*	4.5*	—	—	24	—
(8) Manuring	0.13)	0.04	—	5.4	4.6*	—	45)		
(9) Nursery	0.07)			4.0*	3.4*	—	31)	35	—
(10) Harrowing	0.03	..	—	3.5*	3.0*	—	15)		
(11) Transporting (by bullock cart)	0.05	..	—	6.5*	5.5*	—	12	—	—
Sub-Total	—	—	—	2.0*	1.7*	—	6	—	—
(C) Other Activites (Sweeping, cleaning, child care, personal care, play, sitting etc)	9.79	7.94	8.42	—	—	—	334	280	—
(D) Rest & Sleep (approx)	10.00	10.00	14.00	1.5* (average)	1.5*	1.7*	878	715	655
Total	—	—	—	—	—	—	550	500	650
				—	—	—	2473	2505	1598

Col. I : Source : Compiled from data given in ASTRA, 1981 : *Rural Energy Consumption Patterns : A Field Study* Indian Institute of Science, Bangalore.

Col. II : *All estimated or approximated figures.

(i) N. L. Ramanathan and P. G. Nag, : *Energy Cost of Human Labour*, National Institute of Occupational Health, Ahmedabad,

(ii) R. Rajalakshmi, 1974 : *Applied Nutrition* (Second Edition), Oxford and IBH, New Delhi.

compared to that on men? To determine this, we have to examine the hours per day spent on domestic and agricultural activities and translate these into calorie costs. Table 2 (col.I) present the break-up of hours per day spent on agricultural and domestic activities by men and women.

The most significant aspect of Table 2 (col. I) is that while women average about 6 hours a day on survival-related and agricultural tasks, men average only 4 hours a day on the same. Also, the ASTRA study did not monitor other domestic work such as cleaning, sweeping, washing of clothes and utensils and child care, all of which are calorie-intensive and all of which are performed almost exclusively by women. On the other hand, most of the other (i. e., non-enumerated) tasks carried out by men are sedentary in nature - such as visiting the tea shop, trips to panchayat offices, talking with friends, and so on.

We have now to translate the activities of men and women into calorie costs and compare them with calorie intake. However, this is not as simple as it seems for once again the neglect of women in social research or the ideological biases within existing information systems becomes a handicap.

Ramanathan and Nag have reviewed virtually all calorie cost studies in the country for various activities in their paper *Energy Cost of Human Labour*. They found energy cost estimates for only 10 agricultural activities, compared to 70 industrial and military activities. Furthermore, there were no female equivalents for these agricultural tasks, as though women have not been participating in agriculture for several millenia !

The unkindest cut of all is when we find that the few women's energy costs (10, to be precise) which have been measured are clubbed under the category of 'sedentary people' and include such pleasant tasks as sewing, knitting, typewriting, piano-playing and singing. Where have 90% of India's women gone - the ones who work from morning to night at back-breaking domestic and economic tasks and also carry the burden of pregnancy and child care?

Under the circumstances one is forced to approximate the energy expenditure of women in the concerned tasks by using the fomula :

$$\text{energy cost/minute/adult male} \times \frac{\text{Basal Metabolic Rate female}}{\text{Basal Metabolic Rate male}}$$

(the BMR for moderate workers is used throughout the formula)

This gives us the estimates of energy cost per minute per activity for men and women presented in Table 2 (col II). Please note that all starred figures are estimates based on the above formula.

We are now ready to calculate the activity-wise energy output per day for man and woman, shown in Table 2 (col III).

A note of explanation in needed here : Agricultural activities are obviously seasonal but here they have been averaged over the whole year to obtain a daily figure, which is more appropriate for determining daily energy output and comparing it with calorie intake. Thus, during some months of the year, agricultural activities will account for much higher energy expenditure than shown in Table 2 (col. III)

We see that the calorie (energy) expenditure of women is higher than that of men. The difference appears more marginal than I suspect it really is. First of all, the 'other' activities of men, could not be clearly enumerated.

The shortage of off-season employment opportunities makes it doubtful that they spend a lot of energy in non-agricultural activities. Therefore one can postulate that during off-seasons the total calorie expenditure of men may be significantly lower than that of women.

Secondly, we see that most of the energy expenditure of women is on daily, life-supporting tasks which must be performed regardless of season and which are generally not shared by men - viz, cooking, fetching water, gathering firewood, washing, cleaning, and child care.

Thirdly, many of the above activities create a demand for human energy because of the scarcity of other energy resources. If cooking fuel and water were readily available close to the user and the efficiency of stoves improved, a saving of nearly 500 calories per day per woman could be effected. Is there a need to bring about such an energy saving at all ? If food intake more or less matches calorie output, there would appear to be no cause for concern. ASTRA's nutrition survey (unpublished) in the village Ungra (based on monitoring of food purchase and use over a two-month period) found that the average individual intake per day was around 2300 calories.

But this, like all other nutrition surveys in the country, assumes an equal distribution of food within the family - a highly questionable assumption.

The staple diet in this area is 'ragi' which is cooked to a dough and separated into balls for eating. When local women were questioned as to how they distribute the balls, their answers provided the following ratio : 2 balls for a man, 1.5 for a woman and 1 for a child. Obviously this would be a questionable basis for disaggregating the overall calorie consumption of the family - but it gives us a rough idea of intra-familial inequalities in food-distribution. It also shows that food intake is determined not only by work output, but also by social and cultural factors which have to be studied, described and tackled.

Let us for a moment, return to the above ratio and assume it is valid. Applying it to the overall cereal consumption per day per family (4.24 kg) the relative food intake per man, woman and child would then be 3270 calories, 2410 calories and 1640 calories per day respectively. This means an intake deficit of nearly 100 calories per day per woman, whereas a man has an intake surplus of nearly 800 calories.

A deficit of 100 calories a day doesn't look serious until we link it to other facts : (i) The vast majority of the population have worm infestations, and these parasites can 'steal' as much as one-fourth of the total food intake. (ii) This intake level for women is a 'maintenance' level which makes no allowances for the additional 500-600 calories required during pregnancy and lactation - and Kamala Jaya Rao (1980) has shown that one-third adult Indian women are in that condition at any point in time, without the benefit of additional nutrition during these 'vulnerable' periods.

All of the nutrition programmes in the country are aimed at pregnant and lactating women - though how much of this extra nutrition actually reaches these women is a moot point (Natarajan, 1974). But what of the nutrition deprivation suffered by girls from infancy to pregnancy? And what of the women who have fulfilled their reproductive roles, but must continue to work for their family's survival without enough food to meet their needs?

Health hazards of cooking stoves and fuels

Beyond the nutrition factor there are other ways in which the village energy system affects women's health. Domestic fuel scarcity is only one part of the crisis women face. Having obtained some form of fuel, poor women are forced to cook on stoves which are both primitive and inefficient. The traditional chula, used in the vast majority of Indian homes, ranges from a crude pit or U-shaped pile of bricks to the more sophisticated fired clay or metal stove. The cooking efficiency of these stoves is dismally poor : between 3 and 10% (Geller, 1980). Since the fuel efficiency of a stove determines not only fuel consumption (and hence fuel-gathering time) but also the length of time spent in cooking, the traditional chula condemns women to spend at least 3 hours a day on cooking, and that too for most of their lives!

As if this were not a severe enough penalty, some recent studies have highlighted the extreme health hazards to women and girls where conventional bio-mass fuels like firewood, cowdung and crop wastes are used as cooking fuels (SNDT, 1983).

Dr. Kirk Smith, energy programme chief of the Resource Systems Institute of East-West Central Honolulu, conducted a study in rural Gujarat in association with the National Institute of Occupational Health (Ahmedabad) and the Jyoti Solar Energy Institute (Baroda). The study was conducted in 4 villages of the Kaira District. Smith's team found that traditional bio-mass fuels emit more Toxic Suspended Particulates, (TSP) benzo-a-pyrene, carbon monoxide and polycyclic organic pollutants than fossil fuels. Thanks to the crudity of stoves and the poor ventilation of the rural home, these fuel emissions produce a deadly disease trap for women and girls - for the study found that the women begin regular cooking at around 13 years of age (Indian Express, 1983).

Clinical studies by the Kirk Smith team found that women spending around 3 hours a day on cooking were exposed to 700 microgrammes of particulate matter per cubic metre, compared to the safety level of 75 microgrammes. The benzo-a-pyrene inhaled alone, was equivalent to smoking 20 packets of cigarettes a day. (SNDT, 1983)

In another study conducted by the Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER), 20 albino rats were exposed to cow dung smoke and soon developed chronic bronchitis, bronchiolitis and emphysema. The JIPMER Study suggested this as a possible cause of the high incidence of bronchinal disease among women and older girls in India (Indian Express 1983). In light of these facts, it is not surprising that respiratory disease is one of the major causes of death among women in India (SNDT, 1983).

One of the solutions developed to combat this problem is the 'smokeless' chula. The 'Nada' chula and 'Dholadhar' chula, among others, are some of the most sucessful designs. Designers and disseminators have reported not only fuel savings of 50% with these chulas, (IGDP, 1982) but the remarkable changes they have wrought in the lives of women and children; the fuel saving has released precious time which has been used in a variety of ways, including, as one woman put it, to "just lie down and rest" (Sarin, 1983).

Unfortunately, women's ill-health and undernutrition is not of equal concern to all. There is a growing school of thought which uses theories of biological adaptation (the 'homeostasis' theory) and clever statistical gymnastics to prove that there is in fact no such calorie gap (Sukhatme, 1981).

The doyen of this school is Prof. P.V. Sukhatme, a biostatistician with considerable clout who, a decade ago smashed the theory of the 'protein gap' in the diets of poor people. He demonstrated that the protein gap only occurs when there is a *calorie* gap - but when overall intake of calories is sufficient, the amount of protein is also adequate (Sukhatme, 1972). He was undoubtedly responsible for elbowing out the vested interests who would have liked to manufacture and market supplementary protein to people who had barely enough to eat.

Today his work has taken quite a different direction - a direction which has frightful implications for women. To grossly oversimplify his theory, he states that just as there is inter-individual variation in food intake, there is also an intra-individual variation. So at times we eat more, and then we eat less. Thus, ascribing some arbitrary norm such as 'recommended daily allowance' is meaningless, since both inter- and intra-individual food intakes will fall into a normal bell curve, with the majority of people in the centre and a few at either extreme, even though everyone is healthy (Sukhatme, 1981). From here, he goes on to state, that the only two indicators of malnutrition (either in the form of overnutrition or undernutrition) are : whether body weight remains basically constant (i. e., it is maintained), and whether the normal level of activity (for which read 'work') is maintained. He believes that anyone who meets the above criteria cannot be termed malnourished.

Sukhatme also does not want us to be carried away by Western norms of how tall or heavy we should be. A thin, small person is neither stunted nor underwight - she/he has merely 'adapted' to efficiently use the little food to be had while continuing to labour away for survival.

Therefore, this 'calorie-gap' suffered by women and by many of the poor is of little consequences because they 'adapt' themselves and carry on. A comfortable theory indeed ! Women, in fact, are the stumbling block in Sukhatme's theory. Can women 'adapt' to calorie deficits of 500 or 600 calories during pregnancy and lactation ?

Even if they can, Sukhatme ignores the possibility that such adaptation over a lifetime may have disastrous consequences on health. Is this why more women die, and die earlier than men ? (HFA, 1981) Is this why maternal mortality is so high - 400/100,000 ? Is this why the average birth-weight of poor babies is as low as 2.5 kg (NIN, 1971), leading to so much child wastage ? In other words this may be the starting point of the vicious circle of maternal undernutrition, low birth-weight babies, high infant mortality and high fertility. In this context, health care services can play an important role in alleviating the health problems of women to some extent - but do they?

First of all, women's health has been confused with maternal health — once again on the assumption that women and maternity are one and the same thing. The only women-oriented programmes in the national health sector have been Maternal and Child Health Schemes and to some extent Family Planning. The health system has yet to waken to the fact that there are a large number of women in need of health care who are neither pregnant nor lactating.

Secondly, the outreach of health services is very poor with respect to women. Examination of in-and-out-patient records of medical institutions reveals that for every three men who avail of these facilities only one woman does so. This is by no means because women are healthier, but because in the Indian family, the importance given to a woman's ailments is considrably less than that given to a man's illness.

Thirdly, the very nature and structure of the health service system mitigates against its reaching women. Our health system is institution-based. Women have neither the time, mobility, child care facilities nor the leisure to travel long distances at great expense to seek out the services available in hospitals and health centres, often at the loss of a day's wage. A domiciliary system which reaches the doorstep would automatically benefit more women than today's set-up.

Finally, in our culture, it is women who can best reach out to and care for other women. Yet in the present health services, male functionaries heavily outweigh the females. Although the number of women doctors has been steadily rising, few of these are working in the rural areas. It is the lone cadre of Auxiliary-Nurse-Midwives, poorly paid, poorly supervised and equipped, sexually harassed and overloaded with work, who are the sole guardians of women's health. Even the celebrated Community Health Worker Scheme, defeated our hopes when over 80% of those selected and trained turned out to be men.

Conclusions

The scarcity of other energy resources in a rural area creates a demand for human energy - particularly in survival-related tasks. When human energy is expended, women contribute the greatest share. But in comparison to this energy output, women get a lower share of food intake, and face a nutritional deficit. Added to the work burden, women also suffer further energy deprivation due to repeated pregnancies and breast feeding, high morbidity and intestinal infestations. Health care can alleviate this burden to some extent, but women apparently have less access to health care facilities due to the nature and structure of these services. These factors naturally affect all the poor, but women are more seriously affected because of their low status, and their social and economic roles.

I cannot presume to offer solutions—the complexity of the problem is mind-boggling. But I can and do raise a series of questions which must be answered if we are to even begin tackling the problem. The questions are :

(1) What is the actual pattern of women's work in different regions?

(2) What is the energy cost of the activities performed by men, women and children in different socio-economic groups - both urban and rural?

(3) What are the effects of human energy saving on nutrition status - with and without increasing food intake?

(4) Are the calorie intake norms or recommended daily allowances for women at various activity levels realistic?

(5) What is the actual food intake of women (at all ages and biological stages) and men ?

(6) How do women utilise the time released by the provision of alternative energy resources for survival tasks ?

(7) What is the actual extent and pattern of morbidity amongst women ?

(8) What is the outreach of health services to all women, and what is the level of utilisation of the former by the latter ?

In conclusion, and although I have said I can offer no solutions, the interrelationship between energy scarcity, women's work, nutrition and health suggests a three-pronged strategy :

Women's deprivation is occurring at three levels: the socio-cultural level, the environmental level and the service-programme level. The erosion of rigid patriarchal system has to occur, and all women's movements are aiming at this. Improving the availability of energy resources with priority for the activities performed by women (collecting fuel and water, cooking, and so on) is another facet of the strategy, and one where alternative technology can play an important part. Finally, there is an urgent need to restructure and expand the scope of existing programmes to reach out to women and draw them into the health care network.

How best all this can be achieved is a matter for further debate and discussion. But it is clear that the major thrust has to be on the political front, by mobilising women to analyse their situation and articulate their demands.

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commodities would offer Tanzania more options than that of devaluing its currency or curtailing its development programs. The amelioration of terms of trade would offer Tanzanian coffee farmers better returns on the crop they now produce, obviating the need to expand production at rates of 5 and 6 percent per annum. Improved terms of trade would also alter the economic circumstances of women and offer the possibility of better health and nutrition for themselves and their families. The New International Economic Order holds the promise of a future for Tanzania radically different from the grim one currently predicted.

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a) Awakening the Women : To understand the reality of the bhutali phenomenon in all its different dimensions. (In the minds of many woman there is a lurking doubt that the bhutali may be real. This comes to the fore especially in the minds of women affected by unfortunate events and they support their husbands in the hunt for the witch). This awakening is part of the wider struggle of the women for emancipation and equality. This awakening must also form part of the general awakening of the male population. (The men too have a tremendous fear of the witch and which is the reason for the vehemence with which they act to annhilate her). Since the bulk of the population is illiterate, the process of awakening will have to make extensive use of drama, song and discussion.

b) Improved Health is the cornerstone : Because if one goes through the earlier part of this paper one notices that the event that triggers the witch hunt, is in most cases 'unexplained' disease or death. The deterioration of the adivasi health system is a major area of concern when one looks at the bhutali problem. Any effort will have to be directed to attain three goals :

i) A re-evaluation and change of the adivasis understanding of health, disease, and health care. ii) Taking health to the grass-roots in the form of more radical health care systems and creative responses to the health problems iii) Developing a local integrated system of preventive health care

c) The Enlightened Bhagat is the Key : As the central person in the traditional health care system of the adivasis, the bhagat plays a crucial role (whether positive or negative). Hence any action for integrated creative health care would necessarily need to include the 'enlightened bhagat' (Any attempt to substitute the present with a parallel system even if it provides a superior and more efficient system would be counter-productive). Those 'enlightened bhagats' would have to be involved in a process that is geared to : i) improving diagnostic skills. ii) identification of herbal remedies and their medicinal porperties, together with methods of cultivating and preserving various herbal plants. iii) Development of supplementary skills and medicine to complement those areas where the local systems and remedies are insufficient. iv) Development of preventive health care as a system in its own right with the bhagats.

d) Education to develop scientific attitude : A consistent programme to introduce a scientific temperament coupled with the struggle against superstition should run through the whole effort which would integrate the various parts as one integrated look at life and its different processes.

This short paper tries to put forward what we are thinking and hoping to put into effect. We need assistance and co-operation at every step. Your solidarity is as necessary as our efforts. We hope you will become part of this process of struggling for the liberation of the adivasi and the women in particular.

HEALTH OF WOMEN IN THE 'HEALTH' INDUSTRY

sujata gotoskar, rohini banaji and vijay kanhere

The authors of this article provide a new dimension to all those working for rational drug policy, against misuse of drugs, and so on. Individuals and groups working in health have so far formulated their programmes with a concern for the consumers of drugs. But an important section, the producers of these drugs is left out. The authors' study of health problems of women workers in the drug industry shows that they are the first and worst sufferers. They stress the need for health groups to orient themselves towards producers of drugs, as workers need their expertise, and to find a strong and reliable ally in their fight against the controllers of drug industry. Health groups, trade unions and women's groups have many meeting points.

In the last two decades, some amount of thought, research and action has gone into the health hazards posed by the drug industry vis-a-vis the consumers of the products. Voluntary health groups and agencies are exposing the dangerous effects of drugs taken in quantities of 5 milligrams a day over years or also just once. However, hardly has any concern been directed against the effects of these drugs on the producers, the people working in the companies producing these drugs. The workers in their work process are exposed to the same drug, inhale the same drug, the drug enters their systems thorugh touch, through the mouth and through their respiration. They work for 9 hours a day, day after day, year after year, producing hormones, vasodilators, antibiotics etc.

If one has to look at the drug industry from the point of view of the health effects on the producers, one cannot be confined to a narrow conception of health as a lack of disease initiated by a drug. The conception of health effects has to be broadened considerably.

Drug Production and Worker's Health

The last ten years have seen a phenomenal increase in the production of Bombay pharmaceutical companies and in that of newer industrial centres. Many more liquid orals, tablets, vials, ampoules have been thrown in to the market. This is leading, not to increase in employment, but to the extraction of more work from less or the same number of workers. The impact of this process is increasingly being felt by the women on the packing lines. Behind the heavy advertising campaigns stand overworked packers lifting heavy ampoule-rings or heavy crates of bottles. This fantastic increase in production, from 22,000 ampoules per shift to 60,000 ampoules in 7 years or 8,000 to 50,000 per shift in 11 years, with very little increase in the number of women doing the work, is brought about in two ways. These two related methods produce two types of health hazards.

The simplest, age-old but out-dated method is to keep the process intact and increase the speed of the machine and hence of the entire process Such *speed-ups* on manually operated packing lines lead to fatigue, weakness, back-aches, aching arms, feet and shoulders.

Work on the packing line involves the fitting of bottles, sealing, labelling, optical checking, packing in boxes, inserting leaflets and case-packing. All these jobs may be manually done or some jobs are semi-automatic or automatic. The manual filling of bottles is extremely strenuous involving holding the bottles with hands, regulating the volume of the liquid by turning a tap or switch on and off, by pressing a foot pedal to start and stop the flow while holding the bottle under the nozzle. The strain is felt most on the arm and feet muscles.

In the manual spooling of adhesives, the operator mounts the rolls of plaster on the machine and pulls by hand till the plaster reaches the spool. "We have to stand on one foot and to pedal with the other to spool, and at the same time guide the plaster, and finally cut it when the required length has been reached. If the roll is tight, continuous pulling by hand is very strenuous. Continual cutting results in corns. Carrying rolls causes chest pains".

All these operations, when manually done cause extreme fatigue. "We have to lift the heavy rings of the capsule machine several times in the shift. It is very exhausting and dangerous as we have to stand on a stool to fit the heavy rings." By itself the single operation may not be very heavy, but repeated over hundreds of times in the 8 hours of shift, everyday, it becomes strenuous and causes tiredness.

Another major health hazard is the deteriorating eyesight of the women working on optical checking. Every vial, bottle has to be checked for the presence of foreign particles. Manual optical checking involves the packing up of one or more bottles or vials (depending on their size and weight), shaking

and viewing them against a strong light, sometimes against black and white backgrounds in succession. These have to be checked by the naked eye. Some women optical checkers told us, "Before we came to work here, most of us didn't have to wear spectacles. Now almost all of us have glasses. Sometimes we have to get our glasses renewed every 6 months."

In semi-automatic optical checking, "the bottles pass on a belt in front of the checker with a strong light shining through them. The speed of the belt is high and we cannot shift our eyes at all". "On our line, production increased from 8,000 to 50,000 per shift in 11 years due to the introduction of automatic filling and labelling machines. The optical checkers have increased from 2 to only 4".

Complaints of eye strain in optical checking were most widespread in companies where the women would have to check liquids for one day or more before moving on to another job. Rotation in jobs is an accepted practice in many of the larger pharmaceutical companies. Different types of rotation schemes exist. All the women who work in sections where jobs are rotated said they liked rotation, for two main reasons: (i) "There are hard jobs and easy jobs and the same people shouldn't always have to do the hard jobs". (ii) "It is boring to do the same job all the time".

Where the workers have complaints of fatigue or tedium and want rotation they could, through their unions, try to devise schemes with (a) rapid rotation, perhaps within lines to prevent strain and fatigue in certain operations, and (b) rotations on a longer cycle, such as three months perhaps between lines, to allow workers to become competent at a variety of operations.

The operations which were earlier either manual or semi-automatic and which have now been automated, almost always involve a reduction in the physical effort required to do the work. However, with automation, managements have tried to combine, two or three operations and a single operator has now to cope with 2 or more machines. Though the quantum of physical effort has been reduced, the strain of minding these machines increases manifold and results in mental strain and tedium.

Where physical strenous functions have been automated the women often told us that the work had become less tiring. Increases in the level of automation have brought about this result by eliminating certain highly repetitive tasks such as holding bottles or vials under a nozzle, pressing a lever foot-pedal etc.

Any method which replaces the hazardous physically strenous and fatiguing work, by work that is lighter, safer and less unpleasant, and does it in far less time, is potentially a means of emancipation from long working hours, industrial fatigue, coercive work routines, health hazards and rigid sex stereotyping. Whether automation ever has this meaning, will depend on (i) the way in which it is introduced, which depends on (ii) how much control unions exercise over its introduction and use.

Experience of workers demonstrates that if the changes are made completely under management control, the chances are that workloads will increase, employment will decline, health hazards will increase and workers lose any sense of stability in their jobs. **It is only when those who actually work on the machines in the factories have some control over this process through their representatives and unions can the potentiailities of automation be realised.**

When production is increased in such proportions, not only is there an increase in workloads and fatigue for the women workers, but it also results in making the women workers less resistant to the effects of the drug they are producing. At the same time, the possibility of the hazards is multiplied due to the sheer increase in the amount of chemicals the workers come into contact, as in the case of optical checking, the eye-strain increases as the number of bottles and the speed with which they are to be checked increases. The increase in workloads or speedups is hazardous in itself and it also increases the intensity of the hazardous effects of the chemicals.

Health Costs of 'life saving' Drugs

Here we will go into the *case-study* of one such product-Isosorbide dinitrate. This is used as a coronary vasodilator for the treatment of angina pectoris patients. It is considered to be a life-saving drug and is sold under different brand names.

An approximately 1,500-word leaflet, besides the references of 22 'scientific' books of one of the companies producing the above drug has only this to say about the side-effects of the drug :

'Side-effects other than occassional typical vascular headaches are not common in effective dose.... Histological (microscopic) examination of the tissues from animals did not reveal any evidence

of toxic injury as a result of administration of the drug'. In fact, says the leaflet, 'the increased exercise tolerance produced by the drug usually results in a gradual lowering of psychic influences, and often gives the patient a new feeling of well-being.'

The leaflet refers only to two possible side-effects, 'headache during the early phases of therapy' which 'disappear within one week of continuous, uninterrupted therapy'. Secondly, 'mild gastrointestinal disturbances might occur rarely with larger doses. These could be prevented by taking the drug with food'. Lastly, the drug 'should be given with caution to patients having glaucoma (severe eye problem).

The women packers who work on these drugs, sorting and filling the tablets into bottles, however, have a different story to tell. "See how our faces are swollen up. This line always gives up problems. Our heads ache, — throbs all day and night. We feel giddy". "We don't feel like eating at all, no appetite, nausea and constant headaches.". . . . "Our monthly period is also affected. Very heavy flow and sometimes two periods in a month."

One of the women operators told us the case of one woman, who had had two healthy children and no family history of abnormal children, had a child who was completely deformed and died a couple of days after birth. This woman had worked on the Isosorbide dinitrate line all through her pregnancy. After this incident, however, the women decided that no pregnant woman should work on the line.

The department where this drug is packed is a small 121X81 room, where 8 workers work together at sorting and filling of the bottles. The sorting woman shakes the tablets in a scoop and the powder flies into the air everytime she does it, at least about 20 times in a minute. The room is air-conditioned with no natural ventilation and with a weak air-conditioner and exhaust. The masks given to the women are very thin, white pieces of cloth and quite ineffective. The women have to stop working every few hours in order to go to the dispensary to get aspirins or simply to breathe air free of the Isosorbide powder. The women cannot explain about this too often, as the management might insist on reducing their trips to the dispensary and push them for more production. So everything remains unofficial - the doses of aspirins, the swollen faces, the fits of dizziness and nausea.

Workers have no access to correct information

The standard scientific books about drugs state the following : "Of 42 patients with agina of efforts given sorbide nitrate, two-thirds suffered from side-effects which included headaches, malaise (feeling of illness), vertigo (dizziness), dyspepsia (indigestion), nausea, epistaxis (bleeding from nose)" (Martindelle.)

"In 14 patients, sorbide nitrate when given 5 milligrams sublingually, headaches occurred in 20% of the patients (Martindelle) "Reports of ankle oedema associated with Isosorbide therapy" (Martindelle).

"In some individuals, the blood accumulates in abdomen and lower limbs, venuous return of the blood to the heart is grossly reduced and the cardiac output and blood pressure fall precipitiously. The reduced supply of blood to the brain may cause fainting preceeded by nausea, shivering, cold sweats. The most likely side-effects of Nitrite therapy are methaemoglobinaemia (which results in breathlessness after exertion), serious hypotension (low blood pressure) and headaches". (Lewiss' Pharmacology.)

"Nitrites can affect ureteral and uterine smooth muscles . . " (Goodman Gilman).

This scientific information obviously tallies more with the experience of the women workers than with the leaflet put out by the management. But the day-to-day experience of the women has had up to this day not much of an effect with the management as there is very little easily available material which the women may use to back up their own genuine problems. To begin with, there is hardly any material or research done on the actual effects of the drug on the producers themselves. The little research that we could obtain with difficulty concerned only the consumers of the drug. And even this was not easily available. The leaflet that is given with the drug is obviously misleading and far from the truth. The labour institutes, chemical directories and chemical abstracts do not list these effects at all. It was only after a great deal of scanning through medical books that the above scant information could be compiled. How are workers who work for 9 hours at the factory and the women workers who have an additional shift at home, supposed to know what it is that they are working at every day ?

There is obviously a monopoly of information and a systematic campaign of misinformation by the management. The management has its own experts, expertise and can handle knowledge and information and use it for its own purpose. If the

workers have to have some control over their own situation, they have to have their own channels of expertise, information and initiate campaigns on that basis.

The hitherto most stable organisations of the workers have been trade unions. The trade unions, however, especially in a country like India, have not been stable and confident enough to take up issues like health of workers seriously and consistently. This is a fairly new dimension and more effort needs to go into such a systematic insistence on issues like health.

On the other hand. voluntary health groups are a comparatively new phenomenon in this country. *These health groups have concerned themselves mainly with the consumsers of drugs and not the producers* This may be so because as individuals interested in health issues, their day-to-day contact is with the consumers. In fact, unless there is such a conscious perspective. health issues of producers may not be addressed at all.

When, however, it comes to the question of the health issues of women workers, there is an additional dimension to the entire perspective. A special focus on the special effects on women workers at the level of research as well as that of campaign can be effected through the insistence of women's groups at the workplace.

These three types of organisations and groups have various meeting points and can come together over very concrete demands and campaigns, which in fact have been suggested by the workers themselves.

The immediate demands in this particular case may be :

1) Immediate research into how the drug enters the system of the workers and its effects. Dissemination of this research; (2) Easy availability of the currently available research; (3) Regular monitoring of the health of the workers; (4) Well-ventilated, larger work-rooms; (5) Proper exhausts; (6) Comfortable and effective masks; (7) Gloves; (8) Rotation in work schedules and new recruitment, so that no woman receives effective, harmful doses.

Much of the work process in the packing of Isosorbide e.g the sorting and filling of the tablets is manual. While sorting the tablets and while filling them in bottles by the scoop, the tablets have to be shaken. This give rise to the powder flying in the air, which the women breath in. Alternately this process is automated, the women will have to fill the hopper which should be covered with a lid to prevent the powder from getting into the air. By automation of this process, less powder will fly and secondly less women will be required to do the work, which in turn will result in a lengthier rotation cycle. If for e.g 54 women work on the product, in rotation, each batch consists of say, six women. There are nine batches with each batch working for three days a month on Isosorbide.

If the process is automated, only three women would be required per shift to work on the product. There could then be 18 batches, working for only one-and-a-half day a month on Isosorbide. The health problems of those working would be considerably reduced as they would be working for less days as well as the atmosphere in which they work would be less contaminated. The workers would, however, have to see to it that the production norma are not increased, which is a common demand of the management in cases of automation. For these demands to be worked out, it is necessary that women workers having similar problems have an opportunity to come together to share their experiences at work and evolve a common strategy. As of today, the women workers do not have a platform through which they can begin to do this. The formation of plant level women's committees and inter-factory women's committees could act as such a platform where women workers could share experiences and take up collective campaigns on common demands.

Campaigns could be initiated to plan and attempt the implementation of alternative production processes centred around the interests of the producers and consumers. And until this alternative is implemented, the above immediate steps have to be realised so that the ill-effects of working on a life-saving drug may be minimised for those who are producing it.

This article is based on research done for the Union Research Group, Bombay, (Bulletin issue 3), and for the Society for Participatory Research in Asia, Delhi.

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THE STUDY OF WOMEN, FOOD AND HEALTH IN AFRICA

meredeth turshen

A study of women's health and nutrition must be rooted in a consideration of land tenure, food production, food distribution, processing, preperation of meals, preservation, storage and consumption viewed as a system. This article, a chapter in a recently published book (see Perspective) seeks to show how economic and political decisions (in this case, in Tanzania), affect women's health status and nutrition. Some of the fundamental causes of malnutrition and disease are, it is felt, beyond the control of African women, and some causes are rooted in the structure of the global economy as it operates at the level of the village economy. The author studies the situation of women's health using theory which is interdisciplinary and historical and offers a new, more comprehensive analytical framework.

The common approach is to look at women as housewives, usually within the confines of a single discipline. Medical anthropologists, for example, typically study the rituals surrounding marriage, birth and death; they catalogue taboos that influence health, such as prohibitions of certain foods during pregnancy and prescriptions of intercourse after childbirth. We are critical of this approach because it results in a static view of society, one that lacks reference to the historical past or political present, one that isolates the local economy and stereotypes women.

In our view the problems of the health and nutrition of women and their families cannot be understood or solved if they are analyzed at the level of the household economy alone. A multidisciplinary approach is needed, which combines the interests and insights of economics, sociology and political science. Looked at through these lenses, women emerge as farmers and marketers, wives and mothers, members of cooperatives and political activists. Women's contribution to the village economy is linked to national and even international economics, in this analysis. These linkages are made necessary by the fact that some of the fundamental causes of malnutrition and disease are beyond the control of African women; some causes are rooted in the structure of the global economy.

The research methodology and analytical framework of the multidisciplinary approach are described in part one. We begin by laying out schematically the relationships between food production and nutrition, between women and health. An explanation of the theoretical underpinnings of the argument follows. In part two the approach is applied to the current situation in Tanzania, where food shortages threaten to lower the nutritional status of families.

How to Study Women's Health

The study of women's health starts with their nutrition which, together with land tenure, food production, food distribution, processing, preparation of meals, preservation, storage and consumption, must be considered as a system. (Note : The United Nations Research Institute for Social Development is carrying out a research program called "Food Systems and Society" that uses this approach). This is because, in the rural areas of Africa, agricultural productivity — in its broadest sense, from plant seeds to the meal served — determines nutritional status. Unfortunately, it is rarely the case that food production and nutrition are conceived as a system; all too often agricultural planners ignore the problems of food consumption and nutrition, especially in countries where cash crops are grown for export (World Bank, 1981).

If the relationship between food production and nutrition is a conceptual one, that between woman and food production is an observed fact in Africa. In many countries the food system centers on women who perform most of the manual labor at all stages of the production process. (Note : The argument for considering food and nutrition as a system together with women's role in agriculture is made in a report prepared for the United Nations Protein Advisory Group [Eide et al., 1977]. As long ago as 1928 Baumann observed that the field work of subsistence farming in Africa is done exclusively or predominantly by women. Yet planners continue to ignore women in their role as farmers and they treat the food women grow for domestic consumption differently from export crops. Even when the commodity is the same—for example, rice and maize are both food crops consumed domestically and cash crops raised for export—and even when women work on both garden plots and cash plantations, their contribution is disregarded. Despite much rhetoric since International Women's Year about involving women in development, male planners persist in designing improvements in cash crop production for male farmers. Barbara Rogers (1979), in her study of development planning, castigates the policy makers of

bilateral and multilateral aid agencies for their discrimination against women.

A concommitant problem with agricultural inputs is that of the very land being farmed. Patterns of communal land tenure, dating back to the pre-colonial era, have changed in this century; under systems of private property now obtaining in many countries, women lose traditional land rights. Where there is land scarcity, as in the coffee farming areas of Mt. Kilimanjaro, male competition for land suitable for cash crops pushes women off their maize shambas and vegetable plots.

The relationship between nutrition and health is one of synergy : nutrition is the basis of good-health and the determinant of the outcome of most diseases. Malnutrition both increases susceptibility to infectious disease and influences the course and outcome of illness. (Note : Resistance to infection is determined by a number of host factors, but a significant variable is the adequacy of immune response; available evidence suggests that cellular immune response and antibody synthesis are two mechanisms by which malnutrition can depress host resistance [W.H.O., 1972]). The interaction of nutrition and infection varies with the type of disease. At one end of the spectrum are diseases not dependent on nutritional status, like tetanus of the newborn, smallpox, and most of the vector-borne infections, although nutrition does affect case fatality rates. At the other end are most of the communicable diseases of childhood, diarrheal diseases, and respiratory infections—the incidence and outcome of these are very much conditioned by nutritional status. It is this latter group of diseases that is most common in Africa and claims the most infant lives. Diarrheas and respiratory infections are not preventable by medical means, however, and it is in this context that the special role of women in health arises.

Women are the providers of informal health care : as wives and mothers they are often called upon to nurse the young and the old, the sick and the disabled. Even as the network of rural health services expands in some parts of Africa, women still undertake the work of primary prevention by preparing meals, drawing water, bathing children, washing clothes, clearing the compound of refuse, and gathering fuel to light fires on cold nights in the mountainous areas of the continent.

This traditional form of informal health care was subject to contradictory pulls in the colonial period. On the one hand, the need for it grew as new types of work gave rise to new health problems and as the public and private sectors of the colonial system failed to provide adequate welfare or social services (Turshen, 1977). The need was especially great in those subsistence areas to which male migrant laborers returned when old, ill or unemployed. On the other hand, women's informal nursing skills were undermined as health care was socialized (in the sense of being performed as a service outside the home) in government and missionary clinics and as traditional medical knowledge was devalued and replaced by western medicine. Demand for home care was rising at the same time as traditional medical knowledge, especially of herbal remedies, was declining

These, then, are the relationships between women, food and health. Our next task is to make explicit the theoretical underpinnings of the analysis. To build a complex argument such as this, it is necessary to draw upon theory that facilitates the process of relating information from several separate academic disciplines—in this instance, agricultural economics, medicine, public health, and women's studies; in other words, there is a need for theory that encompasses interdisciplinary studies. A second need is for historical method, because there is no adequate explanation of the current development dilemma in Africa without reference to African history. Colonial accounts of the last century are not useful substitutes for the combination of oral history and anthropological field work that gives Africans the central role in their own stories.

Third, one needs theory to make sense of contradictions, which seem to abound in descriptions of Africa. One narrow example from African women's history will serve as an illustration. A number of authors (Boserup, 1970; Robers, 1979) have made convincing, if damning, critiques of the education given African girls by Christian missionaries. The emphasis on home economics (interpreted as cooking and sewing), not only belittled the African woman's understanding of her familial environment, but also taught her to want European manufactured goods that were often inappropriate and beyond her means. Yet if one reads the biographies of today's African women leaders, it is interesting to note how many of them are graduates of such classes, or are the daughters of women trained in this way.

Finally, one needs theory to explain the social oppression of women, their subordinate political position, and their economic expolitation. To make

sense of the realities of women's lives in a sophisticated way requires theory that differentiates the nature of constraints on a woman like Jihan Sadat from the actual existence of a poor village woman living in rural Egypt.

To sum up, the theory employed is interdisciplinary, uses historical method, relies on dialectics to analyze contradictions, and combines feminist theory of women's subordination with Marxist theory of class conflict. Hypotheses based on this body of theory are best tested in participatory research. (Note : Sources of information on participatory research methodology are the International Council for Adult Education in Toronto and the United Nations Research Institute for Social development in Geneva). In participatory research, the subjects become the research workers by defining their own problems, gathering empirical data, experimenting with solutions, and using the results to refine the analysis of their problems. This technique is particularly important for women who are too often cast as passive recipients of development programs or, at best, as respondents in surveys. Participatory research empowers women in a way that traditional metnods, including participant-observation can never do. It also has the advantage of speeding up the process of returning research results to the people most directly concerned.

With these research tools it is possible to analyze the international situation in African countries and find out how women, food and health are linked to the economic, social and political system. Internal analysis is insufficient, however, since the national system is subject to international control. One form of international control is neocolonialism, which is continuing economic domination of a former colony by the metropolitan power. Many would say that Gabon is still controlled by France in this way. A more subtle form of control is exerted by international institutions like the World Bank and the International Monetary Fund which dictate the terms on which African nations can borrow money for development projects. Marxist theories of imperialism are useful in understanding international relations, including the role of financial institutions (Brewer, 1980).

Women's Health in Tanzania

There is so little information available on women in general and women's health in particular that it is easier to begin this discussion with a description of the present economic crisis in Tanzania and deduce its impact on women. In terms of levels of analysis, we will be moving from the national up to the international economy and then turning to the village and household economy. This process may be thought of as linking macroanalysis to microanalysis.

The nature of the present economic crisis in Tanzania is described in the following news report. "Tanzania's economic problems... have forced the suspension of development projects in the 1982-83 fiscal year. President Julius Nyerere said the country's small amount of foreign exchange earnings would instead be used to pay for spare parts and other essentials. Observers said that shortages had reduced Tanzania's small manufacturing sector to 30 percent of capacity, and that there were widespread shortages of such essentials as flour, sugar and cooking oil. Inflation is running between 40 and 60 percent annually. Although Nyerere had refused IMF demands to devalue the Tanzanian shilling, the currency was in fact devalued by 10 percent in March, 1982. The IMF had sought a 50 percent devaluation" (*Africa Report*, 1982b).

Why does the IMF seek a 50 percent devaluation of the Tanzanian shilling, and why does Nyerere refuse? Tanzania is unable to balance its international income (composed of export earnings and current borrowing) with its international expenses (imports and debt servicing.) There are three ways to deal with balance of payment deficits: (1) impose import restrictions or capital controls, (2) deflate the economy by reducing economic activity, or (3) devalue the currency (Block, 1977). The IMF recommends devaluation because it leaves the market open and unimpaired, and the capitalist firms that the IMF serves want to continue selling their manufactured goods to Tanzania unimpeded by import restrictions. The firms are not affected if it costs Tanzania twice as much to buy their products.

Nyerere opposes devaluation because it raises the cost of imports and reduces real wage levels. With dwindling reserves of foreign currency and unable to negotiate a loan from the IMF (with which Tanzania has been bickering for years over terms and conditions) he is forced to cut imports. The effect of the cut is to create a shortage of spare parts, which in turn reduces manufacturing to 30 percent of capacity. With machines turned off, men and women seeking employment in Tanzania's small industrial sector must be turned away, those who hold onto their jobs receive wages worth 10 percent less. A new system of financial incentives allows industry to knock an additional 10 to 20 percent off

the pay of 'idle'—that is, less productive—workers (Dimsdale, 1982).

What will be the impact on women workers? Women are concentrated in low paying jobs, in Tanzania as elsewhere; their incomes are already inadequate (Shields, 1980). Urban women thrown out of work will spend more time cultivating their small shambos (the kitchen gardens found near all residences) and may turn to casual prostitution to supplement their incomes, according to a survery of women workers in Dar es Salaam (Bryceson, 1980).

Meanwhile, inflation is running between 40 and 60 percent a year. In North America and Europe, inflation rates of 10 percent are a cause for alarm and government intervention; the impact of rates that average 50 percent in Third World countries less able to absorb inflation is devastating. Since it falls to women in Africa to purchase the food and clothing they and their children need — and in the cities they must also buy fuel and water — inflation will lower their standard of living, including nutritional standards.

One cannot assume, however, that all essentials are there to be purchased at any price, since the article in *Africa Report* states that there are widespread shortages of flour, sugar and cooking oil. These commodities are essential to urban women. Inevitably a black market has appeared and there are reports of hoarding and corruption. According to, *New African* magazine, "Sugar at the controlled price cost Tshs 8.50 a kilo but during a serious shortage, prices can shoot up to Tshs 30 a kilo" (*New African* 1982a).

In the countryside there is a return to the subsistence economy; surpluses are being bartered rather than sold (Dimsdale, 1982). (Note: Subsistence today should not be imagined as a return to the romantic villages described in anthroplogical accounts of the colonial era. Too much change has occurred — in land tenure and cropping patterns, for example — for that past to be recaptured, if indeed it ever existed). If this means that women are now grinding their own grain, pressing oil seeds, and processing sugar cane, then their work load is increasing. One wonders which of their many other duties will be neglected and what will be the impact of increased energy expenditures on their own health.

To secure a large loan from the IMF, Tanzania has adopted a program designed to increase the coffee crop by 5 to 6 percent a year. (Note: Tanzania was unevenly developed in the colonial period, with cash crop areas receiving most of the colony's resources. The coffee areas are on the northeastern and northwestern borders where the climate is favorable. Population density is quite high in these regions). This program will deepen the crisis for women in rural and urban areas, according to our analysis. To understand why we draw this conclusion, it is necessary to read reports on increased coffee production (*African Business* 1982) together with earlier notices of expected widespread food shortages and possible famine (*Africa Report, 1982a*). In 1981 Tanzanian officials predicted that food stocks would run out within a year. In January 1982, the Minister for Agriculture announced that Tanzania would need 300,000 tons of food aid. (Three months later Western nations offered 260,000 tons of emergency food aid) (*Africa Report* 1982a).

Food aid however, is not a long-term answer. Even the official agencies now admit its failure. *New African* (1982b) reported the findings of a confidential report by the European Court of Auditors, which severely criticizes the European Economic Community's food aid to Third World countries during the last decade. A few years ago such scandals were reported, not by official agencies, but by groups like the Institute for Food and Development Policy (Lappe and Collins, 1977) and individuals like Susan George (1976). Of course the donor countries are not yet ready to abandon food aid altogether; it remains a convenient way to dispose of agricultural surpluses "while profiting from the resultant political and economic influence" (*New African* 1982b).

The connection between famine and increased acerage under cash crops turns on insufficient food production. While the IMF is pushing for more land to be given over to a non-nutritive export crop, the World Bank reports that in Sub-Saharan Africa as a whole, food production per person declined in the 1970s. "Imports of food grains (wheat, rice and maize) soared — by 9 percent since the early 1906 — reinforcing food dependency" (World Bank, 1980; 3). To realize what increased coffee production means to rural women in Bukoba or Kilimanjaro where most coffee plantations are located, we must turn to the internal analysis of women, food and health at the microlevel of the household and village economy.

Studies that describe the relationsbip between women, nutrition and food production in northeastern Tanzania were reviewed by the authors of a report prepared for the United Nations Protein

Advisory Group (Eide et al., 1977). These authors conclude that although cash crop areas like Mt. Kilimanjaro are supposedly the prosperous regions of the country, infant mortality is exceptionally high there. (Note: This finding is not reflected in official statistics for Kilimanjaro Region; the discrepancy may be accounted for by the level of aggregation of government data). Infant deaths are more numerous on the mountain than on the poor maize-growing plains to the south. The authors relate this finding to what they term 'culture-specific factors' that help to determine women's position in the family (Eide, 1977 : III. 85).

Factors such as intrafamilial food distribution appear to be crucial when economic conditions are unfavorable, as they are now *(African Business,* 1982). Coffee growers receive an average price of Tshs 15 per kilo as compared with the 1981 world market price received by the Coffee Authority of Tanzania, which was Tshs 28 per kilo, and growers may have to wait as long as six months to receive payment. As a result, an estimated 30 percent of the crop is reportedly smuggled into Kenya, where the price received is six times the Tanzanian price (Dimsdale, 1982). The loss of foreign exchange to the Coffee Authority only aggravates Tanzania's crisis. In these circumstances, the tradition of differentiating between men and women's food and the custom of serving husbands large portions of meat result in nutrition problems for less privileged family members.

Prevailing inequalities in landholdings here are accentuated by coffee production. The wives of better-off farmers with more land and cattle are under less strain than women in low income groups. Wealth allows some women to ride to distant farm plots while poorer women walk. Wealthier women can hire workers to help harvest crops and to transport them, while poorer women may spend long periods away from home walking to their fields, working in them, and carrying heavy harvest loads uphill on the return journey. A little wealth also makes it easier to keep cattle and goats since cash buys lorry loads of grass, which has to be brought up from the plain to feed animals kept in stalls or tethered because there is no grazing land available on the mountain, nor is there space to grow fodder.

Cash crops are a source of income to men and in households where income is pooled — a practice by no means to be taken for granted in Africa (Shields, 1976)— women may profit and use the money to lighten their workload. But studies show that such women are a minority. For the majority of poor women coffee crops "on nearby land will force them to walk farther to grow maize on distant fields; they will have a heavier work load as food producers, less time for household tasks and a bigger struggle to provide the family with nutritious food" (Eide et al., 1977 : 11.87).

For solutions we must turn once more to the international level, not because Tanzania bears no responsibility for its internal affairs nor because there are no further improvements to be made in domestic policy, but because the ultimate determinants of solutions are external. Few countries have tried as hard as Tanzania to improve the living standards of their masses, but government plans have often been sabotaged by unfavorable international terms of trade. Yet the IMF and the world Bank do not suggest changes at the international level; indeed the degree to which they shift responsibility for economic crises to national governments is striking. The adjustments recommended by the IMF as conditions of loans are always national policy changes, which have significant social consequences. The lending policy of the IMF encourages 'loan dependency' in the same way it fosters food dependency and leads to what Cheryl Payer (1975) has called the 'debt trap.'

The World Bank's solutions, presented in the report on "Accelerated Development in Sub-Saharan Africa," emphasizes production of cash crops for export (World Bank, 1980). The Bank claims that there is an extra-ordinary degree of similarity throughout the region in the nature of the policy problems that have arisen and in the national responses to them. (One wonders what role the IMF has played in its imposition of uniform conditions). Among shortcomings of existing policy cited by the Bank are a bias against exports and a bias against agriculture. In reading the Bank report, one experiences the sensation of deja vu; in the nineteenth century, imperialists rationalized their colonial policy with the doctrine of natural advantage. Once again the Bank seems to be advocating that African nations specialize in producing primary commodities for the nothern industrialized nations.

The countries of the Third World oppose that rationale and have submitted a program for change called "The New International Economic Order" (United Nations, 1974). It is not possible here to describe the program in detail; it may suffice to say that implementation of the program of action on trade and development of raw mateials and primary

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commodities would offer Tanzania more options than that of devaluing its currency or curtailing its development programs. The amelioration of terms of trade would offer Tanzanian coffee farmers better returns on the crop they now produce, obviating the need to expand production at rates of 5 and 6 percent per annum. Improved terms of trade would also alter the economic circumstances of women and offer the possibility of better health and nutrition for themselves and their families. The New International Economic Order holds the promise of a future for Tanzania radically different from the grim one currently predicted.

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a) Awakening the Women : To understand the reality of the bhutali phenomenon in all its different dimensions. (In the minds of many woman there is a lurking doubt that the bhutali may be real. This comes to the fore especially in the minds of women affected by unfortunate events and they support their husbands in the hunt for the witch). This awakening is part of the wider struggle of the women for emancipation and equality. This awakening must also form part of the general awakening of the male population. (The men too have a tremendous fear of the witch and which is the reason for the vehemence with which they act to annhilate her). Since the bulk of the population is illiterate, the process of awakening will have to make extensive use of drama, song and discussion.

b) Improved Health is the cornerstone : Because if one goes through the earlier part of this paper one notices that the event that triggers the witch hunt, is in most cases 'unexplained' disease or death. The deterioration of the adivasi health system is a major area of concern when one looks at the bhutali problem. Any effort will have to be directed to attain three goals :

i) A re-evaluation and change of the adivasis understanding of health, disease, and health care. ii) Taking health to the grass-roots in the form of more radical health care systems and creative responses to the health problems iii) Developing a local integrated system of preventive health care

c) The Enlightened Bhagat is the Key : As the central person in the traditional health care system of the adivasis, the bhagat plays a crucial role (whether positive or negative). Hence any action for integrated creative health care would necessarily need to include the 'enlightened bhagat' (Any attempt to substitute the present with a parallel system even if it provides a superior and more efficient system would be counter-productive). Those 'enlightened bhagats' would have to be involved in a process that is geared to : i) improving diagnostic skills. ii) identification of herbal remedies and their medicinal porperties, together with methods of cultivating and preserving various herbal plants. iii) Development of supplementary skills and medicine to complement those areas where the local systems and remedies are insufficient. iv) Development of preventive health care as a system in its own right with the bhagats.

d) Education to develop scientific attitude : A consistent programme to introduce a scientific temperament coupled with the struggle against superstition should run through the whole effort which would integrate the various parts as one integrated look at life and its different processes.

This short paper tries to put forward what we are thinking and hoping to put into effect. We need assistance and co-operation at every step. Your solidarity is as necessary as our efforts. We hope you will become part of this process of struggling for the liberation of the adivasi and the women in particular.

THE 'BHUTALI' PHENOMENON
Why Are Women Hunted Down As Witches ?

kashtakari sanghatana

The Kashtakari Sanghatna is a left democratic mass organisation of marginal farmers and agricultural workers of Thane District in Maharashtra. Even while launching numerous struggles around the problems of the adivasis, it seeks continually to build-up political consciousness in its membership.

Women have been the backbone of the organisation and have consistently remained in the forefront of the movement. However the conscious struggle for women's liberation has only recently become part of the organisation's efforts. Recently, in a women's meeting, a militant Sanghathana member, forced into the background by political repression, raised an issue of vital importance to the adivasi women. She expressed her fears of being suspected as a witch. Once a courageous fighter, now apprehensive of being hunted as a 'bhutali', (witch) her predicament threw into clear relief the contradiction of adivasi womankind - power and powerlessness - reducing them to being victims of cruel inhumanity.

Till today, various problems have forced the Sanghatna to take adhoc measures vis-a-vis the torture of women 'bhutalis'. The efforts of the activists have been reduced to a battle of wits to minimise the brutality. peoples science movement groups made efforts to expose the superstition. But the 'bhutali' remains mystified and entrenched in the adivasi mind and almost defies a rational solution.

The persecution of 'bhutali' reflects the deteriorating health status of the adivasi. The challenge to evolve a creative response to the situation confronts the organisation. This reponse while being innovative and revolutionary needs to be integral to the ethos and existence of the adivasis, their symbiotic relationship to the forest and their faltering steps into modern society. The search for the 'old yet new' is just beginning.

Every single year, with almost unfailing regularity adivasi women of Thane District, become unwilling victims of a bizarre ritual which ends, in many cases, with the whole village (men, women and children) crying in a frenzy "death to the witch". In a rapid sequence of events which allow no single member of the village community to remain unaffected or uninvolved, a group of women (or in some cases a single woman) is suspected of witchcraft and, with no warning whatsoever, forced to stand trial. Put in the dock by the village males (with the village women looking on), and sometimes even in absentia, the women are tried and summarily handed a foregone conclusion : the sentence of guilty. The guilty woman (women) is responsible for the many evils that may have befallen the village. She has to take on herself the blame for all the mishaps that may have happened. She is liable for punishment. The trial is swift and final. The accused stands in the dock, already adjudged guilty. She has neither the right of counsel (any one defending her is in turn an accomplice and immediately suspect) or defence, she is neither tried nor are her pleas recorded. She stands a mute spectator to her 'trial' and a witness to her own execution.

The whole village is prosecutor, judge and jury and finally the executioner. The guilty victim is then subjected to the brutal sentence. In most cases she (they) is stoned. Sometimes death comes as a merciful release. Every single member (for fear of being identified as an accomplice and meeting the same fate) takes part in the execution of the sentence. In most cases the event remains locked in the silence of the village. In very few cases does it reach the outer world.

What is witch-hunting ?
Why and how does it occur ?

Disease and death form an integral part of the lives of the impoverished adivasis. In many instances, poverty renders them helpless. Sometimes several deaths plague a single family, at other times an epidemic ravages the village. On some occasions mishaps befall a village, on other occasions disease affects livestock and cattle. The adivasi wonders at these inexplicable mysteries. He searches for the root cause of these maladies. And he finds 'a witch'. He is then impelled to rid the village of this pernicious cause and hunts down the witch with uncontrolled emotion.

Incidents of witch-hunting take place the year round. But they errupt with increased intensity during the monsoon. The reasons for this spurt in witch-hunting are not hard to find.

1) Increased Starvation, Widespread Malnutrition, Lowered Resistance: The begining of the monsoons finds many adivasi families with depleted food reserves. In many cases food stocks are the balance that remains after sowing. While food has already become scarce during the summer months, the adivasi can migrate in search of work and survival. With the onset of the monsoons, work in the brick kilns, salt pans, sand dredgers, stone quarries and earth transport, comes to a halt. The adivasis return to their villages, many of them empty handed. In the villages the availability of work is almost nil, besides many have to choose between working or cultivating their own land.

The ageold recourse of the adivasi in the face of starvation was to search for food in the jungle. wild roots, fruit, leaves and tubers With these he was able to survive and had evolved elaborate methods of de-toxifying the poisonous roots and tubers, and make them edible. He celebrated this symbiotic reliance on the jungle with the feast of 'kohli' (eating of tender shoots from the jungle). Without eating kohli, the adivasi cannot begin transplantation, (indicative of his understanding that the bounty of the forest took priority to the fruit of his own labour). Today, rampant deforestation and extensive monoculture of commercial teak varieties has drastically reduced the availability of food from the jungle and increased starvation.

The groups most affected by the growing starvation are the older people and the children, who face increased malnutrition and lowered resistance to infection.

2) Inaccesibility of Health Care, Disrupted Communication, Shortage of Money: The rains reduce movement to a minimum. Most of the villages remain cut off. ST services are withdrawn as roads become slushy. The bullock carts, inexpensive means of transport are dismantled for the rains, cart tracks through the fields no longer exist. Taking a sick person to the hospital or PHC is possible only with makeshift stretchers. Added to this is "no money" not only to travel, but also to pay for, medical services because even the PHC doctors will not treat a person, however serious, free. The lack of money becomes a compelling reason for not taking the sick person to the hospital or PHC for treatment.

3) Heavy Demands of Cultivation, Illness as Incapacitation: The adivasi methods of cultivation are backward and labour intensive. Every able bodied person is required for work. The youngest children do baby-sitting, the slightly older take care of the cattle, while the others assist in cultivation. Under such circumstances, a person is considered to be sick only when he is bed-ridden and incapacited. Till such a time (till the person falls seriously ill), everyone works and is not considered sick as long as the person can work. The breakdown of health is considered important only when it becomes an impediment to work.

Most adivasis consider going to the hospital as a last resort, when all other efforts have failed. They prefer the village bhagat because he works free, while the hospital or PHC costs money. Most patients are taken to the hospital when they are very serious. Taking a person to hospital/PHC is a disruption of the work-schedule as many are needed to take the person in a stretcher or remain in the hospital to cook for the patient. Hence the gravity of the illness is important to motivate people to take the patient to a medical facility.

4) Increased Waterborne Infection: The rains wash down the dirt from the hill slopes. Water rushes down the denuded hill sides. The thick forests and undergrowth assisted in the percolation and filtration of water. Now the streams are a muddy flow, carrying with them infection. The jungle serves as a toilet for the villagers and all of it reaches the streams. In addition, the adivasis relish the fish in the streams, which for many families is probably their major source of edible protein. The tiny fingerlings are eaten without removing the entrails. While the use of powdered tamarind leaves help to destroy any micro-organisms in the entrails, possibilities of infection still remain.

To recap, this maze of insecurity and uncertainty, the tribal places unquestioning reliance on the bhagat as his refuge, hoping through him to find a way out of a seemingly hopeless situation.

The bhagat is the tribal priest and medicine man rolled into one. He is a villager like the others, who has initiated himself into 'bhagatship'. He supports himself by his work on his lands, being a bhagat brings in no income, on the contrary it is often a drain on his own time and resources. He performs the few rituals that exist in the adivasi religion. His major function, which continues throughout the year, is as healer and medicine man.

The warli religion is based on spirit worship. Some elements of hinduism have crept in, but remain on the fringes of their worship and ritual. The koknas have absorbed much more of hindu beliefs, deities and tradition. The religion of the people centres around the appeasement of the spirits whose anger the people fear. Religion does not provide any morality or enforce an ethical code.

The adivasi medicine is from the jungle. Over years of experience, the bhagats have discovered a

variety of roots, herbs and medicinal plants that they dispense to the sick. The knowledge of these medicinal plants is handed down by word of mouth. However, once the bhagat has handed down the knowledge of the various remedies, he is supposed to stop dispensing these medicines as with the knowledge he has also handed down the power and efficacy of the medicine. The system of diagnosis centres round 'knots'. The body, according to their system, consists of different knots of muscle, nerve and blood vessel. Good health is a manifestation that equilibrium prevails, with each knot being in place and maintaining the desired tension. Illness occurs when the equilibrium is affected and the knots are either dislocated or lose their required tension. The treatment for illness is either in the form of branding or consumptiom of medicine, inhalation or even tying some herbs on the body.

The bhagat, then, is the immediate and in a sense ideal solution, for a variety of reasons : he is accessible; he is known; he is understandable; he is inexpensive; he is reliable; and, he is acceptable. Hence he forms an integral part of the adivasis healing system.

The treatment that the bhagat gives is a combination of, spirit worship and offering to appease the angry spirit, and the use of herbal medicine combined at times with branding. The proportion of spirit worship and dispensing of herbal medicine varies widely with different bhagats. The efficacy of the bhagat however is progressively diminishing. The reasons for the decreases in his effectiveness are largely beyond his control.

a) Deforestation and Monoculture : Large tracts of mixed forests are being felled and replaced by monoculture of teak. A teak plantation supports no other forms of flora or fauna. With deforestation most of the traditionally used herbs are difficult to find. Many bhagats decrease the use of herbs because finding the herbs is a time consuming process. The numbers of herbal medicine-men is also on the decrease.

b) Lack on Continuity : As handing over knowledge of herbs means that the bhagat loses his power and efficacy, many bhagats die with their extensive knowledge acquired over the years. The tradition is not handed down.

c) Modern Diseases and Epidemics : with migration to the slums and shanty towns on the fringes of the cities, many adivasis return with infections which are totally new. The adivasi pharmacopia can no longer cope with the new diseases.

d) Lowered Health levels : The destruction of the forests, the elimination of mixed forests (with a variety of fruit and nut trees), the disappearance of game and the general growth of the population coupled with increased exploitation has had a severe effect on the diet of the adivasis, their intake of protein, vitamins and trace minerals resulting in a general lowering of the health of local adivasi population.

Caught in a vice of growing demands on his knowledge and powers of healing on the one hand, and a growing inability to deal with new conditions both in terms of diagnosis and therapy, a significant change is taking place in the system : a) there is a distinct shift in the bhagats modus operandi, moving more and more into spirit worship and appeasement, rather than dispensing herbal medicine, b) The tribal medical system is becoming progressively ineffective and with it grows the bhagats' failure.

To the mind, the new situation is inexplicable. They do not understand the changing circumstances that contribute to its deterioration. The bhagat cannot fail because he is in continual communication with the spirits. He can do no wrong. The blame has to be fixed elsewhere. And so, the witch becomes the cause of all the calamities and mishaps that befall a family or the village.

What are the events that culminate in this brutality?

The first event that triggers-off a witch hunt is either a prolonged illness, an inexplicable death, a series of deaths in a family, an epidemic that affects the inhabitants of a village or the livestock, widespread crop disease or failure, a number of mishaps or calamities that occur, or a combination of them.

It begins with a murmur, ('there is a witch') either emanating from the bhagat's mouth or from one of the affected individuals or groups. The murmur grows into a crescendo as the word spreads. The male members of the village start to take notice, the women of the village begin to fear.

A collection is made by the villagers to cover the costs of discovering the witch. A group of villagers is assigned the task and they go from bhagat to bhagat in search of an elusive prey.

The bhagat tries out a variety of rituals, (dann herne - read the message in grains of rice; diva herne - identify the witch in the light of a lamp), vati chalavne (using a cup which 'moves' and identifies the witch), he may conduct the sacrifice of a chicken or goat and try and read the indications spelt out in the entrails. The group of villagers may go to more than one bhagat to make certain of the identity of the witch. The bhagat who identifies the witch is not usually from the same village or locality. But through careful, intelligent questioning he is able to locate

either quarrelsome women, destitute women, women with poor family support, women who are generally socially weak, midwives and so on. The bhagat then proceeds to identify the witch and generally gives a vague description of the women on the basis of the descriptions unwittingly given by the women themselves. Once an identity is given, the group of men may go to another bhagat for a confirmation. Here too a subtle process of questions-and-answers is carried out and the identity of the witch given in similar though vague terms.

Once the process of identification is over, the next step of the village is to find the woman to fit the identity. Depending on the vagueness of the description given, the villagers (male) call for an identification parade. The parade can also consist of making all the women stand on a tava (frying pan) made red hot, on the assumption that the witches' feet will not burn. Sometimes this is by-passed and the witch is pointed out by one of the villagers and supported by the others. A third possibility is all the women who come close to the description are beaten-up till they confess to their nefarious activities and their crimes.

Once a witch or witches are identified, the whole village goes through the bizarre ritual of exorcising her of the evil spirit, or her association with the goddess Himai. Acting on the assumption that she feels no pain, the woman/women are beaten with clubs, stones or whatever else the villagers can lay their hands on. No one, whosoever they be (man, woman or child), whatsoever their relationship with the culprit be, wheresoever their sympathies may lie, whatever their beliefs may be, can abstain from this brutal activity, because an accusing finger will point in her/his direction. She/he will be accused of being accomplices of the witch.

The witch/witches are beaten till she/they fall senseless. Sometimes they survive. Survivors in most cases leave the village because the sword of an encore hangs continually on their heads. If a witch dies, she is summarily buried (not burnt) and the village maintains a stonewalled silence. If news of her death leaks out to the police, the villagers settle on who will take the onus of the 'murder' and assure him with money and legal assistance and the assurance that no one will testify against him at the trial.

After the ritualistic sacrifice is over, the catharsis complete, the village settles down with a sense of release that the cause of their anxiety has been eliminated. The women still shudder at the frightening events that has shattered their lives and a gnawing fear that they could be next in line.

What does the Bhutali phenomenon represent?

At the outset, we must make it clear that the efforts to understand the phenomenon are in no way complete and need further elaboration. We are putting down our reflections as they have occured to us, hoping to organise them further as we learn more about the living and thinking and feeling of the adivasi women and men.

a) The torture and death of the bhutali provides a bizarre ritual which serves (provides) as catharsis - a ritualistic release of tension/aggression resentment of the tribal accumulated in his experience of the many painful events that continually plague his existence, the feelings of helplessness which accompanies his efforts to resolve them, the fears and insecurities that harass him all the while, and his forced acceptance of the unwanted unacceptable events of disease, death, mishaps and calamities. Through this catharsis, he finds release without having to confront the truth of the situation and thereby is reconciled once again to the situation.

b) The torture and death of the bhutali, thereby provides a rationalisation (explanation) of the failure of the bhagat to heal, and the relative inefficacy of the medical system. This rationalisation helps to diffuse any attempts to reassess the system of healing. The process is enhanced by the subtle shift from dispensing herbal medicine to sorcery and witchcraft that has taken place in the modus operandi of the bhagats.

c) The torture and death of the bhutali legitimises the man's innate suspicion of the 'vile-guile-deviousness' of women.

(The efforts of women to develop their own means of self-defence and countering the brute force of man have always been interpreted as scheming and guile). Hence in warli society every woman is a potential witch. No woman can ever claim to be free from this cruel possibility.

d) The torture and death of the bhutali provide a mechanism that compensates man's inability to resolve the problems of his existence (the here and now), by projecting (transferring) the root cause of all that is evil (painful) in his present outside of himself (beyond). This compensation helps him to reconcile himself to his here and now, without being forced by the nature of the events into seeking a rational explanation for them.

e) The torture and death of the bhutali serves as the 'ultimate' mechnism of control of women by men. It manifests the use of brute force (mens' forte) to crush the spirit of women and keep them in perpetual bondage. The accustion of being a bhutali is

continually resorted to by man to maintain the subjugation of women. (such references can be observed even in interactions between husband and wife). The torture and death of the bhutali which takes place in the presence of women remains a constant reminder that the duty of women is to conform and obey even when the order/command is a painful death.

f) The torture and death of Bhutali hence becomes the final (definitive) seal on the domination of women by men. The threat of the acrimonitious investigation and trial culminating in a violent brutal punishment hangs continually as a sword on the head of every woman, threatening to snap at the slightest provocation.

g) The torture and death of the bhutali therefore is geared towards a conclusive suppression of any act of defiance on the part of women. The bhutali can be seen as the personification of defiance to the male order (organisation) of his world. She defies their efforts to reorganise their lives according to their plan and hence deserves the brutal treatment meted out to her.

h) The torture and death of the bhutali remains a constant warning to every woman that 'any act of insubordination to male domination will meet with a violent end'. This warning needs to be reinforced from time to time and hence periodic witch-hunting expeditions serve both a therapeutic as well as a preventive function in terms of the malaise of male-dominated society namely, the presence and thinking of women.

i) The torture and death of bhutali is related to the mystique that grows round 'blood - foetus - pregnancy' in the primitive mind. The mystique develops in the sense of awe and moves into the realm of fear. The male in his attempt to control the fear, seeks to control/crush/ suppress the root cause of the fear, the women. The domiant male also revolts against the realisation of the superior position of women which comes through their power to create and sustain life. His role in the creation of life remains minimal. His refusal to admit his subordinate place finds its expression in his act of domination.

j) The torture and death of bhutali is the logical culmination of the Pure-Impure Contradiction. This ritualistic impurity is extened into the interpretation of the female principle as dark, unruly, anarchic, devious, dangerous; while the man remains pure, rational, righteous. In the 'impurity' prejudice lie the roots of torture of womankind and their death to rid society of the 'evil principle'. The bhutali is a devotee of Himai, the goddess (the only female principle in the warli pantheon) of evil. The Principles of Good and Evil are embodied in man and woman.

k) The torture and death of the Bhutali (in many cases the suin/midwife) represents the ancient rivalry between the Bhagat and the Suin. The Midwife in her role of assisting in the birth of new life has knowledge of the mysteries of life which will always remain inaccessible to the bhagat. Her knowledge brings power and draws her inexorably into the power struggle with the Bhagat who triumphs in condemning her to death.

l) The torture and death of the bhutali is a manifestation of the Principle of Good (the Bhagat-male) finally eastablishing his supremacy in crushing the Principle of Evil (the Bhutali- woman). The bhagat as tradition goes can do no wrong nor can he harbour any evil towards anyone. All wrong and evil can be born therefore only in the womb of woman, and takes physical form in the body of a woman.

m) The torture and death of the bhutali remains a flagrant contradiction in the organisation of warli society. On the one hand the two sacraments (rites of passage/initiation) namely the zoli : (tying of the cradle) which initiates the new born child as a member of the tribe and is given a name and the lagin (marriage-the rite of initiation into the perpetuation of the tribe) by which the man and woman become adult members of the tribe are both performed by adult women. The male has no effective role to play in either of these two rites. Yet which being the High Priestess of the community, the woman must be continually kept in her rightful place. The Bhutali is the warning that the Mighty can be thrown down from their lofty thrones and made to mingle in the dust. This contradiction in warli society remains unquestioned.

n) In fact, the torture and the death of the Bhutali, as has been from time immemorial, becomes the rationalisation for the failure of man to organise his universe. The bhutali becomes the scapegoat that exonarates man of his failure in exercising his 'divinely appointed' responsibility to keep order in his world.

Where do we go from here ?

It is sometimes disconcerting to discover that the fear of the bhutali is so deeply rooted in the adivasi mind that the eradication of this horrendous annhilation of women suspected as being witches defies an easy solution. And yet there must be a way out. Our own struggle to find a way out of this malaise that strikes a death blow to the awakening of women throws up five possibilies. We share them below.

(Contd. from page 86)

commodities would offer Tanzania more options than that of devaluing its currency or curtailing its development programs. The amelioration of terms of trade would offer Tanzanian coffee farmers better returns on the crop they now produce, obviating the need to expand production at rates of 5 and 6 percent per annum. Improved terms of trade would also alter the economic circumstances of women and offer the possibility of better health and nutrition for themselves and their families. The New International Economic Order holds the promise of a future for Tanzania radically different from the grim one currently predicted.

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a) Awakening the Women : To understand the reality of the bhutali phenomenon in all its different dimensions. (In the minds of many woman there is a lurking doubt that the bhutali may be real. This comes to the fore especially in the minds of women affected by unfortunate events and they support their husbands in the hunt for the witch). This awakening is part of the wider struggle of the women for emancipation and equality. This awakening must also form part of the general awakening of the male population. (The men too have a tremendous fear of the witch and which is the reason for the vehemence with which they act to annhilate her). Since the bulk of the population is illiterate, the process of awakening will have to make extensive use of drama, song and discussion.

b) Improved Health is the cornerstone : Because if one goes through the earlier part of this paper one notices that the event that triggers the witch hunt, is in most cases 'unexplained' disease or death. The deterioration of the adivasi health system is a major area of concern when one looks at the bhutali problem. Any effort will have to be directed to attain three goals :

i) A re-evaluation and change of the adivasis understanding of health, disease, and health care. ii) Taking health to the grass-roots in the form of more radical health care systems and creative responses to the health problems iii) Developing a local integrated system of preventive health care

c) The Enlightened Bhagat is the Key : As the central person in the traditional health care system of the adivasis, the bhagat plays a crucial role (whether positive or negative). Hence any action for integrated creative health care would necessarily need to include the 'enlightened bhagat' (Any attempt to substitute the present with a parallel system even if it provides a superior and more efficient system would be counter-productive). Those 'enlightened bhagats' would have to be involved in a process that is geared to : i) improving diagnostic skills. ii) identification of herbal remedies and their medicinal porperties, together with methods of cultivating and preserving various herbal plants. iii) Development of supplementary skills and medicine to complement those areas where the local systems and remedies are insufficient. iv) Development of preventive health care as a system in its own right with the bhagats.

d) Education to develop scientific attitude : A consistent programme to introduce a scientific temperament coupled with the struggle against superstition should run through the whole effort which would integrate the various parts as one integrated look at life and its different processes.

This short paper tries to put forward what we are thinking and hoping to put into effect. We need assistance and co-operation at every step. Your solidarity is as necessary as our efforts. We hope you will become part of this process of struggling for the liberation of the adivasi and the women in particular.

Why don't you write for us ?

This periodical is a collective effort of many individuals active or interested in the field of health or interested in health issues. The chief aim of the journal is to provide a forum for exchange of ideas and for generating a debate on practical and theoretical issues in health from a **radical or marxist** perspective. We believe that only through such interaction can a coherent radical and marxist critique of health and health care be evolved.

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If you wish to write on any of these issues do let us know immediately. We have to work three months ahead of the date of publication which means that the issue on Women and Health is already being worked on. A full length article should not exceed 6,000 words and the number of references in the article should not exceed 50. Unless otherwise stated author's names in the case of joint authorship will be printed in alphabetical order. We have retained the spellings and referencing style of reprint articles. You will appreciate that we have a broad editorial policy on the basis of which articles will be accepted.

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All articles should be sent in duplicate. They should be neatly typed in double spacing, on one side of the sheet. This is necessary because we do not have office facilities here and the press requires all material to be typed. But if it is impossible for you to get the material typed, do not let it stop you from sending us your contributions **in a neat handwriting** on one side of the paper. Send us two copies of the article written in a legible handwriting with words and sentences liberally spaced on one side of the paper.

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Give Us an Answer

All our life is on fire, all our prices rising,
Give us an answer, O rulers of the country !

A handful of American wheat, a kilo of milo mixed with chaff
Doesn't our country grow crops
Or do we have only mud-mixed grains ?

Give us an answer.....

We have forgotten the colour of milk
Coconuts and dried fruits have gone underground
Our children have only jaggery tea for nourishment

Sweet oil for cooking is the price of gold
Coconut oil for our hair is not to be had
Without rock oil for lamps we are familiar with darkness

We burn in the summer, we are drenched in the rains
We bear the rigor of winter without any clothes
Why don't we yet have any shelter ?

We toil night and day and sleep half-starved
While the parasites fill their bellies with butter
Why does the thief get food while the owner is cheated ?

There are pastures for the cattle of the rich
For forest development land is preserved
Why is there no land to support living people ?

Tall buildings rise before our eyes
The roads cannot contain these motorcycles and cars
On whose lobour has such development been built ?

We filled the jails for independence
We hurled bombs into the cars of the white men
Did we do it to fatten the sacred cow ?

When we ask for a rise in wages, for work for the unemployed
Why are we met with jail, beatings and bullets ?

Now you have taken a new disguise
And appear in the colours of socialism
But we no longer want for today, promises of tomorrow !

Now we will stand on our own feet
We will throw caste and religious differences to the winds
We call for the sisterhood and brotherhood of all toilers !

We vow today to fight with our lives
We will bury capitalism in the grave
And sound the drums of our state !

Bhaskar Jadhav, 1971
(Original in Marathi)