OUR BODIES, OURSELVES

Organising Women on Health Issues

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This article tries to draw on experiences which were made while organising rural women in Tamil Nadu, mainly landless agricultural labourers of Dalit background. Health had not been a primary aspect in this process of organisation, it had been used as one of several "entry points", but as things developed, it turned out that health education became a focal point since it raises the crucial question of women gaining control over their own bodies. This control over women's bodies, as it emerged, is one of the most important factors conditioning women's potential to organise and to participate in decision making. This discovery came as a surprise because "health" is not usually seen as a high priority by village women themselves. The participatory research process itself was a means to build consciousness about such social controls and to find ways and means to break them down.

THE participatory research process which was part of a project of PRIA (Participatory Research in Asia), took place in villages near Arkonam, North Arcot among members of a voluntary organisation called Society for Rural Education and Development (SRED) and among women belonging to an independent organisation called Rural Women's Liberation Movement.

It is characteristic that even the formation of SRED as an organisation trying to facilitate rural women's movement; was already the result of a longer process of organisational experience. The initial attempt had been to organise Dalits (they were using the term Harijans at the time).

SRED today works in 50 villages of Arkonam and Thiruttanni taluks, 35 villages are "consolidated" villages where cells of the Agricultural Labourers Union and the Rural Women's Liberation Movement Sanghams (founded in 1982) have been formed, 15 villages are "new" villages in which work has only started recently. Women's Sanghams and Agricultural Labourers Union function largely independent of SRED. North Arcot, like Chingleput, is on the whole a very dry area depending on the monsoon which often fails. Irrigation will be by wells and village tanks. As in many other parts of Tamil Nadu, the water table has been affected by the bore wells. There are two crops, mainly rice, but also dry crops like ragi, maize and kambu (a millet).

Women agricultural labourers have 120-180 days of employment, men up to 220 days. Agricultural wages are as low as Rs. 6 for men and Rs. 4 for women. Supplementary income comes from wood-cutting and selling, also from brickmaking. The land holding pattern is such that there are largely small holdings and only very few cases of land concentration. This of course confines the scope for wage struggles within narrow limits. It is obvious from this background that the people with whom SRED works live in abject poverty and struggle for their very survival.

Integrating Health Work with Women's Organisation

The SRED did not start off as a health organisation. However, poverty being so rampant, health is clearly an important problem. Thus, health work came in mainly as an entry point for women's organisation. It was integrated with other activities like self-employment schemes: mainly embroidery and tailoring to start with, then mat-weaving, weaving of towels and sarees and carpentry. Plans are in process to branch out into cycle and transistor repair. Dairy and poultry schemes have also been tried.

In Arkonam, a special women's shop sells sarees and readymades. The effort to offer weekly opportunity for gyneacological check-up had to be abandoned due to lack of response. Apart from such attempts of income generation, building up rural women's organisation was the main objective. The Rural Women's Organisation has again and again taken up rape cases, wife murder cases, wife-beating cases, also issues like water supply and road building, accessibility of the village tank to *all* (i.e. including harijans and menstruating women) as well as health issues, much of the time by putting organisational pressure to make defunct government services available to the people. Recently, a journal Women's Voice (Mahalir Kural) has been launched to report on women's problem and the activities of Rural Women's Organisation. Again, the journal will also have a section on health, especially drawing attention to nattu vaittyam (indigenous herbal medicine). A drawback is that there are too many men on the editorial board because women lack training in journalism.

The basic concept is to equip women activists to be barefoot doctors, to have a basic understanding of common illnesses and treatments and to make them conscious of improving nutritional standards even under pressure of abject poverty.

The need for sustained health work first became visible in 1979, when a widow approached the organisation in need of an abortion. Since she was ashamed of expressing her problem straight away, she shrouded it in flowery expressions commonly available in village Tamil for this kind of occasion. (I have "not taken bath" for 2 months, i.e. missed the menses). The two young health workers did not understand her and sent her away with some aspirin. A few days later the village drums announced a death. The widow, in fear of ostracism, had committed suicide. It was decided to intensify health work and to link it up with rehabilitation of widows who are generally considered to be inauspicious and a social liability. A full time health worker trained in primary health was appointed and she took responsibility for training mainly middle aged and elderly women in primary health, among these a number of widows and village dais.

From the original 35 villages covered by SRED work, the women were drawn to get training as barefoot doctors. Since they are nearly all illiterate, the training went on for three to four years.

There are hardly any institutionalised health services provided by SRED. The community centre at Ulliambakkam runs a primary health clinic providing allopathic as well as nattu vaittyam (non-allopathic) services for common illness. Once in a week a private allopathic doctor comes voluntarily for consultation in more serious cases. At Kaverirajapuram, a cobblers village, once in a week a health clinic goes on under a tree with a homeopathy doctor who comes as volunteer. In Konalam centre, clinic work was started but had to be abandoned because of transport problem (it is inaccessible by public transport). At Mulvai a clinic was started with a gynaecologist, but this too had to be abandoned because of transport problem.

There are now eleven girls at the Kallaru centre who are working in self-employment schemes. Six of these also do part time health work. Three women full timers of SRED are appointed for training work in primary health. SRED has altogether eleven full-timers now (seven men and four women). Even the men animators who mainly work with the union and do work with men and women there, get all the primary health education with special emphasis on women's problems.

Emerging Concepts of Health

When health work was taken up by SRED, it was only partly integrated with the perspective of women's organisation. It was intended that health work should help to rehabilitate widows and would make basic knowledge of primary health available to a large number of women. However, the content of health education was rather complex and, as it turned out, rather contradictory. It cannot be claimed that all the underlying assumptions have been fully clarified but at least certain trends have become identifiable.

On the one hand, there was an attempt to make government health services available which would imply a curative allopathic approach. This was complemented by seeking the help of voluntary agencies working with an approach of preventive medicine along allopathic lines. This also implied a certain technical enlightenment about family planning methods, much along the lines of government programmes but without the coercive implication of these. The underlying assumption here was that use of family planning methods would automatically benefit women. On the other hand, there was an effort to enable women to really master their own health situation as self-reliantly as possible. This effort was undertaken by methods of nattu vaittyam mainly on herbal base, as well as cheap food supplements. The participatory method which was pursued, finally led to the insight that, instead of using health exhibitions prepared by experts, a team would be formed to prepare an exhibition, especially on the reproductive cycle and birth control. This led to a conflict with the technical approach pursued before and to the discovery that perceptions of sexuality were crucially influencing women's ability to apply birth control methods as well as women's ability to gain mobility and organise. Since these discoveries were an integral part of the participatory research process, it is necessary to follow this process step by step.

In the initial phase, a two day meeting took place, one day with animators of SRED and one day with about 30 women from the Rural Women's Liberation Sanghams. Initial discussions circled around questions like: (1) What are the most common illnesses? (2) How frequent are death in childbirth and child mortality? (3) How frequent are abortions? and so on. It turned out that all of these questions can only be answered within the overall context of abject poverty of the people in this area. Most common illnesses like diarrhoea, dysentery, fevers, breathing problems have all to do with general malnutrition, lack of water and basic hygiene and the constant worries of survival. Apart from this, some ailments were identified as occupational or environmental. There was widespread tuberculosis, probably with underlying byssinosis, among the workers of a cotton mill and there was a village where people suffered from water-induced paralysis. While death in childbirth is not a very frequent occurrence nowadays (partly because of the thorough retraining of village dais), child mortality remains high, especially among girls. Abortions were obviously widespread and a follow-up on this question showed that they are more rampant than assumed. While government services are available in a number of places, they are often defunct and in many cases people also do not have the money for the bus to go to the next health centre.

This overall situation accounts for some of the basic priorities in the health work which were pointed out: To strengthen self-reliance by teaching cheap basic nutrition and herbal medicine; to help to make existing government services available; to propagate family planning.

It was then decided to proceed with the participatory research in the following manner: (1) To document experience where people had organised in order to make government health services available to them. (2) To document the use of herbs, home remedies, indigenous medicines (nattu vaittyam) and to record the positive and negative experiences with such methods; also to document positive and negative experiences with allopathy in comparison. (3) To go more specifically into the question of *women* and health—how do women understand their own bodies? What is their understanding of the reproductive cycle, of birth control etc? Are information and contraceptives available? What are the social taboos? (4) In which sense is the health work an entry point for other women's work? How does it relate to the other work and to the process of getting organised? Why does this work pick up in some places and not in others? (5) What are the most important aspects of the women's work to the women themselves? Why do they feel it is an advantage to get organised? What are their difficulties in getting organised?

It was felt that in order to come to grips with questions 2-5, it would be necessary to have extended discussions and one way to generate them would be to conduct health festivals in different villages with exhibitions, skits, songs and pattimantrams (debate). Apart from the festival itself, the collective process of preparing it would give a lot of opportunities for exchange and clarification.

Already at this stage it became visible that there are indeed very strong social barriers against women taking control over their own bodies. It turned out that many of the village dais who knew everything about delivery, have a very rudimentary understanding of the reproductive cycle. Many women said they did not know about birth control methods. Some had used abstinence in order to space births.

The women said that the health work helped them a lot to build women's sanghams and most sangham members have an acute awareness of health and nutrition, so much so that many sangham leaders become free lance barefoot doctors and health workers. They felt that they learned a lot in the process and derived self respect from this. At the same time their competence about nutrition and simple illnesses also had increased their awareness of health as a business, the profits of the drug industries. Ironically, it seemed often to be the abject poverty which turned out to be a learning aid here. Since expensive nutri-

tional supplements and sophisticated medical services were out of reach anyway, the "do it yourself" approach looked like the only viable option. Among the slightly more affluent families, the drive for self-reliance would be less and the influence of advertising and impact of a consumerist allopathic approach to health more. It was also felt that the health topic needed to be discussed more in the agricultural labourers union and that building a new health system needs to be part of overall transformation of society.

Deepening Levels of Participation

Originally, the health festivals which were organised also included family planning propaganda. Though this propaganda was not particularly oriented towards achieving targets, it shared the commonplace middle class assumption that small families are necessarily happy families, that women only have too many children out of sheer ignorance and that women will happily apply family planning methods once they get acquainted with them. These assumptions had obviously been inculcated in the process of training health workers to propagate family planning and were not supported by the actual experience of working with village women. It became clear in the process of the participatory research where they went wrong and how they needed to be corrected.

A series of health education meetings were held with different types of people, e.g. the girls who learn tailoring in the Kallaru Centre, social workers, nurses, village dais, women who belong to the women's organisation. Apart from general health topics like hygiene, use of native medicine, etc. special emphasis was laid in these meetings in building up knowledge about the functioning of the reproductive system and to build up a different attitude among women towards their own bodies. This is no doubt an extremely difficult task, since everything related to menstruation, sex, childbearing and childbirth is usually taboo and it definitely belongs to the upbringing of a "good girl" not to mention about "these things". The general pattern is that "men are supposed to know" while women are best kept in ignorance. The underlying social assumption is that a girl who has any sexual experience, has been "spoilt". A further assumption often is that even "knowing about those things" "spoils" a girl.

It is also difficult to evolve methods which allow women to open up. One method is sharing personal problems in small groups of two and three. Another method is to talk about all parts of the human body and their functions in order to build an awareness that sexual and reproductive functions are as natural as any other functions of the body. Besides, slide shows were used about the reproductive system. On delivery, role playing has also been used.

There are different kinds of barriers to be overcome in different categories of participants in this kind of a programme. Among young participants, most of whom will be unmarried, there is a general embarrassment which has to be dealt with, giggling, and a certain reluctance to face realities. Among village dais and more elderly women from the women's sangham, there is greater sobriety in facing reality and drawing on one's own experience but the actual level of information is very low.

In a meeting with young girls in which I participated, the embarrassment was such that participants closed all the windows while slide show was going on so that nobody would be able to overhear what was discussed and the showing of slides was accompanied by exclamations and giggles. While the girls expressed afterwards that they found it useful to know all these facts, the question arises how they can be dealt with in real life since the actual taboo of knowing is so great that admitting such knowledge easily leads to accusations.

In another meeting with elderly women (village dais and women's sangham leaders) it turned out that though the women had experience and understanding about childbearing and delivery, many of them did not know about methods of birth control. Some of them had used abstinence in order to space child births. Some confessed to having had abortions. Some had reservations because they found it risky to go in for permanent methods because of child mortality. The tendency in the discussions was to place before the woman the options of birth control (e.g. loop and copper T, operation, etc.) in such a way that they appeared as the scientific way to go about things while abstinence from intercourse was looked at as unscientific and unnecessary infringement of the marital rights of the husband which would create tension and misunderstanding.

In the course of the discussions it became visible that the approach of the SERD animators was somewhat inconsistent. They had the tendency to depict tubectomy as a very good method of family planning because it solved the problem once and for all. It also transpired that, if a woman gets operated, she may have even less control over the frequency of intercourse than before because "nothing can happen" anyway. The man can assert his "right" over her body more easily since no risk of creating further offspring is involved. Woman also felt that they would face more accusations of infidelity if they used contraceptives. The animators applied a "harmony model" oriented towards fertility control only, suggesting that it was quite unnecessary and unscientific to deny a man intercourse in order to space births. It became visible that abstinence in some cases was a simple way of ascertaining sovereignty over one's body—an effect which could not be achieved with all the nice scientific technical methods which may in fact contribute to weaken a woman's control over her sexuality. Women also come up with their views that having to be sexually available hampered their mobility. They found it difficult to come for night meetings because they would be late in coming home. Even elderly women complained of the need to be sexually available very frequently. Sexuality was very much perceived as part of the sexual division of labour, women providing services and man consuming the same. It also became apparent that even women's access to hygiene is very much related to sexual division of labour as well as threat of sexual violence.

While certain general rules like tethering cattle or covering food can be easily followed, it turned out that women do not easily have basic access to hygiene. On being questioned about when they take bath, the usual answer is "on Friday". Friday is the day then they take bath, put turmeric, flowers and clean clothes and go to the temple. The men on the other hand have a daily bath. The problem is not scarcity of water because women may be handling water all the time, washing clothes, scrubbing vessels, watering plants. The problem is one of the division of labour and length of the working day. Women simply do not find the time to take bath. A bath is a luxury reserved for man. (Indeed, detailed enquiries into the working day of women and men among landless agricultural labourers have shown that women work up to six hours more every day.)

Another problem is the lack of privacy. It is more difficult for women to take a bath because women have to be constantly careful not to expose themselves to other men's eyes. This problem also affects their toilet habits. Women go to the fields very

early in the morning or late in the evening. The contradiction is that it should be dark in order to be less exposed, on the other hand, it is more dangerous to go out in the dark because of the danger of assault. All this leads to constipation and strain on the bladder. The problem gets aggravated during menstruation and pregnancy.

These conditions are so much taken for granted that it is extremely difficult to discuss them at all. It is extremely hard to think of any alternatives. Common toilets in the villages ("WCR toilets", a government programme) never work for lack of maintenance. One also wonders whether it is right to have public toilets for women and men in one cubicle just separated by a wall and with different entrances. If the toilets for women were in one locality and those for men in another, it might work better. Private toilets are entirely absent because of the money investment, water problem and fear of bad smell close to the living place. An experiment with a Gandhian dry toilet by two health workers was also given up. So at the moment, it is very unclear in which direction to go. However, by being able to slowly talk about the problem it becomes clear that the situation is quite unbearable and thus the motivation to tackle it slowly grows.

There are also questions about how to deal with menstruation. Women use old rags for sanitary towels and it should be explored whether it could become an avenue of self-employment to produce cheap sanitary towels at the sewing centre in Kallaru. It was also observed that bathing places for women have vanished over the last ten years due to environmental factors. Generally, the water table in the area has gone down because of bore wells. Many temple tanks have gone dry and others have been reclaimed for agriculture. Even where they still exist, the men are washing lorries in them. So the old custom of women going to the village tank to bathe, wash clothes and chat with each other has been abandoned. This not only undermines cleanliness but also women's solidarity. The question comes up whether the women's organisation can try to create a new place for women where they can wash, bathe, chat and spend some time together.

The Social Roots of Abortion

It transpired in the course of time that abortion is a much more gigantic problem than was evident from the beginning. In a discussion with middle aged and elderly village women it turned out that nearly all of them had experience with abortion, either undergoing them or performing them or both. Abortion is virtually a 'cottage industry'. It is usually carried out with home remedies as eating green papaya, swallowing large quantities of camphor and turmeric. The most widespread and most dangerous method seems to be the use of irakkan chedi (a plant the white blossoms of which are offered at Ganesh chathurthi). A dried yellow leaf of the plant is taken and the stick in the middle of the leaf is taken out and shoved up the birth channel into the uterus. This procedure causes ferocious infection and bleeding and any lead to severe puss formation and even blood poisoning and death. All the same, the method is widespread since it is free of cost and very "reliable" in the sense that the foetus does not survive. Often women have to go in for medical treatment in order to survive.

As far as infanticide is concerned, it remains a pious wish to say that girl babies should be treated equal with male babies. A substantial part of the problem of child mortality is in fact the problem of the morbidity of the social system of patriarchy. At the present moment, it is not yet visible how the women can go beyond discussions towards concrete solutions. The sobriety with which some of them admit infanticide is breathtaking and heartrending at the same time.

The facts of abortion and infanticide again raised the question why family planning is used only by a few. It was recognised in the course of the discussions that "family planning" as such is often resented as a form of government interference in family affairs. It is therefore much more meaningful to discuss the problem as birth control in the overall context of allowing women control over their bodies and over their health. The unpopularity of sterilisations is based on two factors: a) People shun irreversible methods because of child mortality, b) socio-cultural barriers. Men think they lose their "virility" when they get sterilised. They think they will be "weak" and unable to work sufficiently to support the family. There is also a feeling that a woman who has lost her fertility for good is treated with less respect. The problem seems to be that such "loss of respect" does not get compensated by a feeling of having gained control over one's own body because control over sexuality remains entirely with the man and may in fact be more than before. So the humiliation and actual subjugation which may go with operation may make it less acceptable than the risk of having abortions. Though the abortions entail great suffering, they are a matter of woman's own choice at a crucial moment and they are executed entirely among women. Thus, to get away from the abortions can only be achieved by means which would in fact enhance a woman's control over her own body.

Conceptualising Sexuality, Fertility and Male-Female Relationships

A series of 45 posters was made (basically using VHAI slides and *Our Bodies, Ourselves* as models) entirely on the the reproductive cycle, the sexual and reproductive organs, ovulation, fertilisation, pregnancies, the birthing process, cancer detection, sterilisation etc.

This exhibition has advantages over slides in that it can be used without electricity and that women can look at it at their own place. While a slide show just reels off under their eyes, they can go back to earlier posters for clarification, can contemplate them at length if necessary and ask for explanations. It is very important to be able to dwell on the problem at length because the actual embarrassment of facing one's own insides in this way is beyond all measure. Women admitted again and again to have been shocked at what they saw but they also expressed surprises, joy and pride. Even the health-worker who explained the posters had to fight her embarrassment and had a tendency to rattle down the information in great haste in order to have done with it as soon as possible. It was later decided to avoid this and to first give the women a chance to react and to ask questions. One old woman objected violently: If women know all this in advance, how will they ever have the courage to get married at all. But young women counter-argued that this would support them to be less ignorant and helpless than before.

The exhibition was first shown in Ulliambakkam to about 50 women of different ages who had come from surrounding as well as far away villages. They were all sangham members. It was later shown to the girls in the Kallary centre who are in the self-employment training and partly in health training. When we discussed the exhibition in these different collectives, we discovered some lacuna in it which were later overcome as a result of these discussions. The 45 posters only dealt with the female body exclusively. It therefore did show tubectomy but not vasectomy.

This had done out of a feminist motivation to come to terms with "our bodies, ourselves". However, it was felt that this approach was not true to reality. The male contribution to pregnancy became visible only in the form of a few sperms, the

most expressive poster of this kind being that of a giant sperm wriggling its way towards the egg ("pampu pole"—"like a snake", as the women said). It was felt that there is surely more to getting pregnant than just that. Why did it seem to be difficult to face and depict this "more"? One underlying problem seems to be the sheer habit of exhibiting, exposing and even dissecting a women's body without great problems, quite in contrast to the actually imposed "modesty" and "shyness" of women. On the other hand, while men uninhibitedly and even shamelessly expose themselves, including their private parts in public while they relieve themselves, there is much more of a tamboo to actually depict a man's body, leave alone his genitals on a poster. This is one reason why we feel so free to dissect a woman's genitals and reproductive organs while we find it difficult to look at a man's penis and testicles with the same kind of detachment. It was therefore felt necessary to depict the man's reproductive system as well and to admit the involvement of the penis in intercourse. It slowly surfaced that there is a need to understand in greater depth the relationship between sexuality and fertility in order to come to terms with the overall problem of birth control and control over a woman's body.

The difficulty in doing this can be easily illustrated by the fact that one of the great revelations to women is the news that they actually have "three holes" i.e. urinary outlet, vagina and anus. Virtually none of the women were aware of this before marriage since there is total taboo on talking about one's body. One young girl said that she thought for a long time that talking to a man and laughing could make a girl pregnant since this was what her parents forbade her to do. Even when giving birth the first time, some women are still confused where the child actually comes out. In the posters, the female genital organs were entirely depicted from the point of view of fertility. The fact that women have a sexual organ of their own in the form of the clitoris which is not related to fertility was felt to be too much of a shock to be disclosed at this stage. The female body is seen entirely in terms of fertility, even as far as woman's own subjectivity is concerned. Women may be "male sex objects" but the question how they could possibly be subject of their sexuality and perhaps enjoy it, is kept out completely. Even women's protest against making women sex objects is often carried out by mobilising values of motherhood and nurturing. Women as sovereign sexual being seem to be unthinkable to women and men alike. However, this is not just a question of a women's general quality of life, it has quite devastating medical implications and at times becomes a question of life and death.

Men, on the other hand, are primarily seen in terms of sexuality, they are first of all sexual beings. The fact that their orgasm is achieved by ejaculation of sperm which make pregnant (while a woman's orgasm is entirely independent of fertility) is generally neglected. Since it is the woman who gets pregnant, fertility is "her" problem. But in fact "her" problem is that sexual satisfaction *in the man* is related to fertility. Precisely this is her actual health hazard. It was therefore felt that an exhibition on the reproductive cycle needs to depict these facts of life in a truthful manner.

Summing up, it can be said that the health work had focus entirely on problems of fertility which was seen as a "women's problem" which had virtually nothing to do with sexuality as far as the woman is concerned. Sexuality only came into the picture in the form of rendering sexual services to men who were seen as sexually starved and needy but had virtually nothing to do with fertility except that, unfortunately, the sexual act does make women pregnant. The task identified was therefore to acknowledge woman as a sexual being, to acknowledge the right to control her own sexuality to acknowledge man's responsibility for fertility which would also establish the necessity to see male sexual needs in relationship to female sexual and other physical needs and to the problems of fertility as a shared problem.

Perceptions of Marriage

These discoveries led to deeper discussions on sexuality and fertility and on the actually existing patriarchal system of the family. It came out that women, while they see themselves as childbearers and as beasts of burden, most of the time experience sex as one more household chore like fetching water and firewood, cooking and serving food, finally surrendering their own body. These discussions were very interesting because the women felt free to speak out in a large group while at the same time a few of the men animators were also present so that there was a certain amount of interaction between women and men as well. Since men are seen as primarily sexual beings, the assumption seems to be that sex is their birthright and their supreme need, their "full satisfaction" an ultimate goal to which all other considerations have to be subordinated (e.g. refusal to use condoms). In a big meeting with fifty women only two said their husbands used them. On the other hand the sexual satisfaction of the women does not come into the picture. Since the men enjoy sex, they presuppose that women also do so. On the question whether they know what their women feel they said: How can we know, we have no words to talk about "such things". Men were completely taken aback when married young women said that they enjoyed caresses and tenderness while they often hated actual penetration.

Since "full sastifaction" of the man is the supreme value, the women needs to be ever ready. Women are often not allowed to go to night meetings leave alone to seminars which last several days, because they will not be available at home. The women are also frightened that if they do not provide these constant services, the man may shift to another woman and ditch them. Even elderly women face the problem of daily intercourse.

This led to the characterisation of a man's attitude towards marriage as a "facility" (Tamil: vasathi). Men get married when their mothers get too old to cook for them and they expect from it all the services like cooking, washing, health care, childbearing and rearing and sex. The one service they render in return is "protection"(pathukappu) which in fact only becomes necessary because of the general violence against women in society which makes marital rape preferable to the constant danger of indiscriminate sexual use, gang rape and the like.

It seems to be clear that unless woman's right to control their own bodies becomes an accepted human right, the use of contraceptives remains a remote possibility and women may go on for a long time undergoing home made abortions and allow their babies to die of neglect.

Discussions on Menstruation, Pregnancy and Delivery

In the workshop which accompanied the exhibition and which brought out most of the crucial insights which are summed up above, a lot of other information also came to light which, at a closer look, seems to be very much related to the social mechanisms which withhold from a woman control over her own body. All the women believe in seclusion during menstruation. They should not touch foodstuffs (especially pickles), should not go out, should not bathe and put flowers etc. They experience

themselves as impure and weak. They should not use disposable sanitary napkins because if some animal eats these, this will cause the fertilised egg not to settle in the uterus or early miscarriage. If menstruation ceases in a woman due to anaemia (which does happen since anaemia is widespread), this is ascribed to a "spirit". It is also related to the goddess Katteri. When they are pregnant, women are more susceptible to be possessed by spirits. They are also not to cross rivers and should avoid going out. There are the most comprehensive food taboos on pregnant women (on the list of foodstuffs to be avoided are : coconut, mango, papaya, jaggery, raw rice, grapes, bananas, jack-fruit, sweet potato, potato, maize, kambu (a millet), tinai (another millet) and a number of vegetables, including kirai, and eggs). Women are even restricted in their water intake. One really wonders how they keep alive at all with a diet chiefly consisting of rice and virtually nothing else to go with it. The idea is that the placenta may grow too big or that the child will be too big and delivery difficult.

Women are also kept in the dark about delivery. Since they are brought up in the belief that a spirit or a god leaves the child at the doorstep or that the old lady who sells vegetables has brought it along, they find it difficult to envisage the process of delivery even during first pregnancy. Some think the child many come out through vomiting from the mouth, others believe the belly may open underneath the naval. Some believe that the child comes out from the rectum. Some believe that the child comes out piece by piece, hand from hand, eye from eye and then gets assembled. Only three young girls had learned about pregnancy and delivery at school and one girl had got a rather realistic picture by overhearing other women talk about it. While exposures like the poster exhibition go a long way to set such beliefs right, a lot remains to be done to enable women to be in command of their bodies during delivery, by breathing exercise and methods of natural childbirth. It is quite a step to recognise that the pain during labour is due to contractions and that the most efficient way of dealing with it is not to clench one's fists and grind one's teeth while waiting for it to go over, but that there is an active way of combatting the pain by systematic breathing and relaxation. It is envisaged as a future step to go into methods of natural childbirth more systematically. It also remains to be explored to what extent this process can be explained to men and whether men can be involved in deliveries in a supportive way.

It is also important to see these prevailing superstitions about women's bodies during menstruation and pregnancy in the overall perspective of violence against women and oppression through perpetuated ignorance. The tendency sometimes is to ridicule women for their ignorance and superstitions. However, many of these are just an expression of concretely experienced powerlessness and isolation. Nodbody would nowdays easily come forward to blame a Dalit for his belief in untouchability. His mindset will be seen as the product of an oppressive system. Women's minds deserve to be understood in this overall framework as well.

Lessons Drawn

It is certainly not easy to draw clear cut lessons from a learning process as complex as the above described. One definite result is that the participatory research project itself has created more intense involvement and mass participation in the health education. Apart from this, the following observations can be made:

1. Certain contradictions were discovered between different objectives within the health programme, e.g. the activity of making defunct government services available and then dispensing health services rather at random, was in contradiction with the overall approach of using nattu vaittyam, making people subjects in dealing with their bodies instead of making them objects and consumers of treatment.

This is no doubt a very far reaching and complicated problem which can probably not be resolved on the ground of experience within SRED alone. Experiences of a more participatory use of allopathy have to be taken into account and also experience in the use of different systems (like, ayurveda, homeopathy, yoga treatments) need to be absorbed.

2. Another contradiction which became visible was between organising and pursuing a very technical, propagandistic approach towards family planning, much along the lines of government programmes. In the course of the research this approach changed completely towards birth control in the context of establishing women's control over their own bodies and their own health, and becoming clearer about the link between sexuality, fertility and social controls.

3. During the change of approach, major changes in language became necessary, e.g. today it will no longer be said that a girl "has been spoilt" if she has been sexually used. Also, the traditional word karparhippy for rape (which means destruction of chastity) has been replaced by balat karama (sexual violence). While it may look surprising that all this should be part of a health programme, it touches deeply upon the underlying assumptions about and attitudes towards a woman's body.

4. It became increasingly clear thay many health problems cannot be tackled without tackling the underlying social root cause. E.g. the prevalence of illicit abortion and occurrence of female infanticide cannot be tackled without making the effort to break male sexual controls over women's bodies and transforming social relations and production relations within the family. Even access to basic hygiene is dependent on this.

5. It was felt that this is indeed quite a frightening perspective because it means overthrowing thousands of years of historical heritage. The question is how this can be done concretely. Some possibilities seem to emerge: (a) The discussion on the relationship between sexuality and fertility as reproduced above and the different impact it makes on the roles of men and women in the family and in society at large needs to be deepened in the women's sangham and among men as well. (b) Methods have to be evolved to help people, women and men alike, to face these new insights and to live with them. Since women in the village as a rule cannot walk out on their husbands, they have to find a way to survive in dignity as also to take a lead to transforming the relationship. Since women are traditional relationship-builders, they have the wealth of a historical heritages to own and to fall back on. Of course, their major objective should not be to redeem men but to learn to live their own lives. All the same, some redemption of man may occur in the process.

Apart from the need to collectively support women (e.g. against wife-beating in concrete cases or by holding seminars on rape, including marital rape), there will also be the need for individual counselling of persons and couples. If such counselling happens in the overall context of building women's movement, agricultural labourers union, health movement and people's science movement, the effects of it will be much more constructive and transforming than the normal opiatic marriage counselling or just technical advice on family planning.

The experience of SRED on the relationship between women's health and the structures of patriarchy in the family and society at large need to be shared with people working in the field but also in the women's movement, people's science movement and other mass movements.

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