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### Women, and Health in Rural India: An Anthropological Perspective

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Women, and Health in Rural India:  
An Anthropological Perspective

Honors Thesis,  
Anthropology Department,  
OBERLIN COLLEGE, Ohio

Kelly S. Ward  
April, 1988

"What is needed, I will suggest, is not so much data as questions...What we know is constrained by interpretive frameworks which, of course, limit our thinking; what we can know will be determined by the kinds of questions we learn to ask."

M. Rosaldo, 1980

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## SYNOPSIS BY CHAPTER

### CHAPTER 1: INTRODUCTION

In chapter one I define the problem, that public health in rural India is mostly governed by cultural and socio-economic forces. Efforts to improve rural health in India have in the past had varying levels of success, depending on how well they understood the root causes of problems and the ramifications their programs would have on the general lives of rural inhabitants.

I argue that social science literature has largely misunderstood the issues which need to be addressed, viewing health problems as results of "irrational" behavior by rural peoples. I argue that the question of rationality, whether one accuses or defends a particular behavior, is irrelevant. The important issues concern what the context of behaviors are, and what they mean to those people engaged in them.

I also argue in chapter one that health care requires more than just technology, it requires an understanding of the human elements of life, illness, and healing. Anthropologists could be indispensable in discovering and analyzing how cultural and socio-economic factors interact to affect and react to illness and health issues.

In addition, I point out that studies done to discover these elements must be local, rather than generalizing, in nature. India is not homogeneous by any means, and the health programs which are most successful will be those which address specific, local needs in locally appropriate ways.

## CHAPTER 2: WOMEN AND HEALTH

Chapter two addresses the relationships between women and health in rural India. I argue that women's health needs there have been generally misunderstood, and their poor health has therefore been attributed to only certain of its many actual causes. I point out that there has been a tendency in social science literature and research to focus on reproduction and children's health, allowing those issues to upstage the health issues of women themselves. I suggest ways in which the official Indian health system (Primary Health Care, or PHC) must be rethought and restructured to relate more effectively to rural women.

I also address nutrition in chapter two, explaining that nutritional programs need to offer more practical and appropriate means of education and supplementation than they have in the past. The extent and effects of malnutrition in rural India have been underestimated, because it acts as a catalyst for many other, more visibly debilitating conditions. Malnutrition is also not listed among the major killers in statistics on Indian mortality, but it is the most widespread problem chronically suffered by the living.

Poverty is a major cause of most of rural India's health problems, but until (and unless) that is changed, anthropologists and health workers must look closely at how available resources are allocated, as well as how supplementary measures will be received and modified by village populations. It must be kept firmly in mind that larger forces, such as poverty, political

pressures, etc. are ultimately at the root of health problems, and the investigation of cultural elements is not an excuse for "victim blaming". The purpose of these investigations is to discover how culturally acceptable measures can be taken to alleviate problems given those larger root causes. The ultimate goal is self-determination and self-reliance among rural people, organized to fight those larger forces effectively.

### CHAPTER 3: FAMILY PLANNING

Chapter three concerns family planning. I explore the differences between "population control" and "birth control" as goals for programs. The former is a political motivation, and has no place in equitable health programs. The latter should focus on a genuine concern for women's health, which is detrimentally affected by bearing multiple children while undernourished, overworked, and fending off or suffering from infectious diseases. I discuss various reasons given by rural inhabitants for having children, and point out that those issues need to be addressed in order for any family planning programs to be effective.

I also present the question of sterilization vs. spacing methods, and a conceptual breakdown of the motivations behind each separate stage of the reproductive process. I argue that birth control is an issue of women's self-esteem, and sense of empowerment to affect their lives and health.



#### CHAPTER 4: INDIA'S HEALTH CARE PROGRAM

In chapter four, I discuss in more detail the problems of the Indian Primary Health Care system. I identify the false premises on which it is based, concerning rural life, especially as these relate to women. In effect, the government gives a uniform, egalitarian system of care, which ultimately cannot reach large numbers of people needing different forms of care.

India's network of health extension workers could be much more effectively utilized, if the unique advantages of that network were better understood. Anthropologists could identify in what capacities local communities would most enthusiastically receive these workers, and how they might better serve those communities. Extension workers should be taken more seriously, better trained, better supervised, and no longer thought of as "supplementary" to the PHC system. In many cases they represent the extent of any health care available to rural women. Anthropologists could also serve to identify which individuals would be most acceptable to which factions of local communities. Social "status" in rural India is very complex, and changes according to social circumstances. Therefore, health programs should not be structured (nor should extension workers be chosen) on the basis of assumptions about individual status. It is crucial, rather, to have communities choose worker candidates. In addition, more women must be trained as extension workers.

#### CHAPTER 5: TRADITIONAL AND WESTERN MEDICINE: MAKING CHOICES

Chapter five examines how choices are made between traditional and Western medical options. I present some

misconceptions about what "traditional" medicine is in rural India, and point out that it is in fact made up of many different traditions. I argue that past social science literature has often presented an image of a generic "insider" point of view, and that no individual shares such a view with every other rural inhabitant. It is vital to work within the contexts of particular communities, village factions and groups, families, and individuals.

I argue that people are practical, that they will choose health care which 1) is readily available to them, and 2) most completely fulfills their expectations for treatment. Therefore, it is important to understand and take into account the expectations people have, their goals for treatment, how they have diagnosed their problem and thereby chosen a practitioner, and what their criteria for judging a practitioner are.

I then address some theoretical considerations, concerning the distinction between the "body" and the "mind", moral associations with illness, causal models, self-diagnosis, and differential significance attributed to illness.

## CHAPTER 6: CONCLUSION

In the final chapter, I reiterate the role of the anthropologist in public health programs. I warn against the manipulation of people through the knowledge gained by anthropological research, emphasizing that the "native's point of view" in question must include not just differences in causal theory or medical techniques. It must, rather, include what is

the experience of living in a given community, with a particular social and economic status, a given list of health problems, and a specific cultural context from which to view all of those factors. What does it mean to have a specific illness there, what are the pressures to be faced, and how does it alter one's life and the life of the community? What, in fact, do those people desire in the way of improvement?

Past anthropological analysis of how illness and healing function in "traditional cultures", have been motivated by the desire to observe and analyze, not to change. They represent a quest for theoretical knowledge, and do not attempt to be "applicable" in the sense I advocate in this paper. Therefore, their ethnographies and analyses depict cultures operating in a political and socio-economic vacuum. Illness and healing in those societies, those anthropologists say, play vital roles in purging social unrest and reinforcing ideological structures. I argue, however, that the illness those anthropologists are describing is not caused by mass poverty, class oppression, or political manipulation and discrimination. In actual, contemporary rural India, disease and poor health do less to rejuvenate and unify communities than to threaten and drain them, physically, mentally, and emotionally.

After decades of defending its purely academic legitimacy, it is now time for anthropology to prove its practical worth. Anthropologists must accept the responsibility of applying theory to real life. They must provide assist, however they can, people

from different cultures understanding and helping each other to survive and lead happier lives.

## Chapter 1: INTRODUCTION

In this paper, I argue that public health in rural India depends on the cultural and socio-economic forces shaping local behavior, including responses to health issues. In addition, I suggest that women's roles in rural areas are closely connected (or can be) to the health of their families, their communities, and themselves. I also argue that health planners in the past have emphasized female roles in family health care and largely neglected the health of rural women themselves. I then demonstrate that an anthropological perspective on the relationship between culture and the motivations and perceptions of rural inhabitants is essential for gaining a thorough understanding of Indian rural health. Fabrega (1972) defined the issue this way: "...a medical anthropology inquiry will be defined as one that a) elucidates the factors, mechanisms, and processes that play a role or influence the way in which individuals and groups are affected by and respond to illness and disease and b) examines these problems with an emphasis on patterns of behavior." (cited by Chaudhuri, 1986 p3)

### RESEARCH PROBLEMS

Research materials on this topic were difficult to come by, illustrating the lack of adequate investigation which has been done in the area. I am not alone in this problem. Chaudhuri also writes that in a listing of works on the sociology of medicine containing 622 entries, only 4 or 5 were studies done on

India. (Ibid., p4) Most of the literature specifically concerned with India was written by social scientists, and consists of accounts of efforts to introduce new technologies into rural areas, complaints about insufficient numbers of Western-style (allopathic) personnel available to these areas, and somewhat shaky explanations of why rural peoples won't accept new family planning methods. The implication in much of this literature is that rural health problems are all due to the "irrational" non-cooperation of the populace, their seeming refusal to seek out medical help or to adopt new methods of carrying out their daily work. Relatedly, writings on women's health, with a few worthy exceptions, tend to focus on reproduction and child care. They are generally frustrated descriptions of women's "non-compliance" concerning birth control. In sifting through these various arguments, I found that what seemed to be important information about rural behavior patterns and motives regarding health care was often broad generalization based on well-meaning but highly inaccurate assumptions and premises.

It is virtually impossible to generalize, with any accuracy, about India. Its landscape and climate range from parched desert, to lush jungles, to frozen mountains. The variety of people and cultures found across India is extremely diverse. It has perhaps the most diversified population of any country. To be a Hindu is to belong to any one of literally hundreds of different sects of Hinduism. Local cultures contrast sharply from village to village, affecting the way religion is practiced. The same is true for Islamic, Buddhist, and Christian

communities. There are vast differences between "tribes" within tribal India, and the rest of India is divided along caste and class lines, which may determine almost every aspect of one's social and professional life. This variety of cultural norms will, of course, shape health problems and responses in particular ways. It is then important not only to identify localized problems and complications which vary from place to place, but also to analyze local "successes" and advantages. For example, the New York Times reported recently that the state of Kerela has an annual birth rate of 23 per 1000, while the all-India rate is 33 per 1000. (New York Times, 1/29/88) That same article (appropriately entitled "Where Birth Rates are Kept Down and Women are Not") pointed out that women's health in Kerela is far better than elsewhere in India, although it is one of the poorer states. "Kerela is the only state in India in which women outnumber men, apparently because women in Kerela are healthier and eat better..." (Ibid.) Also, "the literacy rate for women here is...nearly three times the national rate" and "perhaps most impressively, the average age of marriage for women is 22 years, compared with a little more than 18 nationwide." (Ibid.)

Women in Kerela seem to live better than women in some other parts of India. Why? How has it happened? The New York Times article suggests a connection to the "legacy of education brought by Christian missionaries and the unusually high numbers of job opportunities for women", as well as Kerela's "influential Communist Party" and "heavily Christian state", both of which "have been cited as factors in the state's heavy spending on

health and social programs." (Ibid.) Kerala is not a perfect state, but the differences between Kerala's experience and that of other states should be analyzed carefully in search of positive elements which could be modified and applied to other areas. The Times says that "In a country where women are generally less well off than men in terms of health, education and family status, Kerala is cited by feminists as an example of how improving the quality of women's lives can yield far-reaching results." (Ibid.)

It seems logical, then, that an anthropological examination of both a general and a particularistic nature might both alleviate some faulty preconceptions and allow more effective health planning for specific rural people. Although certain general medical problems exist across rural India, particular areas experience distinctive problems, which must be understood before effective medical planning and health care can be implemented. This paper represents a starting point for such an investigation, calling for small scale anthropological studies of individual areas, in order to discern the critical influence of cultural factors on local health care.

#### MORTALITY RATES

In deciding how to conduct my research, I first tried to focus on particular diseases which were the "worst" killers in India. I looked for mortality breakdowns by cause of death for India, but had great difficulty in finding any up to date statistics. Comments in some statistical sources pointed to difficulties in obtaining any accurate reports of cause of death



in India, because of:

- Lack of enough qualified individuals to report on deaths officially (Galtonde, in Bose et al, 1982 p174);
- Inaccessability to much of the rural population (Ibid.);
- Conflicting conceptualizations of illness types among laypersons; and
- Social pressures dictating what people felt were "acceptable" causes to report.

Lists of causes of death also may not indicate which chronic health problems are suffered by vast numbers of the living. Measuring health by mortality rates also gives rise to specialized, distinct intervention programs, such as those set up to fight solely against leprosy, malaria, or cholera. These focus mainly on the pathologies of specific diseases, rather than on the human conditions which allow illness to flourish. The existence of "cures" for many of these diseases, considered against their persistence among thousands of victims attests to the presence of very significant "non-medical" forces at work.

What is needed, then, is a shift of emphasis away from mere pathologies and lists of biologically distinct illnesses. Health must be viewed as an integrated issue, and the response to health problems must be an integrated response. (McEven in Taylor, 1983 p80) In other words, health problems must not be classified by the technical "disciplines" they relate to, but should be thought of in terms of the human factors which collude to induce certain types of illness. Health programs should be organized according to which responses can best be carried out together and thereby most effectively. And they must recognize that while "disease"

is a mechanical problem, poor health and illness are human problems. (See Appendix 2, p94)

An anthropological perspective is crucial in recognizing that such separate cultural factors as caste, class, occupation, wealth, locality, and the implications of gender, etc. play very strong roles in determining individual behavior, and also interact in complex and crucial ways with one another.

For example, anti-malarial campaigns have included the spraying of DDT in household compounds to eliminate mosquito breeding grounds. However, some communities have very strong ideas concerning who may have access to these compounds, and when. This access varies with the caste and class of the household members, and their respective ideas do not always concur with those of the anti-malarial workers. "They used to be considerate to use, and take into account that we Pirzade women live in purdah. For several years they used to send quite young boys to each house to spray DDT. That was good for us. But last year, they sent an adult man - and of course we couldn't let him in as none of our men were at home. That is very cruel of the government. Do they want us all to catch malaria?" (Informant cited in Jeffery, 1979, p108)

In this example, the government has failed to respect the cultural norms of the local people. The Pirzade inhabitants view the situation very differently from the anti-malarial planners. They feel that they have been denied anti-malarial protection since they are unable to admit the workers to their compounds. An anthropologist might have been able to foresee this conflict, and suggest that either younger workers be sent, or else that

adult workers make their visits at hours when Pirzade men would be at home. It is thus clear that disease control and health programs represent much more than the solution of technical problems. The cultural factor is ubiquitous.

Sometimes the choices people must make are even more basic to their survival. R. Desowitz describes a situation in a village on the Bangladesh border, where inhabitants were suffering from malaria: "Malaria control was an almost ridiculously simple matter of clearing away the vegetation...The malaria-control people were happy...but the local population protested vehemently....It turned out that the vegetation was not a mean weed, but a carefully nurtured water lettuce, a staple of the local diet and one of the townspeople's few marketable crops. The villagers, balanced precariously between grinding poverty and malaria-induced debility, had no recourse but to opt for the water lettuce. [Emphasis mine]" (Desowitz, 1981 p16)

#### INSIDER VS. OUTSIDER

Communication between rural people and public health workers should keep misunderstandings and differences of priorities such as the example above, to a minimum. Joint community and health worker efforts should be made to keep everyone's priorities and perceptions clear, ensuring that the "insider" and "outsider" positions are equally understood, so as to render them cooperative, rather than mutually exclusive. Here the anthropologist's role may be transformed into that of interpreter, helping each "side" to understand the viewpoint of

the other. The anthropologist in this role may be very important, as this kind of communication is often difficult without such a mediator. As Guy Stewart argues, at worst the ideas and opinions of community members are seen by health officials "as obstacles to be overcome rather than factors that might transform the planning, design, application, and evaluation of a program." Alternately, Stewart states, the community is "coopted" into the program "through invitation of those views supportive to the professional plan. Thus communities often have a nominal rather than substantive and infusive representation." (Stewart, in Tulchin, 1986 p60) It is crucial that communities indeed have that substantive and infusive role.

#### CONCEPTUALIZATIONS OF ILLNESS AND CARE

Medical anthropologists have been fascinated by the different body concepts and cause-effect belief systems which different peoples have. Often patients do not hold the same model in their minds as doctors and health workers do. This is true especially when doctors and health workers come from cultural settings different from those of their patients. The basic points of conflict generally concern:

1. Who is ill: some people "experience as 'illness' conditions which others regard merely as 'problems of living'". (Engel, 1977 p133) For example, Desowitz reports that "To the citizens of Rangoon [capital city of Burma]...formed feces are abnormal. The diarrheal norm is accepted, for, after all, one hardly realizes one is ill if one is never well." (Desowitz, 1981 p19)

2. What is a symptom: "For patients...the difficulties in living...are usually viewed as constituting the entire disorder. Conversely, doctors often disregard these problems because they look upon the disease as the disorder. Both views are insufficient." (Kleinman, 1979 p252);

3. What is the classification criteria for illness: In other words, different specialists will look for various signs of illness, ask questions, and probably classify a single condition in a variety of different ways, according to their area of expertise. Patients will do a similar classification, which may or may not coincide with that of the particular specialist they are seeing; and

4. What is the model of cause and effect in operation? Explanations of illness need not always contradict each other. Often symptoms are attributed to a physiological "cause", but the whole condition is said to have been brought about by spirits or other supernatural forces. Therefore, once the spiritual force has been appeased or sent away, then the Western-style treatment is able to begin healing the bodily damage which the spirit has cause. (Welsch in Romanucci and Rossi, 1983 p49) Welsch observed this among rural dwellers in New Guinea: "There was...a clear distinction between treatments that dealt directly with the agents causing as illness and those that helped restore normal bodily functions." (Ibid.)

Many writers have pointed to this distinction between "disease", meaning the physical pathology of the body, and "illness", which represents the individual and social experience

of "being sick". (Lewis in Romanucci and Rossi, 1983) They suggest that allopathic doctors generally only deal with the former, while the patient seeks help for the latter as well.

#### GOALS OF ANTHROPOLOGICAL RESEARCH IN HEALTH

Without an understanding between patients and practitioners concerning these points, effective treatment is difficult. As George Foster explains, medical anthropologists have been hired in the past by public health organizations "to learn those things about health beliefs and practices of the peoples that enable health care providers to convince them of the superiority of modern medicine over their traditional therapies." Trying to "convince" people to abandon their ideologies is an unrealistic and inappropriate way to approach health problems. Foster says that health organizations are beginning to understand this fact, and that "Today the goals of international health programs are more realistic, namely to determine and develop appropriate forms of health care that will meet the diverse needs and expectations of the world's peoples." (Foster, 1982 p189) Anthropologists should be instrumental in identifying what those needs, expectations, and perceptions are.

For example, the Wisers (1973) observed that in the village they worked in, unsanitary and "casual" methods were used in delivering babies. This is true of many rural villages, and efforts to "teach" new methods have been more effective in some areas than in others. In the Wisers' village, however, "This, with all the neglect which follows" is not due to "ignorance", nor is the child unwanted. Rather, it is done purposefully in

hopes that the birth will thereby go unnoticed by any malevolent spirits or the evil eye. (Wiser and Wiser, 1973 p75) The issue for anthropologists and health workers is then not how to convince these people there are no evil spirits to fear, but rather to find ways in which more sanitary methods of birthing can be used without being conspicuous to any such spirits.

Another example concerns an effort to distribute black ferrous sulfur tablets to pregnant women in southern India. The underlying perception these women had of all hard tablets was that they appropriated the body space holding the fetus, and also interfered with digestion. (Nichter and Nichter, 1983 p243) Rather than trying to "convince" these women that the pills would do neither of those things, the more realistic approach was simply to offer the sulfur in an alternative liquid or powder form.

Thus, health care requires more than technological advances and "convincing" arguments. Since social, cultural, psychological, and economic factors continuously affect every dimension of rural health, an anthropological perspective is essential. It can provide great insight into the interplay of human factors shaping and constraining the physical well-being of rural people.

Examples of similar constraints on health care illustrate the levels of complexity of this problem. For instance, many cholera victims go untreated because victims' families see that cholera virtually always means death, and to transport a victim all the way to a distant health center (and then have to

transport the body all the way back) is far more trouble than it is worth. Thus, the spread of cholera, which is an infectious disease, can go unchecked.

Yet another example concerns leprosy. Although the disease can be arrested, its physical and emotional damage is generally irreversible. Families know that if reported, leprosy victims will be removed from their homes, to receive treatment in a location isolated from them. They do not want the separation of that family member, nor do they wish to invite the vicious social stigma which leprosy can bring to the family of any victim. Therefore, many cases are not reported until the disease has progressed so far that it can no longer be hidden from the community. At that point several other family members have probably been infected.

#### POVERTY

The largest common factor in all health problems in rural India is poverty. It complicates and compounds everything else, and stands as an obstacle for all types of solutions. The 1978 census found that 77% of India's population was living in rural areas, and 40% of that rural population was living below the poverty line. Efforts to improve public health through better sanitation, nutrition, domestic agriculture, or any other means undertaken thus far have been relatively helpless in the face of such poverty. This is especially manifest in the case of malnutrition, which is a cause of, or a complicating factor for, virtually every other health problem in rural India.

Rural India's health problems are not merely technological



ones. They reflect economic and cultural circumstances which must be recognized and understood. Anthropologists should take a leading role in the sort of investigation needed for such sensitive understanding. Specific factors effecting different groups of rural inhabitants must be identified. As a prime example, the health needs of rural women, have been misunderstood by health planners in the past, and attempts to improve their health situations have not been designed to fit effectively into their lives. I will develop this argument further in the chapters that follow.

## Chapter 2: WOMEN AND HEALTH

The main health problems for Indian women have been defined and ranked by K. Gulhati as follows:

1. High maternal and infant mortality
2. Maternal morbidity
3. Lower life expectancy
4. Mental disorders
5. High suicide rate
6. Malnutrition

(Gulhati, in Blair, 1981 p82)

There are several difficulties with this list. First, it is not entirely meaningful to say that the three worst health problems are high mortality and morbidity rates, and low life expectancy. These do not identify any of the reasons for poor health, and they are not helpful at all in conceptualizing what needs improvement. Gulhati's observations are correct, however, in that Indian women's death rates are consistently higher than men's at all ages until 50. And the male/female ratio in India is growing each year, though it varies regionally. (Murthy, p78, and Coyaji, p2, in Blair, 1981) It is interesting that the first two problems on the list use the term "maternal". Why are the top two health problems listed as occurring among mothers? Some possible answers are:

1. Because women's health is often equated with maternal health;
2. Because mothers in rural India are actively "maternal" for a large percentage of their lives, and can therefore be referred to and labelled as "maternal" for much of their lives;
3. Because the stresses of motherhood for these women are

enormous, and perhaps adversely affect the largest number of them;

4. Because motherhood, as it exists for rural Indian women, exacerbates all other health problems for them.

To elaborate on this last point, maternal stresses are acting as catalysts for other problems, and those need to be identified separately (i.e. overwork, malnutrition, infection, etc.) It is the combination of these factors which overcomes women, and makes finding short term solutions very difficult.

In many discussions of the work and conditions of rural women's lives, it is difficult to separate out what is specifically "maternal", and what is just "domestic". Women's lives are certainly complicated by children, but they are already heavily burdened even without the duties specifically involved with childcare. What rural women do, and their health, should not be equated with their roles as mothers.

Another interesting point in the above list of health problems is that it lumps together maternal and infant mortality as Indian women's top health problem. This implies confusion of "women's health" with "mother's performance". Certainly a mother's health has an impact on that of her children, but the reverse effect seems difficult to identify. (The only such relationship I can find is that women will have more children if they believe that several of them will die early in life, and numerous pregnancies are hard on the mother's health.)

Malnutrition ranks sixth on the list, the lowest in importance. But in fact malnutrition is a contributing force to all of the other health problems in rural India, including those

above it on Gulhati's list. Lack of adequate or appropriate nourishment make overwork, infection, and disease even more difficult and debilitating. Relatedly, Biswara et al write "...a close relationship exists between malnutrition on the one hand and timing and spacing of pregnancies on the other." (Cited by Suskind in Greene, 1977 p15)

As for the psychological and emotional state of poor women in rural India, as well as the suicide rate, there is almost no material from which to draw any meaningful discussion or conclusion. These are important areas of investigation, and it is unfortunate that so little related work has been done. not one I care to simply speculate about here. There is almost no material on this topic from which to draw any meaningful discussion or conclusion.

The real factors responsible for poor health among rural women are many, and need long term attention. Education and literacy rates, differential access to medical attention, financial stability, and occupation and social status all directly and profoundly affect the state of women's health. These are what truly need attention from those working to improve the health situation. In the meantime, I argue, India's rural health system of Primary Health Care (PHC) needs to be rethought, to change and improve how it relates to women. The PHC system must stop relegating the issue of women's health to Maternal and Child Health care (MCH). Because MCH facilities and personnel are specifically geared toward "maternal" and child care problems, they are inadequately prepared and equipped to provide

for the full range of women's health needs. This care must take into account women's domestic constraints and maternal complications. But it must also recognize that women's health problems are more numerous and complex than just those affecting infants, and are in fact a part of the larger picture of general rural health.

Restructuring of the Indian health care system for rural areas would present an important challenge for anthropologists, to identify the real, underlying factors responsible for persistent health problems, and to help find ways of solving those problems in ways acceptable to and appropriate for individual communities affected.

#### NUTRITION

"Internationally, malnutrition probably remains the most important cause of ill health..." (McKeown, 1978 p66)

It is generally acknowledged that many rural women are malnourished. Yet often nutritional programs "for women" focus on the impact of mothers' nutrition on that of their children. (Sanchez, in Blair, 1981 p111) Thus, women's own nutritional needs and status are upstaged. But a careful analysis of what effects the combinations of their gender, marital status, caste and occupation, etc. have on their nutrition, would reveal a wide variety of variables which need to be identified and acknowledged. An anthropological look at particular areas and communities in question, would allow for more specific understanding, and avoid broad generalizations. Some examples of these types of variables might be:

1. Wives often eat last. A national survey found that in 48.53% of families interviewed, men eat first and women eat the leftovers. When food is scarce, they are hit first and hardest (Coyaji, in Blair, 1981 p3);
2. Men in a household often get the "best", most nutritious foods. Often women of a household are vegetarian while the men are not (Katona-Apte, in Raphael, 1975 p46);
3. Some women fast (for religious reasons) more often than their male counterparts (Ibid.);
4. Women may be fed particularly poorly after childbirth and during menstruation (Ibid.);
5. Some communities hold that substantial foods are bad for expectant mothers and their unborn infants (Ibid.);
6. Pregnancy and lactation require extra calories;
7. Some women nurse into their next pregnancy (Ibid.);
8. Widows often eat only once a day, consuming "light foods" (Ibid.);
9. Getting water and fuel, pounding grain, etc. require extra calories; and
10. Infectious (parasitic) diseases can "steal" up to 1/3 of the total calories actually eaten.

Anemia is a good example of a special nutritional deficiency among women. It is considered to be a MCH problem, because it especially affects mothers. In fact, anemia accounts for one-sixth of all MCH deaths. (Ramalingaswami, in Blair 1981 p7) However, it is really caused by a combination of basic malnutrition, overwork, and various other factors, fatally exaggerated by the extra strain of pregnancy.

Anthropologists ought to study the belief systems underlying the food habits of rural women, especially those concerning pregnancy and the post partum period. These studies,

however, should be local and not generalizing. Pelto and Pelto (1983) did such a study in Tamilnadu, and observed that "...the lists of avoided foods varied, and most individuals did not avoid the full list. The results from this survey...suggest something of the interpretation that may occur concerning the applicability of usually held proscriptive principles." (Pelto and Pelto, 1983 p191) Clearly it is important to study which particular interpretations are made by the women of any local community under a health care program.

The Indian Primary Health Care System is structured on the premise that mothers are the most active force in the health care of children. Women are generally responsible for their families' nutritional needs, and are often the basic food growers and providers. The PHC system as well as independent nutritional programs have focused on teaching rural women the basic elements of "nutrition", for their families and children. Unfortunately, the problem is not that simple. Mothers have limited resources, including time and energy, as well as a shortage of food or money to provide meals for their families. Their knowledge of nutrition is obviously crucial. But in exposing them to alternative ways to feed their families, health workers must be sure their advice is practical. Nutritional supplements are often expensive, or logistically difficult to acquire; suggested preparation methods are often time consuming, laborious, and sometimes simply unappealing; and new technologies sometimes prove impractical or disruptive to the overall systems and routines of work. It is not that these women are not motivated to be effective mothers and wives, and often may themselves feel

that their results are less than satisfying. Moreover, they may feel their performance is being judged as "bad" by the health workers. But they may simply not have any realistic options. Public health efforts are perhaps justified in centering nutritional programs on women, but they should focus on relieving, rather than adding to their loads. (Briscoe in Tulchin, 1986 p113) And they must always be conscious of not insinuating "poor performance" by mothers.

It is true for everyone in these communities, not just women, that malnutrition is a complicating factor in all other health problems. It is very much underestimated because the additional illnesses are perhaps quicker to kill victims, and thus are more easily identifiable as the cause of death. For example, the mortality statistics indicate that infectious and parasitic diseases constitute the leading cause of death in India, representing almost 20% of India's total deaths in 1964. (Bose, 1982 p163) Why are there such high morbidity rates for infectious diseases?' Education and sanitation are important factors, but another large element is that the majority of victims simply don't have enough calories to fend off these illnesses. This is a circle: "...the malnourished child is susceptible to infections that occur secondary to a depression of several host defenses. Once infected, the nutritional status further deteriorates, and he becomes even more susceptible to secondary infection." (Suskind in Greene, 1977 p11) McKeown elaborates, explaining that "Malnourished people contract infections more often than those who are well fed and they suffer



more when they become infected. According to a recent World Health Organization report on nutrition in developing countries, the best vaccine against common infectious diseases is an adequate diet." (McKeown, 1978 p64)

(See Appendix 8, p103)

#### CURES: ECONOMIC AND CULTURAL

The biggest obstacle to solving nutritional problems seems to be that they are attributed to only certain of their multiple causes. Poverty is the largest one, and must be relieved. But until that ideal solution is achieved, the ways in which existing resources are distributed and handled within households and communities in circumstances of such poverty, must be given full attention. An anthropologist investigating how nutrition is conceived of and dealt with in particular areas (rather than just working out estimated caloric intake) could certainly shed some light on how best to approach the improvement of programming. "It is sometimes forgotten by nutritionists...that man does not think of his food in terms of calories and nutrients...It is the convention of the society which decides what is food and what is not food, and what kind of food shall be eaten and on what occasions...A better knowledge of the social aspects of eating is therefore of great importance to understand the nutritional status of a group of people." (Hartog and Johnson in Pitt, 1976 p100)

#### VICTIM BLAMING

Statements such as "Religious taboos such as the Hindu

prohibition of beef consumption in India have greatly affected efforts to improve the nutritional status of the population" (Suskind in Greene, 1977 p13) are of little use or meaning. It implies a stubborn refusal to cooperate with health improvement programs. It does not consider that if those programs offered only beef as a protein source, they effectively presented the recipients with an ultimatum: Either remain protein deficient, or break a cardinal rule of the religion which structures your entire life and shapes how you perceive the universe, by eating meat. The statement essentially blames malnutrition on its victims.

This type of victim-blaming is subtle and difficult to detect. The ideology is sympathetic to the poor, and holds that they are "victims" of cultural and environmental forces which have made them victims of poor health. This argument is opposed to more overtly racist theories about genetic inferiority and social Darwinism, and declares that it isn't the victims' fault they are "ignorant" or otherwise "unable" to maintain good health. It is the fault of poverty. Yet notice that the focus is still on what is "wrong" or "dysfunctional" about the victims. While it isn't their fault, the cause of the problem is still found in the victim. In a brilliant analysis of this phenomenon in social science literature concerning the United States, W. Ryan observes that "The miserable health care of the poor is explained away on the ground that the victim has poor motivation and lacks health information." While it isn't his fault he lacks motivation and information, it is still an inadequacy on his part

which is seen as the root of the problem. "...Meanwhile, the gross inequities of our medical care delivery systems are left unchanged. As we might expect, the logical outcome of analyzing social problems in terms of the deficiencies of the victim is the development of programs aimed at correcting these deficiencies. The formula for action becomes extraordinarily simple: change the victim." (Ryan in Vogeler and De Souza, 1980 pp111-113)

An example of more successful cultural understanding and compromise is offered by James McEven in The Narangwal Experiment. He describes researchers' experience of finding that the people of the community under study normally called in a special diviner when a child showed signs of what Western medicine calls marasmus. The diviner would declare whether or not the child had SOKHA ("drying up"), which was believed to have a supernatural cause. If the child had SOKHA, it was considered doomed, and efforts to revive it were abandoned as hopeless. When researchers were able to revive such children, right in their own homes, those villagers lost the sense of fatalism which had formerly surrounded marasmus, and were eager to learn the more successful methods of revival. (McEven in Taylor, 1983)

The key is that the villagers were not asked to accept all of bio-medical theory or illness. They simply observed that a particular Western treatment was effective against the physical aspects of SOKHA, yet were still able to appease or remove the responsible spirit in order for the rehydration to work on the child's body. And the treatment itself was not offensive or inappropriate for them to use within their cultural setting.

#### OTHER VARIABLES: GENDER

Nutritional programs have also been known to simply feed the wrong children. Again, in these cases, an anthropological investigation might have shown that high- vs. low-caste distinctions determine which children enjoy priority in feeding, and who could afford to come to where food was being distributed by the program. (Ibid.) This issue also involves the gender variable. Male children, often receive deferential allocation of food. In fact, in the Morinda study (Levinson, 1972), sex was found to be the single most significant variable for nutritional status. (cited in Miller, 1981 pp88)

"Permanent patterns of differential consumption, whether formalized into taboos or practiced from habitual expectation, can certainly have significant consequences. As an expression of power relationships, differential access to food characterizes many societies - from differences in class and caste to differences between men and women or between adults and children." (Pelto and Pelto in Romanucci and Rossi, 1983 p192)  
(See p29 this paper)

Caloric discrimination between girls and boys is more commonly practiced in Northern India than in the South, and ethnographic reports concur that the births of girls are more often welcomed in the South than in the North, where they are often considered a profound disappointment. (Ibid., p97)

Weanling diarrhea, a condition resulting from inappropriate foods in the transition period from nursing to solid food, is a leading cause of death in the northern state of Punjab. In a

village cited in B. Miller's The Endangered Sex, 7 male children as opposed to 18 female children died of the illness. (Miller, 1981 p88) The death rates in the Punjab in 1965 were 168.4 per 1,000 females under 1 year old vs. 144.6 for males, and 103.8 per 1,000 females under 2 years of life vs. 45.7 for males. (Ibid.) More boys than girls make it to hospitals, the ratio being 2 or more boys per one girl in the North, and 1-2 boys per 1 girl in the South. (Ibid., p100)

There is in fact real concern for the distortion of the male-female ratio in the rural North. Clearly there are multiple forces at work, and the ways in which they compound one another are important and complicated. Class, caste, gender, and many other variables are involved. For example, the male-female ratio among upper class Northern farming families who own land is high, while people of the South with no land of their own have a "normal" ratio. (Ibid.) (See Appendix 3, p95)

These figures all point to a "male preference" among many rural parents. It is more prevalent in the north of India, and the contrast between north and south is quite drastic in some places. Kerala, a state in the extreme south of India, is reported to be "the only state in India where women outnumber men...Elsewhere in India, especially in the North, it is men who receive special care from childhood on." (New York Times, 1/29/8) As pointed out elsewhere, it is probably no coincidence that 70% of Kerala women are literate, which is almost three times as high as the all-India average for females. In addition, while the average Indian bride is 18 years old, the average for Kerala is 22 years. (Ibid.)

Certainly such a widely spread phenomenon, with such important ramifications as male-preference has, would be well served by a thorough anthropological investigation. Its root causes must be identified, and the cultural norms and practices in which it is manifest and passed on must be understood. Social science literature so far does not contain much information or speculation about why male-preference exists in those circumstances. (One such study is B. Miller's The Endangered Sex, 1981. A body of feminist literature, however, can be found which attempts to analyze trends such as this one in more general terms.)

It falls largely to anthropologists to take on this sort of investigation, since they are sensitive to the subtle and interconnected ways that parts of culture operate. For example, medical neglect and differential nutrition are unseen causes and catalysts of other health problems. On the World Health Organization list of mortality statistics, there is no category for neglect of any kind. Does it count as "violence", or "malnutrition"? Admittedly, caloric and medical discrimination and neglect are difficult to assess accurately, as they are not practices which people are likely to be open about, or even purposefully "practice". However, there are indications in the statistics on children's nutrition, weanling diarrhea, male/female ratios of health center clients, etc., which show where these problems predominate. By not acknowledging the distinctions between various causes of malnutrition, or between overall clinic clientele rates and differing rates among poor men

and women, these problems are largely ignored or denied, and their causes remain intact.

#### OFFICIAL RESPONSIBILITY

Whose responsibility should it be to solve them? Is it a legal issue, to be left up to the courts and law enforcers? Is it a public health problem, for health workers to tackle?

If these problems are not accurately identified and analyzed, then no one will be able to tackle them. Public health workers, who are already responsible for keeping track of children's weight and other nutritional indicators and the clientele breakdown at health centers, are the only officials in a position to do such reporting. However, anthropologists could well be hired to analyze those reports, and to study the related practices and belief systems of the villagers involved. In a later section I will discuss how the Primary Health Care system needs to alter its assumptions about women and their health needs. Nutritional neglect, however, must be approached (once reported) in a deliberate way. Anthropological (or sociological) investigation ought to take place, to discover the origin and extent of male-preference patterns among particular groups. Although overt female infanticide is illegal in contemporary India, it sometimes occurs through the more subtle methods of neglect. The legal system must assume a strong position against neglectful behavior in this extreme form. A government cannot (and should not) decree that people's attitudes and opinions must suddenly change, but it can and ought to define clearly what resulting behaviors will not be tolerated. Ultimately, it

is up to the health workers to offer acceptable means of equal allocation of what there is, and practical means for adequate supplementation. But they must first be made aware of the reasons behind such discrimination. These include both "sexism", and an even more persuasive force, profound poverty. This implies the need for a minimal anthropological or sociological training to be included in the medical education of health workers in rural India.

#### VIOLENCE

Violence towards women is also not considered a special category on the World Health Organization mortality breakdown list. Wife beatings are lumped together with armed robberies, while automobile accidents are listed as separate from other types of accidents. Wives who have been deliberately burned in disputes over dowry are reported as domestic accident victims. Murdered widows have been reported as voluntary sati victims. (Sati is the practice of widows burning themselves alive on their dead husbands' funeral pyres, and is officially illegal in India.) These widows would be classified on this list under "suicide and self-inflicted injuries". Very few cases of sati actually occur in India, and I am not suggesting that they need their own category. I am arguing, only, that violence which occurs towards women specifically because they are women should be listed as such, in order to understand that there is more at the root of these incidents than accidents and general "criminality". Otherwise, the true causes will never be



identified or dealt with. Sati provides a vivid example of government as ineffectual in its position on an issue. The laws concerning sati state that it is illegal to perform any activity to "emulate" sati. However, a recent case of sati resulted in some government officials travelling to the site and paying homage, "as individuals", not as "officials". (India Today, 10/1987) Clearly there are strong feelings about sati, and its ideals. Again the government cannot expect to outlaw "opinions". But it can and indeed must be clear and firm about ending destructive behavior, and be prepared to back up its stand through legal measures.

While I have argued that fertility considerations are not the extent of women's health concerns, they are certainly crucial in understanding the sum total of those concerns.

The most important part of designing a family planning strategy, is to be sure of the program's motives and goals. If population control and birth control are not kept distinct in planners' minds at all stages of planning, the project becomes distorted.

#### POPULATION CONTROL

Confusion between "birth control" and "population control" has caused a great deal of trouble for family planning programs, both in how they are organized and run, and how they are received. Birth control programs should aim to improve women's health by providing them with birth control options to be used at their individual discretion. Population control, on the other hand, is the aim of programs focused on limiting or reducing the size of certain whole classes of people. The political motivations behind many theories of "overpopulation" and "population crisis" have allowed the fertility of different "classes" of people to be controlled by governments and higher classes. For example, proponents of the "life-boat ethic" advocate mandatory sterilization and an end to support or aid to the poor, due to their belief that there are not enough resources to go around the world. They feel that richer classes (and

countries) have proven their right to "survive" at the expense of the poor. (For an alarming example of this viewpoint, see Hardin, 1974 in Vogeler and Desouza, 1980)

#### POPULATION SIZE

Commoner (1975) explains that population growth and size are regulated by a phenomenon called the demographic transition. "In these processes, there is a powerful social force which, paradoxically, both reduces the death rate (and thereby stimulates population growth) and also leads people voluntarily to restrict the production of children (and thereby reduces the population growth). That force, simply stated, is the quality of life -- a high standard of living, a sense of well-being and of security in the future." (Commoner, 1975 in Vogeler and Desouza, 1980 p188)

Commoner traces the rapid population growth rate in India to the period of British colonization. He argues that the first phase (the stimulant phase) of the demographic transition occurred as a result of British-made roads, engineering, agricultural innovations, etc., which stimulated the Indian economy and improved some living conditions. But the wealth created by these innovations was not returned to the Indian population, to improve the standard of living for Indians. Instead, that wealth was taken out of the country and enjoyed in Britain. Therefore, Commoner argues, the second phase (the regulatory phase) never took place in India. (Ibid., p190f)

In short, Commoner argues that "...there is a kind of critical standard of living which, if achieved, can lead to a

rapid reduction of birthrate and an approach to a balanced population...The chief reason for the rapid rise in population in developing countries is that this basic condition has not been met." (Ibid., p189)

This view of how population size relates to political and socio-economic factors supports my argument that focusing on "population control" is not an appropriate or effective approach to alleviating poverty or massive health problems. Rather, the relationship should be understood as working the other way around. "One wonders what would happen if the Indian government simply took the sensible and humane step of providing decent health and voluntary family planning services to its people, instead of herding poor women like cattle into sterilization camps. Not only might human suffering be greatly alleviated, but the birth rate might actually come down. (Hartmann, 1987 p240)

#### COERCIVE STERILIZATION

The classes affected by population control programs are not unaware of this manipulation, and are therefore suspicious of any interference in their reproductive behavior. They are angered and fearful about forced and coercive sterilization. And they are aware that the wealthier classes have their own socio-economic reasons for wanting to exert control over lower class reproduction.

Many inhabitants of rural India fear that any efforts to promote family planning will in fact turn out to be sterilization campaigns. This stems largely from the India's Emergency of

1975. At that time a massive mandatory sterilization scheme was carried out on rural men, involving actually holding men down and operating on them. Memories are still bitter, understandably, and researchers just asking questions about fertility behavior have been driven out of villages by suspicious village members who hurled stones at them (McEven in Taylor, 1983)

More recent examples of political pressures for sterilization are also abundant. The New York Times reported recently that "There have been widespread reports throughout India, of fraudulent reporting of sterilizations and of sterilizations being performed on women who can no longer bear children, just so quotas can be met. (New York Times, 1/11/88 pA10) The same article tells the story of a village resident named Mrs. Kumari. Her village's "headman" was trying to convince her to be sterilized because Gurha, their district, was "one operation short of its annual female sterilization quota imposed by the authorities...The village headman...knew that if Gurha failed to meet its target, the chief family health officer, who happens to be his wife, could lose a pay increase due next spring." (Ibid.)

#### POPULATION CONTROL VS. BIRTH CONTROL

There is indeed a distinction to be made between "birth control" and "population control" as goals for programs. They are (or should be) motivated by very different sets of concerns, and therefore have very different methods and priorities. It is dangerous to equate the two. Even more dangerous is to hide "population panic" under the guise of

concern for individual health.

"Birth control" programs, in contrast to "population control" efforts, should be genuinely motivated by concern that numerous pregnancies under these circumstances contribute enormously to the rapid deterioration of women's health. There are certainly other forces at work, and one should be careful not to blame fertility for the extent of women's poor health. But those are long term, broad, societal problems, such as malnutrition. A woman's ability to control the spacing and total number of her pregnancies would give her the power to do something about her health in an immediate, tangible, individual manner.

The goals for family planning projects, should be always on a personal and specific level, addressing individual needs. They should consist of giving women the power to achieve:

1. Spacing of pregnancies more evenly and conveniently (for mothers);
3. Fewer births before having a son; and therefore
4. Ultimately, fewer total births per mother.

By the last two statements I mean only this: Many mothers (and fathers) are determined to have a certain number of sons. Until they achieve that number, they may be willing to have many children, even more than they would like to have, in the hopes that the next time will produce a son. "Mrs. Jahan, the health officer, said she had five children before her husband agreed to a vasectomy. The first was a boy. The next three were girls before they had another son. 'I could never persuade someone

without sons to adopt birth control,' Mrs. Jahan said." (New York Times 1/11/88 pA.10) Therefore, once a son is born, or before trying again, with the use of contraception a mother could decide to take a rest. The decision should be left to individuals to use spacing methods at times which they feel are appropriate and practical in their lives, rather than expecting health workers to "convince" people to be sterilized at the convenience of health programmers.

It is important to recognize that to these men and women "birth control" usually refers to "sterilization". It is a major step, and involves a different set of considerations than methods of spacing pregnancies do. "Sterilization's irreversibility, instead of placing the patient beyond conflict, thus may instead engender deep conflict, if the decision, made in haste or under pressure, leads to later regret." (Hartmann, 1987 p234) Investigation should discover why this all-or-nothing attitude is so prevalent. It presents serious problems, and yet the New York Times reported, for instance, that "Sterilization is the family planning means for three-quarters of the families in Kerala." (1/29/88) Also, in a northern district, "...the only method that people seemed willing to discuss during a recent visit was sterilization." (1/11/88 pA10) Why is this so? Perhaps the technologies for spacing pregnancies (diaphragms, the pill, etc.) are impractical for rural women. How could they be better suited to their needs? Or perhaps they are simply not widely offered to rural women. Hartmann reports that in rural South India "Although the rural elite preferred to use the IUD, poor villagers were offered no other alternative but

sterilization in the belief that they were too ignorant to cope with anything else and that their fertility had to be controlled at all costs." (Hartmann, 1987 p239) Cultural and ideological factors about sex, fertility, and power, affect how men and women perceive spacing methods. These issues will be discussed later in this chapter.

#### FAMILY SIZE

A secondary motivation for family planning programs is that large families are difficult to support in poor circumstances. I deem this secondary, because it is a complex issue. While it seems on the surface to be in the best interest of individual households, it may not be. For many argue that in a rural setting, more children rather than less are needed in order to bring in enough income and substance to feed and provide for everyone in the household. This simple fact is explained to officials over and over again by village dwellers. "I have to depend upon my kids to bring in money." (R. Raja, New York Times 1/11/88 p A.10) "The more children you have, the more hands there are to work" (R. Dei, Ibid.) "Another source of income must be found, and the only solution is, as one tailor told me, 'to have enough children so that there are at least three or four sons in the family.'" (M. Mamdani, B. Commoner, in Vogeler and De Souza, 1980 p191)

To outside observers it may seem clear that "too many children" exaggerate poverty and all its related health problems in a whole society. But these are not the concerns individuals



have. Families are profoundly aware that due to those same problems, they are effectively guaranteed to lose one or more (probably more) of their children to disease or starvation, and they have a desire to beat the odds of losing them all. Rural inhabitants are also aware that programs aimed at "population control" are not concerned for their individual well-being, and in fact are often detrimental to individuals. They are therefore not particularly inspired to "cooperate" with them.

Some investigators have tried to explain resistance to family planning campaigns by exploring the concerns which rural people voice about limiting their offspring. These include:

1. Lineage: It is considered to be extremely important that lineages be continued. Family names carry with them social, religious, and economic status and history.
2. Status: Large families hold considerably more respect and higher status than small families.
3. Labor and economics: In a poor, rural community, there must be many hands per household to provide the basics for survival.
4. Retirement: It is the responsibility of the sons of a family to provide for elderly parents who can no longer work.
5. Ritual: There are important ceremonies which must be carried out by sons.
7. Childcare assistance: Mothers rely heavily on elder children (females especially) to help care for younger children, and do domestic work.

But all of these are simply reasons why mothers desire children. Here is hidden a conceptualization problem. These people have been led to view contraception as a means only for ceasing to have children all together. They are responding to

questions about their views on birth control, by voicing their fears that they will be denied any children at all. Again, the question is raised, why is sterilization so dominant? The statistics for Indian couples using birth control of any kind point to the same attitude:

- 23% of couples of childbearing ages for all of India are estimated to use protection of some kind;
- 82% of those are either sterilized or use IUDs, as terminating devices;
- The average age of these users is 32 years (an age when most rural mothers have already born most of their children);
- The other 18% use foams and condoms, and are younger couples, located presumably in urban areas.

(Gulhati, in Blair 1981 pp82)

Indigenous methods of contraception and abortion do exist, and are practiced by some rural women. With the exception of abstinence, these are not overwhelmingly effective, however, and it is difficult to say whether they are not more widespread because they are not desirable, or because they are not considered particularly useful. In any case, the desire for some sort of contraception is present among some women. In 1966 the Indian Ministry of Health and Family Planning estimated that 1 in 4 pregnancies were "terminated in abortion". (Gulhati, in Blair 1981 p83) It is unclear in the literature exactly what that statement means, but certainly some pregnancies (undesired by someone) are being ended. (See Appendix 5, p99)

## BIRTH CONTROL FOR MEN OR WOMEN?

Men and women are both involved in the process of raising a family. Both should, ideally, be involved in making decisions concerning family size, as it will affect, indirectly, everyone's welfare.

However, in real life men and women are often at odds with each other in this regard. When that is the case, the number one reason for family planning should be kept in mind. It is the mother's health and well being which is at issue, and it should be within her power to make the ultimate decision. It is not up to outsiders to decide who'll decide, and family planning promoters should not expect that placing technology in these women's hands will suddenly cause them to assert this power. Anthropologists should study the ways in which these decisions are made, and analyze the dynamics between the men and women involved. (For one such attempted examination, see Poffenberger, 1969) This information could then be used for more effective and appropriate birth control programs. Family planning workers should not only make technology available to rural women, but also institute distribution systems which are locally appropriate and accessible, with adequate related education and follow up visits. Ultimately, they should focus on enabling women to assert power over their reproductive lives as those women see fit. If rural women's health is to be improved, those women need to feel that they have some control over some aspect of their health.

## EMPOWERMENT

"Birth-control use is more a measure of women's increased self-esteem and sense of opportunity than a cause of it."

(Gordon, 1977 p412 cited by Morokvasic in Young, et al, 1984 p207)

Even in the United States, the element of empowerment is often not considered, or is distorted, in discussions of family planning. Considerations of why women do or do not engage in sexual intercourse and do or do not use birth control, should recognize the correlation between these results and a sense of being effectual, of having some control over some part of one's life. In the United States, unemployment, low levels or lack of education, drug addiction, homelessness, and abusive relationships are all variables accompanied by a sense of lack of control, or of being unable to effect the shape of one's life. Not coincidentally, these variables all have correlations not only with each other, but also with high rates of "undesired" pregnancies. To take definite steps towards management of one's fertility requires confidence in one's ability to have a real effect, and to manage it well. If this fundamental confidence is weak, or worse yet is replaced by fatalism, it is unlikely that one will take the initiative to take those steps. Poverty, it seems fair to say, is one of the strongest forces working against feelings of self-determination. Thus, in addressing the fertility behavior of profoundly poor rural women, health planners must acknowledge the need not only for more technology, but also for a sense of empowerment to affect their health and

their lives. "Most 'unplanned' pregnancies are partly wanted and partly unwanted. A frequent solution to ambivalence is passivity - not using contraception, or using it haphazardly. This is a rational response when no alternative is desirable." (Gordon, Ibid. p193)

#### ASPECTS OF REPRODUCTION

I would like here to discuss another subtle, conceptual issue, which shows how careful anthropological study can reveal very sensitive and complex perceptions and motivations for behavior. It concerns a distinction between the different stages of human reproduction, and how these relate to the structure of life and power for the people involved.

M. Morokvasic explains that analysts must learn to "distinguish between unplanned contraception, unwanted pregnancy, and unwanted child", and that "women can be quite clear about not wanting a child, but ambivalent or even positive about wanting to get pregnant." (Morokvasic in Young, et al 1984, pp199f) And, by separating the various aspects of reproduction and examining the possible motivations behind this seeming contradiction, one becomes aware that they are related in intricate and important ways to the power relations between men and women, members of the same gender, and among groups of differing "status" within societies.

Writing about Yugoslavian women, Morokvasic points out that men control the knowledge about reproduction and contraceptive methods. Morokvasic's informants explained that they were convinced that by taking the pill, women would lose sexual

desire, or become adulterous, bear sick children, become ill themselves, or become sterile. Morokvasic examined the ways in which knowledge about birth control is disseminated and manipulated by different members of communities (especially men). She analyzed how these rumors were started, how they were passed on, and in what ways they served to influence and control women's use of and attitudes towards birth control and sex.

This sort of analysis should be done among women in local rural Indian communities as well. Each community holds views of sex and reproduction which will profoundly affect how they respond to and incorporate birth control. For example, among the Muslim women of Pirzade, India, sexual desire in a woman is considered shameful. Consider the cultural ramifications of this norm for birth control decisions. A contraceptive such as the pill could be socially unacceptable. For a woman on the pill is in fact making sexual activity more convenient, and removing any "reproductive" reasons for it, thus seeming to encourage it for its own sake.

Where men are in a position of authority and control regarding sex, they may also largely bear the responsibility for pregnancy. They may be expected to abstain, or use coitus interruptus. It is their place or "duty", to make those decisions, and to carry them out successfully. (Ibid., p202) This is far from saying that men decide "how many children to have". That represents an entirely different (though related) set of considerations and behaviors. However, if women do not

(or are not supposed to) desire sex with their partners, the loss of the threat of pregnancy means women lose an excuse for abstaining. In cultures where men are perceived and expected to be the sole instigators and enjoyers of sex, they have the power to control it. The threat of pregnancy (or indeed, pregnancy itself) can then be women's only defense against their partners' advances.

#### ABORTION

Abortion occurs in areas of India where other forms of birth control may not be commonly practiced. Perhaps this is because abortion can prevent a legitimate but unwanted childbirth without preventing pregnancy, and thus still allow affirmation of the fertility and virility of a couple. Morokvasic suggests that for women to whom "pregnancy is important for asserting their womanhood to themselves, their partners and others in the community, the knowledge that they can get pregnant is important." (Ibid., p207) And, the "ability to impregnate at will satisfies the man's sense of control over the relationship." (Ibid., p201) Are her remarks appropriate for rural Indian women?

These phenomena may or may not be happening in rural India. But these are the sorts of questions and issues which should be addressed in order to truly understand how reproduction, in all of its complexity, functions in any society.

The implications of this sort of analysis for differing communities of rural India must be carefully and individually investigated before any effective planning can take place. The

motivations for Yugoslavian women will not be identical to those of rural Indian women, nor will those from one rural Indian community be identical to those from another. Religious norms vary from village to village, local social histories and institutions are also widely different, as are socio-economic, environmental, and political influences and circumstances. All of these will shape how reproductive issues function and are experienced by any given society.

The relations between different factions within individual societies must also be examined with regard to reproduction. It is important to recognize that family size will vary according to vocation, religion, location, economic and educational status, caste, class, etc. Why is this so? And what are the mechanisms by which these differences are achieved? Anthropological research will show that such variables allow for different living arrangements, different tenets concerning sex, contraception and abortion, divorce laws, opinions about male/female children, labour power required for family survival, domestic/sexual relations, and many more factors in determining family size. Even how a "family" is defined will vary, and will have important ramifications. (See Collier, et al.)

In all cases, however, reproduction is an extremely powerful means of enforcing gender roles and social power structures. It can be a measure of women's relative lack of power in social and economic relations. Then women may be "thus not very likely to seek an effective means of preventing contraception until changes in their status and their relationship with their partner take



place, and they themselves see contraception as the most suitable way to control their fertility." (Morokvasic in Young, et al, 1984 p207)

## Chapter 4: INDIA'S HEALTH CARE PROGRAM

### PHC (Primary Health Care)

The present Indian system of Primary Health Care in rural areas, consists of health centers and subcenters. The health centers' services are free, and there is supposedly a primary or subcenter for every 100,000 population. (Ramalingaswami in Blair 1981 pp7) Each center has at least one auxiliary nurse-midwife and most primary centers also have one basic health worker and a allopathic doctor. (Ibid.)

### PROBLEMS

This kind of system operates on the premise that with enough such facilities, which are set up more for an urban environment than a rural one, rural areas can be treated just like huge cities. This premise is wrong. The ways in which medical care fit into people's lives involve more than just their location, and there is a fundamental difference between the lifestyles of urban and rural peoples which must be incorporated in how health services are planned. For instance:

1. Rural people do not generally live in concentrated areas. There are not always "central localities" for the centers to be located in. The centers operate as though rural areas were really large, spread out cities. Rural populations are far more widely dispersed, and therefore there simply are not enough centers for this kind of service to be effective.;
2. These centers are not well enough equipped to handle all the types of problems faced by rural people;
3. Access to centers is often extremely difficult, due to bad roads, etc.;

4. Often the mere distance from villages to clinics is too far to travel: 80% of clinic clientele comes from

within

a radius of 4-5 kilometers, or 3 miles (Murthy in Blair, 1981 p78);

5. The time required to travel to clinics and then wait for treatment, perhaps returning and waiting for several days in succession, is a luxury which many rural people cannot afford (Baltiwala, in Jain 1985 p47); and
6. Different conceptualizations of who should go for what kind of help, and when, can keep certain members of communities from receiving appropriate health care. (This will be discussed later.)

These centers present especially difficult problems for women:

1. Time is a resource particularly scarce for women;
2. Women are often dependent upon others (men) to get them to the facilities. Depending on various cultural factors, women may live in seclusion and not even know the way, and will need to wait for a male to have the time to take her, as well as convince him that it is essential that she go (Jeffery 1979; Murthy in Blair, 1981 p79) ;
3. For these same women, who may live in seclusion, going out alone, especially far distances and in order to interact on an intimate level with strangers, can be insurmountably intimidating (Jeffery, 1979);
4. The prevailing attitude in many communities is that women's health care is less crucial than men's;
5. Often women continue their daily work and ignore their symptoms for practical reasons, until they are urgently ill and too sick to continue their work. At that point, travelling to a health center is particularly difficult (Murthy, in Blair 1981 p79); and
6. Subcenters and even some primary centers are ill-equipped to deal with such emergencies. (Ibid.)

The existing PHC system assumes patients are being well cared for on the field level, that everyone is being seen by field workers who go into the villages, and that there is

adequate time before an emergency develops to get a patient to a clinic or hospital. In short, it assumes "effective screening of patients at the field level". (Murthy in Blair, 1981 p78) These assumptions, while questionable on a general level, are especially misguided concerning women. In fact, poor women's lives in rural India follow patterns which are in direct opposition to these premises. (Ibid., p79)

#### NEW SYSTEM NEEDED

It seems, therefore, that what is needed is not more of these centers, but rather a different kind of system, one which is oriented more toward the ways in which rural people live. (Murthy in Blair, 1981 p79)

A new system must change the premise that it is the patients who seek out help. This responsibility cannot realistically be placed on rural women. Health care workers must find ways to encourage women to obtain and accept care, and provide practical and acceptable means of supplying it. (Ibid.) Anthropological research will be of great value in identifying how best to approach these tasks.

The new system must also change the present tendency to distinguish between curative and preventive care. Auxiliary nurse-midwives have been directed in the past to refrain from giving any "curative care" to women during their village visits, which are supposed to be for family planning, infant care, and other "maternal" concerns. They are supposed to tell women they must come to the clinic for medications and more "general" health problems. Special attention to women's (especially mothers')

health needs is crucial, and can best be achieved through field worker systems. But this care must not become focused solely on "motherhood" activities, leaving women's other health issues to be dealt with in the general PHC system, which has proven itself inadequate and inappropriate for them. As K. Gulhati argues, the Indian Government's "egalitarian philosophy" regarding health management is geared to fight discrimination. But in treating everyone the same, it misses the specific health needs of women (and probably other distinct "groups", such as particular occupational workers, age groups, castes, etc.) and in effect it leads to large scale discrimination. (Gulhati in Blair, 1981)

#### MISCONCEPTIONS

Some doctors have suggested that women do not go to clinics because they won't see the male doctors who staff them. (Murthy in Blair 1981, p79) However, centers with male doctors do not have significantly higher ratios of male to female patients coming for care than clinics staffed only by females. In fact, even subcenters with an all-female staff had more male patients than female patients. The gender of the staff undoubtedly plays some part in the overall problem of women's health care, but is only relevant if women are able to get to clinics in the first place. The Indian Institute of Management in Ahmenabad states that women of ages 10-50 years make up the largest single group of people with limited access to all curative services. The sex ratios of patients attending the clinics in that study were 3-5 to 1 (male to female). (Ibid.,

p78) The question of the gender of health workers will be important, however, in the section discussing extension workers.

Another theory proposed by some health professionals in India is that women are more resistant to disease, and therefore the patient gender statistics are reflective of women's less frequent illness. Not only is this argument insupportable, but even if it were true it certainly could not account for a ratio of 3-5 to 1. (Ibid., p79)

(See Appendix 6, p101)

#### THE EXTENSION WORKER NETWORK

The network of extension workers (also called field workers) who supplement the health centers should, theoretically, help to solve some of the above mentioned problems. (These are men and women from local communities who are trained to go out into villages and give certain, basic health and family planning care.)

For maximum effectiveness, there should be an emphasis on training women for extension work positions. Women have more access to other women than men do. Many communities have very strict rules governing the interaction of men and women. I have already discussed this element of Pirzade society. (See p17) This is not only true of India, and R. Desowitz provides an example from Nigeria: The village was a muslim community that enforced purdah. When the drug distributors passed the enclosed family compound, the women's hands appeared from behind the fence, as if disembodied, to receive the cloroquine. It remained uncertain how many of those who received the pills swallowed

them, and how many gave the pills to their children. (Desowitz, 1980 p195) Certainly physical exams and discussions of personal health problems would be difficult for male health workers and female patients in these conditions.

Women are also more likely to have insight into the potential health problems for women, and how different responses might fit into and affect their lives. In addition, these positions would generate some financial income for women, allowing for a degree of self-reliance, and also providing "role models" of women actively affecting health, as discussed earlier.

There are some problems with the system as it exists presently. First, the "supplementary" orientation of the field work must shift. The field workers are the primary sources of contact that rural women have with health care, and provide the only chance they have of meaningful, long term care relationships. Clinics and hospitals cannot provide these sorts of relationships, even to those patients who are able to go to them. The field workers ought then to be responsible for the Primary Health Care for these women.

At present, some auxiliary nurse-midwives who run subcenters are also the extension workers for their jurisdictions, and must close the clinics when they go on field visits. They go in the late afternoons, when rural women are most likely to be able to spare the time to see them. Thus they make it impossible for some women to use their only possible free time to go to the clinics for medications and "general" primary care. (Murthy in Blair, 1981 p79)

Field workers are not well prepared for emergencies, for providing curative care, or any form of comprehensive preventive care. They are told to send sick people to the clinics for treatment.

There are nowhere near enough of these workers to cover the entire rural population thoroughly. Their crucial role in the supposed screening process, which is the basis for the PHC system, cannot be effectively carried out. Extension workers are overloaded, which adds to their ineffectiveness. One worker in Uttar Pradesh is said to presently serve 12,000 people in three villages, although she is only supposed to serve 5,000. (New York Times, 1/11/88 pA10) Both numbers seem excessive to me.

Many more men than women have been trained as field workers, at some points even constituting 80% of the extension worker force. (Baltiwala, in Jain, 1985 p47) As discussed previously, male workers have limited effectiveness among female patients. Also, these men are generally expected to continue their other occupations, mainly farming, as their salaries for health work are minimal. This means they are not in the villages enough, and it makes travelling on the job very difficult indeed. (Gulhati in Blair, 1981 p82)

Often field workers are sent out with specific, distinct tasks, such as particular immunizations, contraceptive distribution, etc. These distinct tasks compound the problem of incomplete, fragmented care. More thoroughly trained workers are often led to cities, where their work is more fully rewarded and respected. The salaries for rural field workers give little



incentive to full time workers.

Female and male workers alike have not been taken seriously enough. They are often considered incapable of effective care, by both villagers and health center doctors. Training is often minimal or non-existent. The prevailing belief among doctors is that rural trainees are not capable of handling emergency situations or of giving curative care. (McEven in Taylor, 1983)

The extension worker system has therefore not been used to its fullest potential. Where given the opportunity and adequate training, rural trainees have proven themselves to be highly responsible, capable, and skilled health care providers. After all, they have a vested interest in their results.

For example, infant diarrhea is a major killer in India. In the Narangwal experiment, it was found that "the most effective measure in controlling diarrhea mortality was early detection and consistent oral rehydration in the home." (Ibid., p74) Local physicians and extension workers had all been trained to believe that the proper treatment was to refer infants to health centers for intravenous rehydration, and were suspicious of oral rehydration for being "too simple". When field workers were finally permitted to use the new method, they were found to use it responsibly and very effectively. Mothers became eager to use the new method. (Ibid.)

Another example involves penicillin injections for infant pneumonia. Previously extension workers were required to refer patients showing signs of pneumonia to doctors, who then gave their permission for the extension workers to give the

injections. As part of the Narangwal experiment, however, field workers were permitted to give injections on their own diagnosis, judging mostly by infants' respiration and temperature patterns. They were found to use this authority sparingly, rather than overuse it, and were in fact more "conservative" than area doctors. (Ibid., p75) The Narangwal experiment field workers were well supervised, an important factor which is missing from the present over-all system. Training and supervision of extension workers is less than satisfactory at present, because this responsibility is left to the doctors at the PHC centers. As Banoo Coyaji argues, it is unfair to expect doctors to take on this role effectively. They are overworked at their centers; they do not specialize or even necessarily understand the importance of community health; they are not chosen for any supervisory or educational skills; and they may well view the extension workers with suspicion, condescension, or contempt. (Coyaji in Blair, 1981)

The extension worker system needs to look more carefully at the effects of extension work and how best to utilize it. Field workers should keep tabs on individual families, conduct frequent follow up visits, and report to a supervising medical officer at a local health center. The frequency of field visits should vary, depending on the ages and other particulars of patients. However, a very young infant may require more attention than a busy health worker can provide. So might a chronically ill adult. Perhaps a system of worker assistance from community members could help to ease the strain. Maybe particular members could be designated as responsible for recognizing certain

symptoms or ensuring that certain treatments were carried out, between the field workers' visits. Anthropological research would be able to identify roles and functions for field workers which would seem acceptable and comfortable to local inhabitants. Anthropologists could also assist with local acceptance of the workers in their new roles.

#### CHOOSING WORKERS

In choosing extension work trainees, officials should be aware of local inhabitants' ideas and feelings about who is appropriate for them. Anthropological analysis of social roles and other cultural factors would greatly aid the selection process.

For example, a crucial factor is that of social status, or caste and class. Past programs have recognized the value of training indigenous midwives (DAIS) in improved birthing techniques, since they are already accepted in the role of birth attendant. These programs have falsely assumed that the DAIS are therefore considered "authorities" on how it should be done, and that their advice is respected and followed. They have then taught the DAIS new infant care practices, expecting that other women will want to follow the DAIS' "authoritative" examples. However, DAIS are not in fact "respected" for their role as birth attendants. Birthing is considered a filthy and degrading activity, and is therefore the job of women belonging to the Harijan (also known as "untouchable") caste, the lowest in rank. Their views on infant care and child rearing are not sought after

by other women. In fact, DAIS are not permitted even to touch the newborn after the umbilical cord has been cut and tied.

It is also wrong to assume that DAIS are utilized in the majority of rural births. Statistics estimate that 90% of rural births are attended by "relations" or other "untrained" individuals. (Coyaji in Blair, 1981 p2) It is impossible to accurately assess how many of these individuals are actually DAIS or not.

Finally, officials should not assume that DAIS have general access to other women or any one else, without examining the social relations of individual communities. Careful anthropological study of rural villages reveals intricate caste, class, faction, gender, age, and religious considerations which govern who may interact with whom, where, when, and in what ways. For, it is not only that the lower caste woman is forbidden to touch a higher caste woman, but rather they are both in a mutual avoidance relationship, which neither of them may alter. Neither has access to the other. (See Appendix 4, p96)

"It is incorrect to view traditional societies as static, normatively consistent, or structurally homogeneous." (Gusfield, p351)

The value of working with "traditional practitioners" is undeniable. However, as I have shown above, assumptions about which individuals are appropriate for which aspects of health care, have often been quite uninformed. Planners often use "Traditional Medicine" as a blanket term, standing for what they think of as a single, homogeneous set of practices and beliefs, with "healers" and "holy men" catering to all physical and spiritual needs of the rural population. This is incorrect.

As B.S. Reddy points out, Traditional Medicine is really two sets of traditions: 1) Little (folk) traditions including an infinite variety of specialized local practitioners, and 2) Great traditions, consisting of six old and very formalized schools, namely Ayurvedic, Unani, Nature Cure, Yoga, Sidha, and Homeopathic systems. (Reddy in Chaudhuri 1986, p15)

Folk medicines focus on practical solutions and healing, and are intricately tied up in whole systems of morals, lifestyles, religion, cosmology, body humor conceptualizations, and some magic. Practices differ, according to the specific culture and circumstances of each village. Djurfeldt says "The folk practitioners are insiders to the community. They share the culture of their patients, and their world view. They live, eat, and dress as ordinary people. They are diffusely related to their patients, as friends, kinsmen, employers, or colleagues

(since most of them are part-time practitioners). All this makes for close relations between them and their patients. Their bedside manners make a deep impression. They take care to explain to their patients what is wrong with them. They know that illness is not an individual affair, and discuss it with the other members of the family too. They know who is the family authority, and they know who will decide how to treat the sick person. They can often take time to come to their patients' houses, because they treat only a few patients at the same time. As insiders, these healers are also within the reach of local and particularistic social control." (Djurfeldt, 1975 p162)

Djurfeldt makes an interesting point in the last statement, which he later elaborates upon. He argues that in indigenous medical systems, healing abilities are generally associated with particular types of social status, depending on their specific nature, and the ability of individual practitioners to perform them. In contrast, allopathic (Western-style) doctors have very high social status, which is not always connected with any proven medical ability. Rather, it is due to their cultural associations with authority, either the British (or other Western countries), or the Indian government. While this affords prestige and some privilege, it does not necessarily aid access, and often breeds mistrust. (Ibid., p164) In fact, Gusfield argues that "The role of a doctor, as a technical expert, grants him authority in [Western] culture but not in the Indian village where technical and commercial skills have a low approval." (Gusfield, p361)

But Djurfeldt's first statement above is a very dangerous

one. Not all folk practitioners share the same view of anything with all rural villagers. And, in fact, the different types of practitioners within each village vary greatly in their orientations and conceptualizations. They present a confusing, wide array. Snake bite specialists, midwives, sorcerers, exorcists, oracles, diviners, priests, and astrologers each specialize in particular aspects of health care. (Ibid., p113) Each performs a distinct function, which brings with it a specific social valuation, which will also vary from village to village (and to some extent from villager to villager.) People go to different practitioners for different ills. Many people will go to an allopathic "doctor" for a "fever", but for nothing else. (This situation is further complicated by the fact that "fever" is defined by some as a symptom, but by others as an illness in itself, with no need for further distinction or investigation as to cause. These latter people may not distinguish between a typhoid fever and a pneumonic fever, each of which requires very different treatment.) (Chaudhuri, 1986, p5)

Djurfeldt also points out that while indigenous practitioners can help improve individual health care, they do very little to improve community health, and therefore cannot be relied upon heavily for help in this area.

Another significant factor in many rural health systems is an association between illness and the supernatural world. Spirits and deities (whether evil, malevolent, or protective) witchcraft, and the evil eye, all play large roles in the health

patterns and behaviors of rural Indian people. In these ideologies, transgressions against moral, social, or religious rules (whether committed in this life or a past one) result in sickness or death from a supernatural agent. It should not be expected that people will abandon their ideologies, or their conceptualizations, which form part of the fabric of their cultural existence. As Chaudhuri explains "...I have noted that if there was illness due to evil eye, sorcery or witchcraft, the villagers would never consult a doctor, and take the service of the magician as they feel that the doctors are quite helpless against such forces and only a magician can counteract these evil powers." (Chaudhuri, 1986 p6) Indeed, why should a villager expect a doctor to cure an illness he believes is caused by the evil eye, when the doctor denies the evil eye's existence? An allopathic service offering only "curative care" and not dealing with the multiple causes and effects of poor health, does not present very strong competition for the spiritual forces embedded in the ideologies of rural people. At least spirits and deities acknowledge that there is more to health than pathology, that it relates to the way one lives one's life. These powers can also be related to in a long-term and intimate way. Moreover, moral, social, and religious rules used in this way, present a chance for individuals to actively affect their lives and health. Allopathic doctors in rural India do not yet offer all of that.

In addition, Chaudhuri says about "modern" medicine that "Unfortunately, adequate facilities are not available in many of the tribal areas but the tribals are often accused of not



accepting modern facility [sic.] even though it is non-existent in the area. This has become something like a myth and there is a need to critically analyze the real situation, whether the tribals are really not interested to accept [sic.] modern medicine or whether the modern facilities are non-existent in the tribal areas." (Chaudhuri, 1986 p8)

Traditional medicine in India has always been eclectic, always incorporating and adapting new ideas and techniques, borrowing and modifying influences from other traditions. This in itself could prove to be an immensely helpful orientation. Allopathic medicine might be used more effectively and appropriately if it were presented as simply an additional resource to be experimented with and incorporated, rather than as a didactic, hegemonic system coming to obliterate all other systems in its path. (See Appendix 7, p102)

What there is to be learned from the indigenous healers about medicine is also of great value, which Western medical researchers are just beginning to investigate. I regret that I cannot go into further depth concerning the two way communication and learning between traditional Indian and outside health systems, but very little information is available. The greatest lesson seems to be, however, that traditional methods have been developed and modified for specific use in their local areas, which Western-style medicine ought to learn to do as well.

#### CHOICES

People in rural India, just like people everywhere, are

eager to find and use the most effective means of improving their lives. But their perceptions of those means, and of what would be an "improvement" are for them to define. Chaudhuri writes that "...when both the facilities, namely, traditional and modern, are available, the tribals quite often accept the modern facility." (Ibid., p8) He is eager to clarify that people accept whatever appears to work best. The problem is that the definitions of what is "best" are not always identical for the villagers and outside health officials. For the villagers, there are circumstances surrounding every health situation, pluses and minuses to be weighed for all options available. With all the technology which allopathic medicine has at its service, there are still great numbers of people suffering and dying from illness brought on by poverty, overwork, appalling living or working conditions, etc. all over India. How can these people be asked to desert the beliefs and behaviors they have developed to cope with these conditions, without an alternative which is immediately accessible and can offer something better?

People everywhere will choose the source of medical care which 1) is readily available to them, and 2) most completely fulfills their expectations and needs. Those expectations and needs are defined by culture. Disease (pathology) is experienced by individuals and communities as illness, according to "cultural rules: we learn 'approved' ways of being ill...There can be marked cross-cultural and historical variation in how disorders are defined and coped with." (Kleinman et al., 1979 p252) In

other words, people only consider themselves "sick" under a certain set of conditions, the criteria for which varies widely. And, once they have decided they are "sick", the "sick role" they will play will also depend on cultural and socio-economic factors.

The kind of treatment people seek will therefore vary with their conceptualization of what is wrong with them, their explanation of its meaning and/or cause, and their expectations about each of the treatment methods available to them.

### SATISFACTION

Foster and Anderson (1978) argue that "traditional" healers around the world have a much higher rate of "patient satisfaction" than Western medicine has. (Foster and Anderson 1978, p124) Those healers do more of what they are expected to do, and what they claim they can do, and are more involved with the experience of illness (rather than pathology) than Western doctors. (Ibid., pp136-7) Although mortality rates in many places favor Western methods, patients consider their traditional methods to be "work better". (Ibid., p124) To understand patients' choices of health care, then, it is crucial to identify patients' criteria for judgment. (Ibid., p226)

M. Taussig (1980) presents an ideological problem with Western style medicine, which he attributes to the theories of E.E. Evans-Fritchard: "Science, as we understand it in our day and age...can cite the 'how' but not the 'why' of disease; it can point to chains of physical cause and effect, but as to why I am struck down now rather than at some other time, or as to why it

is me rather than someone else, medical science can only respond with some variety of probability theory which is unsatisfactory to the mind searching for certainty and for significance."

(Taussig, 1980 p4)

He points out, however, that this explanation of the problem implies there is a separation of the 'how' and the 'why', within the conceptualization system of the victim, one part of which is not answered by Western medicine. For people who hold beliefs which link the 'why' and 'how' together, Taussig argues, there may be no such distinction in perception. He says that "...the issues of 'how' and 'why' are folded into one another; aetiology is simultaneously physical, social, and moral." (Ibid.)

#### MIND VS. BODY

A similar issue is the distinction made in Western medicine between disorders of the "mind" and the "body". Western medicine has historically relegated all emotional or cognitive problems to the field of psychology, which it then rejected as a science. This stand is now coming under considerable attack, as more and more evidence of the integrated nature of the human body, emotions, and psyche, is amassed. The one area of "compromise" on the part of Western medicine, is the invention of the concept of the "Psychosomatic" disorder. This is the term used for physical manifestations (pain and illness) of what medical science deems purely "emotional" or "mental" afflictions. Medical science does not generally acknowledge any large degree of control which the mind and emotional realm have over the

physical body, and victims of these types of symptoms are therefore often made to feel their problems are "imaginary" and not "real" problems at all.

In many other societies, however, the mind and body are felt to be one. There is not a conceptualization of two such separate entities. Therefore, emotional and social elements are acknowledged as having a powerful impact on the well-being of community members. Traditional cures are often geared towards exactly those aspects of illness. (See Madsen in Kiev)

The importance of viewing health in cultural context, to truly understand the interplay of individual, social, emotional, physical, ideological, and moral elements, cannot be overstated. Taussig (1980) argues that all illness theories, including our own Western system, are loaded with (be they overt or subtle) moral concerns. In Western as well as many other societies, certain illnesses bring with them moral associations, which affect how victims and often their families are viewed and treated by their communities. Lewis explains that "Special attitudes towards a kind of illness hold fast to name, and a name...may become tainted by moral or emotional associations." (Lewis in Romanucci and Rossi, 1983 p154)

Leprosy provides an example from India. For, although its pathology can be cured, and it cannot be transmitted through casual contact, "lepers" and their families are often ostracized and laden with harsh social stigmas. (Acquired Immune Deficiency Syndrome provides a vivid example from our own culture.)

## SELF-DIAGNOSIS

AS I've argued above, where people go for treatment depends largely on what treatment they expect will give them the results they want. R. Welsch (1983) argues that Western medicine "encourages a view of medical systems as undifferentiated systems of treatment practices. Physicians generally make their own diagnosis and prescribe treatment in terms of these diagnoses; patients merely recognize and present complaints. Given such a situation, the patient's decision to consult a physician is logically the same whether the doctor prescribes antibiotics, a diuretic, or confinement. Where self diagnosis is more typically the rule,...these treatments may constitute quite different courses of action for the patient. This is particularly true when patients select practitioners for specific kinds of treatment based on their own self-diagnosis." (Welsch in Romanucci and Rossi, 1983 p34)

I have already suggested that in much of rural India there is a wide variety of such specialized practitioners, to whom people go for treatment based on what their own general ideas of what is causing their illness. (See p70)

Western-style practitioners are sometimes among the options for care, and are selected for specific types of illness problems, with particular treatments. Welsch observed this type of rural clinic usage in New Guinea: "Patients regularly asked for a particular kind of medication by name, rather than describing their symptoms or case history...They were not seeking a diagnosis and corresponding treatment from the APO [Aid Post

Official]. . . in [some] cases patients viewed the APO as a pharmacist or dispenser of medication, which patients had already decided they needed." (Ibid., p33)

Could this sort of thing be occurring in rural India?

#### ASSOCIATIONS

A problem which patients and doctors may encounter is that "The name of a particular illness or symptom does not necessarily have the same associations for the lay person and the doctor even when they both use the same term correctly. They refer to the same thing, perhaps, yet give it different significance." (Lewis, Ibid., pp151-2) For example, cholera or infant dehydration, may signify to the doctor the need for extensive and immediate treatment. But to a victim and the victim's family, they each may signify near certain death, and therefore that it would be a waste of energy and resources to attempt any sort of treatment.

S.K. Noordeen pushes this point even further, saying that the term "leprosy", for example, represents different things to different types of official personnel. For a medical health worker, it represents a patient with certain clinical symptoms; for a public health worker, it represents a carrier of a communicable disease; for a social worker it is only meaningful once the community has labeled it, and it leads to social conflict; while to a health economist, it means a physical disability for someone involved in production, and a resulting economic loss. (Noordeen, in Bose et al., 1982 p158)

## THE ROLE OF THE DOCTOR

The role of the rural doctor is a complicated one, and difficult to envision realistically. Engel (1977) suggests that "the doctor's task is to account for the dysphoria and the dysfunction which lead individuals to seek medical help, adopt the sick role, and accept the status of patienthood. He must weigh the relative contributions of social and psychological as well as biological factors implicated in the patient's dysphoria and dysfunction as well as his decision to accept or not accept patienthood and with it the responsibility to cooperate in his own health care." (Engel, 1977 p133)

This description leaves out any reference to communication with the patient, respect for the wishes of the patient and his or her family, or understanding of the effects of the given treatment on the lives of the patient and members of the community. Yet, even without these crucial considerations, Engel's list of the ideal doctor's responsibilities is daunting.



THE ANTHROPOLOGICAL ROLE: SOME DANGERS OF APPLICATION

The role of anthropology in public health programs has many parts. It involves analyzing social situations carefully to discover 1) what are the problems which rural people find themselves faced with, 2) what factors and circumstances are contributing to those problems, (including both cultural and socio-economic factors) and 3) what would be the most useful, practical, and acceptable ways to bring about change. In order to achieve these goals, the perceptions and desires of those people affected must be elicited and clearly understood, then energetically defended throughout planning and administration of health improvement efforts.

Never should anthropological insight become a tool for the manipulation of people to act or be acted upon against their wills or without their knowledge. Taussig describes this unfortunate manipulation in a stern warning: "Like so much of the humanistic reform-mongering propounded in recent times, in which a concern with the native's point of view comes to the fore, there lurks the danger that the experts will avail themselves of that knowledge only to make the science of human management all the more powerful and coercive." (Taussig, 1980 p12)

Indeed, this warning applies to all anthropological endeavors. The issue of how to "apply" anthropology raises many ethical and logistical questions. A large body of literature has already appeared addressing these questions. Should anthropologists act as advocates for the peoples they "study"?

Should anthropologists be in administrative positions themselves? Or can these positions too easily facilitate the abuse of power, trust, and knowledge? Might this become reminiscent of the "missionary" ideology which anthropology now frowns upon?

For example, the Wisers offer advice to "he who would help any one group or all groups in [a] village", saying that "By securing for himself the position of economic master, as he would in case he became the landlord or financing agent, he can transfer all rights and duties of leadership to himself." (Wiser and Wiser 1973 p20) (They suggest this as a way of "freeing" village members from their dependence upon local exploitative landlords and financial agents.)

Another example applies directly to medicine: Kleinman et al have suggested that "...if the patient accepts the use of antibiotics but believes that the burning of incense or the wearing of an amulet or a consultation with a fortune-teller is also needed, the physician must understand this belief but need not attempt to change it. If, however, the patient regards penicillin as a 'hot' remedy inappropriate for a 'hot' disease and is therefore unwilling to take it, one can negotiate ways to 'neutralize' penicillin or must attempt to persuade the patient of the incorrectness of his belief, a most difficult task." (Kleinman et al., 1979 p257)

The underlying condescension and presumption that the patient must be forced to take the penicillin even if it requires manipulating him or denying his beliefs, is arrogant, unethical, and counterproductive. For, as Taussig explains, "The patient's

so-called model of illness differs most significantly from the clinician's, not in terms of exotic symbolism but in terms of the anxiety to locate the social and moral meaning of the disease." (Taussig, 1980 p13) The contrast of amulets and penicillin is not at issue. The issue is really that the patient recognizes and tries to identify the cultural elements of his illness, while the doctor tries to exclude and deny those elements and focus on the pathology.

It is therefore the clinician who is incorrect, in that all health problems do indeed have very powerful cultural elements, as I have attempted to show in this paper. And the patient is quite correct in insisting that while bio-medical treatments may correct individual pathologies, they are alone ineffective against the health problems caused and compounded by cultural and socio-economic factors.

#### PATIENT'S MODEL: MORE INCLUSIVE

Taussig argues that "it is a scandal and also self-defeating to appeal to anthropology for evidence as to the power of concepts like the 'patient's model' and the difference between the 'how' and the 'why' of 'disease' and 'illness'. For the medical anthropology of so-called 'primitive' societies also teaches us that medicine is pre-eminently an instrument of social control. It teaches us that the 'why' or 'illness' dimension of sickness bears precisely on what makes life meaningful and worthwhile, compelling one to examine the social and moral causes of sickness, and that those causes lie in communal and reciprocal inter-human considerations..." (Taussig 1980 p13)

I suggest, however, that there is still hope for anthropology's contributions to medicine and public health, that the concepts of "patient's model" and "how" vs. "why" of illness are yet important. The key is to redefine what it is one is classifying within those concepts. If the term "patient's model" refers only to details of traditional healing practices and spirit beliefs, then indeed this concept and knowledge are only useful for manipulation and condescension of the kind Taussig warns us of. But, supposing the term is redefined to include a real understanding of how particular illness comes to exist in a particular place and time, how it affects the actual lives of the people in that place, and what can be done to alleviate not only individual pathologies but also the conditions and many ramifications it has in the community. Then the "communal and reciprocal inter-human considerations" which Taussig rightly champions, would be the focal point of investigations, and health programs would rightly recognize them as the vitally important considerations they are.

#### DOCTOR'S MODEL AND POWER RELATIONSHIPS

It is also crucial to examine all health care programs from both directions. The role of "healing", as I have shown, is very much a part of the culturally-created context of illness. Therefore, the doctors in rural area clinics must come to terms with the fact that their role there will be different than anywhere else, with considerably less power than they may be used to. "In any society, the relationship between doctor and patient

is more than a technical one. It is very much a social interaction which can reinforce the culture's basic premises in a most powerful manner..." (Taussig 1980 p4) Anthropological examinations of real rural situations must look closely at both the inhabitants' and the doctors' "models" and cultural contexts. For, "The doctors and 'health care providers' are no less immune to the social construction of reality than the patients they minister, and the reality of concern is as much defined by power and control as by colorful symbols of culture, incense, amulets, fortune-telling, hot-and-cold, and so forth." (Ibid., p12)

#### THEORY VS. REAL LIFE

The above discussion surrounds several important issues, and present some powerful visions of how anthropology is and should be involved in health planning. Yet these arguments cannot be applied directly to the real life situation in contemporary rural India. Some writers seem to argue that any attempts by non-community members to improve rural health are undesirable interferences. Victor Turner (1967), for example, describes a traditional healer in rural Zambia, saying that "...The sickness of the patient is mainly a sign that 'something is rotten' in the corporate body...The [healer's] task is to tap the various streams of affect associated with these conflicts and with the social and interpersonal disputes in which they are manifested, and to channel them in a socially positive direction. The raw energies of conflict are thus domesticated in the service of the traditional social order." (Turner, 1967 p392) Taussig uses

this passage as an example of how "...the rites of healing readapt society to predefined problems through the medium of the patient;...this process rejuvenates and even elaborates the society's essential axioms. Charged with the emotional load of suffering and of abnormality, sickness sets forth a challenge to the complacent and everyday acceptance of conventional structures of meaning." (Taussig, 1980 p13)

This structuralist view focuses on the systematic incorporation of illness into culture, explaining that the adaptations communities have made to cope with illness are actually vital parts of the overall cultural process. This may be one way in which "illness" and "healing" as abstract concepts function. But the above accounts describe an ideal state in which culture is operating in a socio-economic vacuum. There is no profound poverty, or economic or political oppression from larger forces. There is no external pressure or manipulation of those inhabitants. In fact, this view does not address the actual inhabitants of afflicted communities, or consider their real-life suffering. In reality, such large-scale health problems as exist in rural India today are not caused by or beneficial to local traditional cultures. (A bit of victim blaming is evident here.) And these problems do more to threaten and squelch the local cultures than to "rejuvenate" them or "elaborate on their basic axioms".

Anthropologists must be extremely aware of the nature and use of their investigations and knowledge. It is true, as

Taussig writes, that "It is a strange 'alliance' in which one party avails itself of the other's private understandings in order to manipulate them all the more successfully." (Taussig, 1980 p12)" But it is also true that given the choice of living with malaria, leprosy, or poliomyelitis, or being relieved of these painful, exhausting, and life-threatening physical burdens, I feel safe in saying that most people would (eagerly) choose the latter. And all romanticizing aside, it should be their choice.

The role of the anthropologist and the health worker, then, is to discover what it is people actually desire and need in the way of health improvement, and how those improvements could best be achieved.

#### SUMMARY

I have attempted to show that poor health is culturally and socio-economically caused (chs. 1-3), experienced in culturally and socio-economically determined ways, (ch. 4) and therefore can only be effectively combatted in those terms.

The Primary Health Care system needs to change, to fit more appropriately into rural peoples' lives. The field worker system should be used to its fullest potential, and in more effective ways, which utilize the unique advantages this approach offers.

Women's experiences in rural India must be more clearly understood, and taken far more seriously by a new health care system. The emphasis must no longer be on their roles as mothers, and "women's health" can no longer be equated with

"reproductive health and behavior". At the same time, the effects of "motherhood" on rural women's lives and health must be more carefully investigated and taken into account.

Anthropology has an important contribution to make to the understanding of how all of this could best be accomplished. Anthropologists should examine the socio-economic circumstances of individual villages, as well as underlying cultural elements particular to those areas. India is not uniform, by any means, and the huge variety of situations and cultural adaptations can provide insight into possible answers to health problems in local areas. It is important not to generalize or make assumptions, however, about "Indian culture". There are unifying commonalities and ties between local cultures, but health programs should not be based on those premises.

Family planning, for example, has various complications in different local contexts. Even within a single community, the numerous factions of that community will deal with family issues in widely varying ways. The anthropologist and health workers must be clear about exactly whose needs they wish to address, and be sure to discover exactly what the specific needs and governing circumstances of that particular group of people are.

For instance, since birth control use depends on a large number of complex factors, people of different castes, classes, etc. will respond in different ways. All of these elements must be identified and considered, with the greatest respect for the wants and opinions of those involved.



It is the responsibility of anthropologists in this field to ensure that they are truly addressing the real issues involved in poor health. The differences in treatment are not at issue, rather the goals of different treatments must be understood. Anthropologists must be diligent about respecting and correctly "representing" the lives and wishes of rural peoples.

Anthropologists as well as health workers must never take it upon themselves to make decisions "for" the people they work amongst. The anthropological role involves attempting to clarify the real causes of health problems and facilitate effective communication between health workers and local inhabitants. Health workers should exist in order to respond to those problems in ways which will be profoundly effective and appropriate for local inhabitants, taking their cues from anthropologists and the communities involved.

Condescension and judgement have no place in these endeavors. Victim-blaming is counter-productive, as it does not uncover the ultimate causes of public health problems, which are large-scale and often originate externally to local communities.

Finally, I encourage anthropologists to accept the responsibility of applying theory to real life. Anthropology can no longer claim validity as a purely academic endeavor. Anthropologists must shift their emphasis away from seeking "pure" cultures, untouched by outside influences, as their primary subject of study. Cultures continue to change, and develop problems relating to their current circumstances. These are just as important and pressing as those relating to

"traditional" circumstances. Inhabitants must deal with these very real, contemporary issues in their daily lives, using the knowledge and experience they have brought with them from the past. So too must anthropologists begin to investigate how their views of "culture" apply to the confusing situations in which more and more people find themselves today. All of the observational data and theories of decades of anthropology, must now be shown to have some practical use.

## FINANCE

Briefly, I would like to make a plea for domestic (rather than foreign) funding, wherever possible. The rural population represents a large portion of India's people, and foreign sponsored projects cannot provide long-term solutions on such a large scale. Projects and aid packages funded by foreign governments are necessarily politically loaded, and are therefore unreliable in their intent and commitment. These projects are also generally superficial in nature.

Any effective and far reaching improvement in India's rural health must be built upon self-awareness and self-reliance among India's people. Rural health is a national problem for India, and must be a priority for the Indian Government. Governmental efforts can be more comprehensive, hire more labor power, ultimately reach more people, and work with the legal system to help rural people. Only the Indian Government and the people themselves can improve the quality of rural life, thus attacking the real, circumstantial causes of poor health.

Foreign assistance should only be accepted in forms which will truly help India's poor to gain self-reliance, rather than depend upon the foreign sources. Foreign consultants (anthropologists especially) can indeed play a major role in promoting self-awareness and autonomy, provided they are sensitive to the actual ways and needs of rural Indians, and not prone to simply imposing model solutions created abroad.

Douglas Ensminger writes that the most useful capacity in which foreign advisers can serve is that of helping another

government to gain confidence and learn to better relate to its population, to "effectively serve the people". (Ensminger, A.4) Therefore, he argues, it is governments rather than private organizations which foreign parties should work with. I partially agree with this argument, but I find it overlooks the power of individuals working to improve their lives day to day. I therefore argue that domestic funding should either come from the government, or, ideally, be raised by cooperatives.

Cooperatives are best suited for meeting local needs and for encouraging self-reliance and self-determination on a group level. The best situation might be a network of cooperatives officially registered with the Indian Government. Cooperatives could then serve as organizational "units", involving large numbers of community members in the improvement process, and ensuring better representation of rural people's needs and opinions.

SEWA, the Self Employed Women's Association, is a union for Indian women who make their living in jobs outside of what is elsewhere considered "employment". These women are petty traders, hawkers, crafts workers, wastepaper collectors, quilt stitchers, junksmiths, and a wide variety of other such workers, whose tasks do not have the legal structure which other trade unions are able to work with. SEWA raises money from its members, with minimal contributions from each, and uses it for individual projects.

SEWA has been able to create a "Motherhood Defense Scheme", which provides insurance coverage to these women. Other

insurance plans will not cover them, since they are generally poor and constitute "high risks" medically. Other plans also stop coverage of poor women when they become mothers and have to stop their wage work. The SEWA insurance plan is designed specifically to cover women under these circumstances. The SEWA organization provides an excellent example of the type of self-reliant, case-specific approach which I am advocating for rural health care.

SEWA has also created its own bank, because poor women were not able to borrow capital from other banks. Even after some banks were convinced to risk giving credit to these women, it was discovered that poor women "in filthy clothes, accompanied by noisy children, and the bank staff who were used to educated, middle class clients," had difficulty relating to each other. Also, the banking hours did not correspond to the women's schedules. Therefore, rather than depositing their money, the women often spent it on their families or left it with local money lenders to keep it safe from their husbands and children. To further complicate matters, most of these women do not read or write, and were therefore unable to sign bank documents.

SEWA's bank, the Mahila Cooperative Bank, operates using photographs rather than signatures of its clients, 99% of whom do not read or write. The SEWA bank had a 1984 repayment rate of more than 98%, with \$800,000 (US) of working capital invested from 20,122 savings accounts. The Bank also provides money management training, commercial counselling, legal services, "maternal protection" and life insurance. Here is an example of how a self-reliant, Indian cooperative is best able to work for

solutions to the real problems its members face.

SEWA has supported and organized the formation of many individual cooperatives, which fight their own battles against exploitative conditions, and then obtain or create training opportunities and better positions for their members, in the relations between the work they do and its market. This seems to be a great starting model for how health cooperatives might be set up and run. (My entire discussion of SEWA's activities is taken almost directly from a drafted essay by Ela Bhatt, 1985, as yet unpublished. It is not yet in edited form, and I have been requested not to quote from the draft, but given permission to paraphrase.)

Integrated efforts are reported by researchers to have added advantages over separated services, including:

- More effective use of resources;
- More efficient organization;
- More efficient use of training facilities and resources;
- Better understanding and long-term relationships between community members and health care workers; and
- Better worker satisfaction, leading to best quality work.

(McEven in Taylor, 1983)

Researchers have expressed concern that the use of amniocentesis for sex-typing fetuses could prove to have serious implications in a population which has a pronounced son-preference. It is questionable whether it is poor rural women who will have major access to sophisticated test like amniocentesis. But if this is an issue for other Indian women, then it becomes the responsibility of the government to investigate it critically, and adopt a policy concerning it. (Miller, 1981; Hartman, 1987 p248)



Perhaps the solution lies in compromise. Part-time workers for each of the 2-3 factions in a village, could all report to a supervisor, or just meet regularly among themselves and then report to the health center. Other suggestions include sending workers to foreign areas, where their caste and history are unknown. But this may defeat the purpose of tapping into trusting, local relationships, and getting individual communities involved with their own health care. It is also based on the faulty presumption that all villages share ideologies and beliefs about health.

I argue that all parties concerned would be better served by group involvement right from the start. A broad-based policy on these issues will not be as effective as allowing health workers and individual communities to solve these types of problems among themselves. Rather than sending a lone health worker to "do health" for a village, planners should begin by bringing the community together and discussing with them their needs, goals, gripes, priorities, expectations, and suggestions. Only then can cooperation on all sides be effective. At this point, then, when all parties have voiced their mutual fears and hopes, the community should be asked to choose those members whom it would find acceptable as health workers. Probably the community will choose more than one.

Some writers have suggested that it be left to the women, rather than the whole community, to choose workers. (Jayasekara, in Blair, 1981 p 131) I am tempted to agree, since it is

primarily women who will be utilizing their services, and who have the most limited access to any alternative source of care. However, if the men of the community do not approve of the women's choice, they may make the new worker's job difficult, even limiting his or her access to the women. Also, it should be noted that men and women in a community influence each other. The women's choice would probably reflect the opinions of the men in some ways.

Choosing members from target communities seems to most closely meet the goal of finding someone who shares the same conceptual model of health and proper behavior as the population involved. Individuals from different villages do not necessarily share those conceptual models, or ideologies. Planners should not assume that "rural" people are homogeneous. Each community must be involved in designing the health program best for its specific needs and culture.

## TRAINING

The keys to the extension worker system include appropriate selection, training, and supervision of workers. If these were the primary focus of improvement efforts, and were in fact achieved, the system could be extended almost indefinitely. Subdivision within subdivision of people assigned responsibilities, could provide a very specific, sophisticated, and effective system of health care provision indeed.

Training should be practically, rather than theoretically, oriented. And it should be regularly reinforced, providing workers with the opportunity to raise questions that have come up

in the field, practice and review emergency techniques, and share feedback and experiences. Training should be area specific, with the particular problems likely to occur in particular jurisdictions emphasized. It should also be locally based, to afford practical and specialized experience, low-cost, and easier accessibility for potential part-time workers (especially women).

## BIRTH CONTROL TECHNOLOGY PROBLEMS:

Problems also arise when birth control devices, such as the "loop", are distributed to women, they may not be accompanied by any explanations or chance for questions. For example, D. Ensminger writes that when Indian women were fitted for the loop in an early family planning program, they "should have been told up to ten percent of them would not be able to keep the loop;...twenty to thirty percent would have pain in the early period and...should see a doctor...[that] they might experience a three to four day extension of the menstrual period...[and] if excessive bleeding continued over several months [they] should come in for an examination...They were given very little understanding about the working of the loop and when they went home and had these experiences, they fell for the propaganda against the loop." (Ensminger, 1971 #B1)

The "propaganda" resulting from negative experiences such as these, is found in places other than India. M. Morokvasic quotes some Yugoslavian women as saying "It's not good for your health"; "one has sick children afterwards" and; "one becomes sterile". (Morokvasic in Young, et al, 1984 p202)

In addition, doctors performing sterilization operations are not always reliable. One farmer "said he decided to have a vasectomy after his fourth child, but the doctor failed to show up each time he went. By the time he had the operation, he had six children. (New York Times, 1/11/1988 pA10) And, Hartman reports that "In the autumn of 1985, India was rocked by yet

another sterilization scandal: In a Maharashtra sterilization camp one woman died and seventeen others were in serious condition after being given an antibiotic drug mistaken for a pain killer [and then operated upon]...The doctors paid no attention [to their screams]." (Hartman, 1987 p240)

Finally, the availability of pills and other contraceptives has been poor. Men who go to the cinema may for example see pre-feature short films explaining what condoms are and how to use them, but there may be no condoms available to them anywhere within their area.

It is also interesting to note that in India "Since 1977-78 female sterilization has accounted for 80 percent of total sterilizations, despite the fact that it is a much riskier operation." (Hartmann, 1987 p239)

Western-style doctors are trained to approach health care in a very cure-oriented manner. This approach does not provide for finding high-risk categories for certain problems and their subsequent prevention, and especially ignores special types of groups of factors, such as maternal and child care. One group of researchers administered a questionnaire concerning views about functions and effects of PHC services, to 533 final-year medical students in India. The responses scarcely included any mention of maternal or child health care at all.

(Ramalingaswami, in Blair, 1981, p 105) This shows that medical personnel being trained in India are not necessarily taught to think in terms of high-risk categories, or how different "non-medical" factors will effect their clientele.

Another helpful aspect of the Great traditions of Indian medicine, is their concern for holistic health. The orientation is towards promoting preventive care, be it through religious study, strict dietary measures, exercise programs, meditation, or whatever. This orientation is shared by the most successful public health projects. Perhaps cooperation could be achieved by concentrating on this common goal.

On a practical level, the roles of various indigenous practitioners could be incorporated very effectively into the general medical referral system. (Reddy, in Chaudhuri, 1986 p 33) The screening process for people who need or may potentially need preventive or curative care could be heavily aided by these indigenous health care providers.

## Appendix 8: NUTRITIONAL DEFICIENCIES

Some particular deficiencies (besides basic undernutrition, known as marasmus) provide examples of complications classified in the available statistics under non-nutritional categories:

1. (Anemia in women has already been cited above;)
2. Trachoma and keratomalacia (resulting from vitamin deficiencies) are responsible for a large percentage of the estimated 5 million blind in India;
3. Deficiencies in general have been shown to lower antibody formation;
4. Protein deficiencies are often not detected as such, but the physical and mental development of victims (especially in childhood) will be slowed;
5. If enough protein is ingested, but not enough total calories, the protein will be used to offset the primary caloric need, rather than broken down and used for crucial protein functions such as cell building (This is a condition called Kwashiorkor); and
6. Underweight babies are an alarmingly high proportion of all rural births, due to the undernutrition of mothers, especially young mothers.



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