Living with Illnesses

Report from Himachal

❍ Dhanu Swadi

Sirmour is a district in the south-eastern part of Himachal Pradesh. The trans-Giri area of the district has received little attention in development efforts by government agencies since it is both politically and economically weak and so remote and lacking in facilities that government officials generally avoid working there. Agriculture is the predominant occupation, with mining and public road construction providing employment to a few persons. Some others migrate to nearby urban areas to seek jobs in the informal labour sector. Limestone mining has ruined the area ecologically and there is now a severe shortage of water, fodder and fuelwood in most villages. Mining activity has also resulted in an alarming increase in the levels of pollution both in the air and water, affecting the lives and health of the local population.

Sociologically, this area reflects all the negative demographic indicators possible. Infant mortality is very high, few girls attend school even at the primary level and age at marriage is only about 14 years for girls. The number of children per woman is higher than in most of Himachal Pradesh. Healthcare facilities are often available at a considerable distance and provide only programmatic services. Deliveries usually take place at home or in the fields with no access to hygienic procedures. The summer months see deaths due to cholera or diarrhoea as safer water sources dwindle. Food resources are scarce and women complain of not getting enough food or a balanced diet during the lean periods.

Men sometimes travel to nearby urban areas to seek manual labour work which results in an additional burden on the woman as she has to manage the land as well as the house. Women in the family are of value only as a source of unpaid labour. There are hardly any young, unmarried women in a village. The traditional system of polyandry still exists. As elsewhere men can change wives but unlike many places women can also remarry in accordance with the traditional system or *reet* which involves the payment of a sum of money to the ex-husband. Sometimes remarriage can occur as many as three to four times. If there is no exchange of cash for a bride, the woman loses face and is regarded as of no 'value'.

Given this profile, the area is in need of attention in various spheres of developmental activity. The intervention through a health project I am involved in running hopes to improve the situation in at least one area both by promoting health seeking behaviour and by gathering information to assist health service providers. The health delivery system may then be able to focus on improving reproductive health services by incorporating reproductive tract infections (RTIs) care into existing mother and child health and family planning programmes with a better understanding of and sensitivity to the needs of the locals. It is unfortunate that women who are the primary care givers and healers have no relief for their ill health and very often regard gynaecological problems as a part of the "burden" of being a woman, and do not even bother to practise health seeking behaviour. When so little importance is given to her from the time she is old enough to walk—her nutrition, education, independence and individualism constantly discouraged or suppressed —it is no way surprising that as a stranger in her marital home

a woman gives very little thought to her physical well being. It is critical to get women to talk about their bodies and to make them realise that they should not regard many of their reproductive tract ailments as "normal", so that their health seeking behaviour will improve. This could constitute the most non-threatening initiation into a process of empowerment. When you begin to question the reasons for ill health, you naturally analyse what the processes are that lead to this condition. Interaction with each other and an input of awareness building information, complemented by sensitive care by health providers, would go a long way in achieving health programme objectives.

The project is being carried out with the assistance of a voluntary agency called People's Action for People in Need (PAPN) which is based in Andheri village in trans-Giri Sirmour. PAPN has been active in this area over the last decade and has a network of committed local women and men spread over the far flung corners of the region. Over the years the volunteers have developed good rapport with the local women because of various training programmes that they have been running. These two factors have been a major asset for me as I have been readily accepted by the local women and have been able to get feedback on local customs and expressions and also had a readymade channel to verify any information given to me.

At one of my meetings with the women trainers at PAPN headquarters, I was able to generate a preliminary questionnaire that would help structure focus group discussions. The queries it contained were framed with the following objectives: to hear from local women about self reported gynaecological morbidities (no ranking on the basis of severity was done) and to sensitise them to talking about their hidden (*gupt*) health problems before the formal questionnaire was circulated. This group of PAPN staff was then asked to canvass information on the questionnaire circulated in areas they worked in by talking to groups of women.

Questions We Asked

What emerged from the male questionnaire was interesting—it reflected male responses to their own reproductive morbidities. There were 23 schedules with responses mostly from groups of women and one from male respondents. Most of the discussions were conducted with groups of women at Mahila Mandal meetings, though some of the questionnaires were canvassed from individual female respondents within their homes. (The total number of women canvassed was 176). The community that was targeted consisted of married women about 16 years of age and upwards. The responses revealed the prevalence of eye-opening male and female morbidities which have received very little attention in this part of the country. Since most of the responses gathered were during group discussions and the rapporteurs were asked to record all remarks made by the women it is not possible to tabulate individual responses. Therefore, only a general report of the findings follows here.

One set of questions related to the respondents' under-standing of the term health —did they feel they were healthy? They were asked to record common problems: Why do women fall ill or what are the reasons for falling ill? One of the questions sought their response on what they understood about their bodies? The intention of the question was to generate discussion within the groups. A gender aspect to health was brought up with a single response generating question by asking who in the household succumbs most frequently to disease. This was followed by asking where the ill woman gets treated and where the male gets relief for his sickness. The issue of what were the conditions women felt were required for good health was also discussed in the groups. This section also focused on self-reported symptoms of gynae-cological morbidities and access to health care while a second part concentrated on pregnancy and abortion—the need, techniques and contraception.

Men's Problems

The discussion with males (four persons were part of the group canvassed) brought out a certain awareness of the environment's relation to health. Men complained of ill health due to a polluted environment, specially water which affects their digestion. Males in the area are comparatively better nourished and are not required to carry water, fuel or fodder on their heads every day. They reported sexually transmitted diseases *dhat* or white discharge, passing of blood along with semen after sexual intercourse, pain in the penis during intercourse and sores near the penis.

Contrary to the belief that men have access to health care, the males in this area have also reported the lack of *shikshit* (trained) health personnel and hospitals to provide relief for their problems. When probed further on the use of the word *shikshit*, men complained that the staff at the local

health centre were unable to provide suitable or effective treatment for their sexual problems and that the distance and the paucity of adequate transport were deterrents to using either the Dadahu referral hospital facility (34 km from Andheri) or the district hospital (40 km further). Where even men have a problem of access, women are even more deprived of any care or relief for their suffering.

When men were questioned about the symptoms they were aware of their women's morbidity, the information which emerged included: irregular menstruation, heavy bleeding during the periods and inability to carry a child to full term. They thought the reasons women get these ailments are: women do not consume nutritious food, too much housework, tensions related to family and husband, child marriage, hiding 'secret' diseases like vaginal itching, boils or prolapsed uterus, not using a clean cloth during menstruation, giving birth to more than two or three children, and finally men feel that women fall ill because they often abort pregnancies.

Men were also aware of women's problems during pregnancy and reported the shortage of trained *dais* (midwives) to help them out during difficult deliveries. That women have considerable freedom to interact and share their fears and problems with their husbands was reflected in the statements the male respondents made about female morbidity. Men have also reported that both men and women are treated for their ailments at home except that men fall sick less often. An obvious inference is that if the health services were accessible and sensitive to these issues, both men and women are likely to seek help for their reproductive problems.

Photo : K.T. RAVINDRAN

Women's Responses

All the women canvassed reported without any hesitation that they did not understand much about their health but were positive about not being healthy. All the women were unanimous in stating that men fall ill less often and that they (men) get treated first at home and only later seek help from a health facility. Women on the other hand have a lot more health problems related to their 'hidden' parts and only seek help when they "fall flat on their backs, or cannot move any more". Till then they seek local remedies.

The most common health problems reported by women (ranked in order of their frequency) were excessive or irregular menstruation, anaemia, miscarriage, vaginal ulcers, bleeding during pregnancy, prolapsed uterus, pain while passing urine, itching in vagina, abdominal pain, lower back pain, leg pain, infertility, incontinence, eye pain and poor sight at night, breathlessness, rectal bleeding during defecation, constipation, dizziness and pain in breasts. All 23 schedules of women's responses have reported white *rajmal* discharge as a problem suffered, with 21 mentioning red discharge either along with or separately from the white one. Prolapsed uterus in which the uterus comes out, uniformly features in all the respondents' lists of morbidities including the male responses.

People here believe that certain kinds of food like white rice, arbi, meat and some dals are the cause of white discharge but food taboos are not strictly imposed as the shortage of a variety of food makes it impossible to observe most of these food-based taboos. Women stated that they ate whatever they could get, in spite of its being "hot" and therefore, kept suffering from white discharge over a long period of time. None of the women mentioned the relationship between sexual intercourse, poor menstrual hygiene or septic delivery procedures and white discharge, though some of them linked lower back and abdominal pain and white discharge to tubectomy or sterilisation procedures as they felt that their problems began after they underwent a sterilisation

procedure. Embarrassment in seeking treatment was expressed by all women concerned but most women felt that if the doctors heard what they had to say patiently they would be able to go to them with less fear.

Reasons for Ill Health

The reasons they gave for their poor health were varied—having an alcoholic husband, not getting enough love from the family, constant tension in the household, excessive sexual intercourse (more than twice or thrice a week); sexual acts during menstruation, too many husbands, being beaten by a husband, bearing too many children from a young age, anaemia, lack of food or a nutritious diet. Only one schedule mentioned not having any children or having only girls as a cause for women's morbidity. Having to carry heavy headloads and excessive and exhausting workload is a cause for illness cited by all the women questioned. Children's ill health and husband staying away from home over extended periods for work and engaging in questionable activity (*ulti sidhi cheez*) was reported by 50 per cent of the women surveyed. One woman reported that it is destined for some women to be perpetually unwell.

Abortion and Contraception

Where abortion was concerned all the women flatly denied ever 'killing their child', and reported that they had to take permission of their husbands or the elders in the family to abort. The techniques used for this process are as follows: drinking a decoction of goat droppings and ash, drinking soapy water, taking any medicines lying around the house, getting the stomach massaged by a *dai*, eating the bark of the *shingar* or the *beeul* tree, drinking alcohol, tying the stomach tightly with a long cloth or rolling on the floor with a log under their stomach. When asked about the success rate of these methods a few women jokingly remarked that the large number of children each one had should be an adequate answer. Interestingly a single woman reported either the knowledge or use of medical termination of pregnancy procedures at the government health centres.

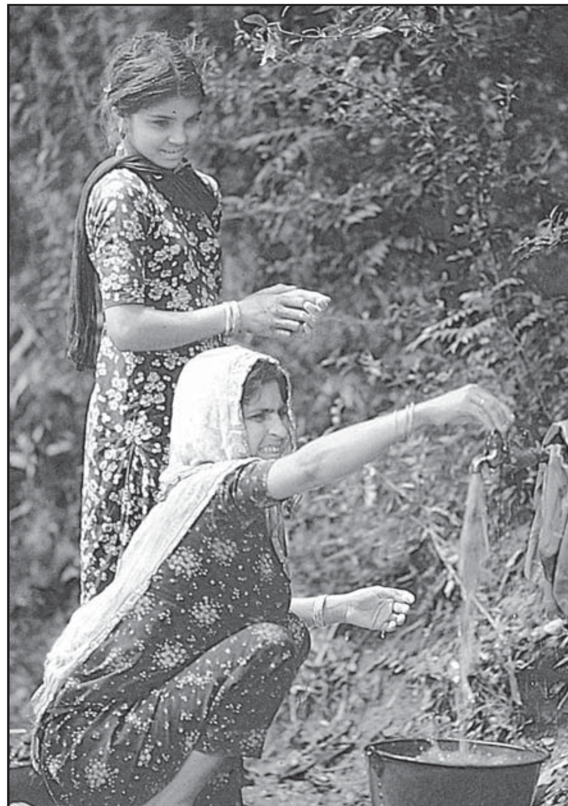
Contraception was another issue raised in the questionnaire. The male responses were interesting. They advocated the use of only the 'deluxe' Nirodh condom. The women all reported knowledge of Mala-D, the copper-T and the condom. However, they also stated that they did not know enough about them and were too scared to try them out. But they would like to use something to delay or stop having children. The contraceptive method most commonly used was tubectomy.

The responses gathered from this preliminary exercise made me even more aware of existing gynaecological diseases and the necessity of conducting laboratory and clinical testing of the target population to obtain more accurate data. There was also a demand from all the women respondents to arrange for treatment.

To Sum Up

The burden of RTIs falls most he avily on women of reproductive age as infections acquired during unsafe childbirth, illegal or unsafe abortions, and unsafe sex account for a very high percentage of disability in women in the developing word and yet most women would not seek treatment due to the fear of being labelled immoral. More importantly, many women perceive the symptoms of RTIs — occasional pain and abnormal vaginal discharge—as normal. Women who have had RTIs since adolescence may not know which signs are normal and which are not.

RTIs cause a heavy emotional stress, especially when they damage fertility, a large number of women are unable to conceive or even carry the foetus to a full term because their reproductive tract has



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been damaged by an RTI. Women in the general population are considered to be at low risk because most of them do not have high rates of partner change or multiple partners. It is of crucial importance to note here that RTIs are not only acquired through sexual contact. In developing countries like India, RTIs can be acquired also during childbirth, IUD insertions, tubectomy procedures or abortions where hygienic procedures are not strictly followed. Poor menstrual hygiene leading to an endogenous growth of bacteria in the external reproductive tract could also result in carrying the infection into the pelvic cavity during sexual intercourse. Women, are frequently vulnerable to these infections (for all the above reasons as well as) because of the behaviour of their partners: male promiscuity, that is, multiple partners and visits to prostitutes.

Women generally do not have the power to determine whether, when and with whom they can have sex. Biologically, women are also more vulnerable because transmission of several STDs is more efficient from men to women. The consequences for women are more serious than for men, and women who have infections do not normally seek treatment. Further in the developing countries, women have little if any, accurate information on the causes, consequences and treatment of STDs or other infections—endogenous or acquired through iatrogenic procedures.

Refocusing attention and resources on RTIs in women emphasises that a woman's health is more important than the control the state seeks to have over her fertility. ❑

Yogini

In the black stone idol's heart
a wound begins to bleed.

A child is climbing
the steps to the shrine.

In the elongated staircase infinite steps emerge.
To his resounding footsteps
Dark hidden alleys open up.

Strange undulating serpents of light appear
fragile threads breaking off at his touch.

Hidden among these serpents of light
lies the thread that holds my enchanted life.

Will he find it?
Will it crumble at his touch?

O Bhole Shankar
what shall I do?

Will no one stop him?
Where is the clamorous crowd of incense burning
drum beating devotees?

Soon the child will enter my sanctuary.
What shall I do O Bhole Shankar tell me!

Shall I grow spiky thorns
on these threads of light?

Shall I pile up mounds of
skulls on the floor?

Or

Stuff the whole shrine
with headless tailless
Questions?

O Bhole Shankar Tell me!
Shall I turn him into stone?
Black stone?

One more Black stone statue
in the shrine?

In the morning the priest
in ceremonious procession
will take out a new resplendent
black child god.

K.L. Sahi