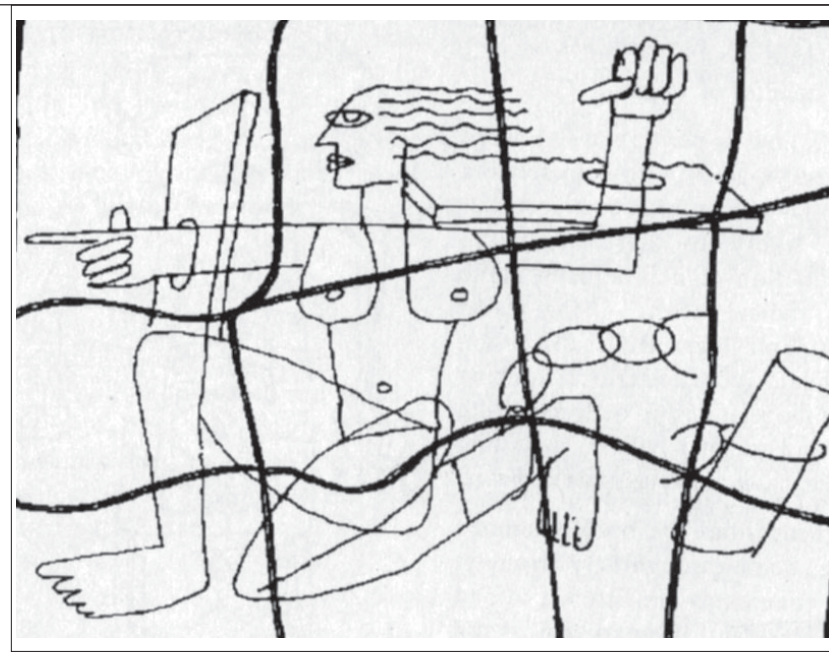


BOOK REVIEW

In Our Own Hands

Na Shariram Nadhi (My Body is Mine)

Sabala and Kranti

Review: Paige Passano

NA Shariram Nadhi (My Body is Mine), written by Sabala and Kranti, is a creatively presented document of an experiment in training women from various villages in Andhra Pradesh to become health facilitators in their respective communities. Contentwise, the book takes a similar approach to the well-known book on women's health, *Our Bodies, Ourselves*, a pioneering project by the Boston Women's Health Collective, but it departs from the latter in the fact that it is rooted within the Indian social context. It addresses specific health issues that face women in this country which the American book, consumed primarily by an educated western audience with access to a high standard of health care, cannot possibly address.

The impetus for this project came out of a need to give women alternatives to the public health system, in which men's health is seen as that of producers, and women's as reproducers — with a primary focus on ensuring that women perform their reproductive functions "properly" and in accordance with demographic aims. Sabala and Kranti, who have been working as health activists in rural areas since the '70s, became aware of the result of this biased perspective: "Everywhere women were treated shabbily — called irresponsible, unhygienic, looked upon as passive, domesticated consumers with money to waste. Women had no right to ask for information or to question." In order for women to be able to counter these norms, the authors believe that certain health matters, including gynaecological exams, must be taken into women's own hands.

The training group of 18 women met in Hyderabad for a week out of every month during a 10-month period. Other than the authors and one independent activist from Hyderabad, the participants included nine women wage-labourers from *mahila sanghas* (women's groups), and six women from various NGO project teams. Members of diverse groups were represented — including Dalits, members of the Enadi and Lambadi tribes, Other Backward Castes, and a few from the higher castes. Many of the participants' communities were in desperate need of basic health care because they were located in remote areas with poor transportation facilities, and they had been basically ignored by the government health system.

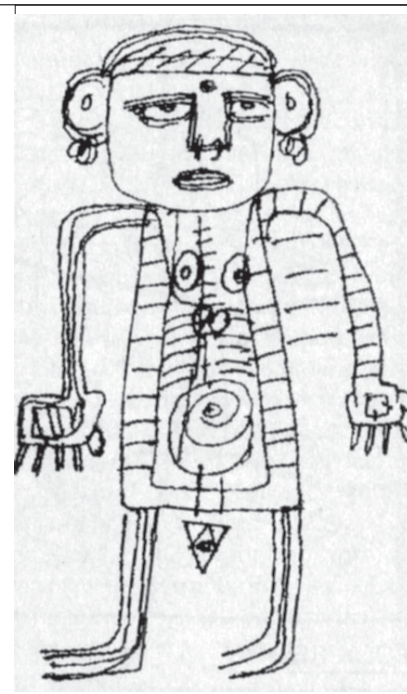
The training session, financially supported by the Unitarian Universalist Association (who also funded the book), the Global Fund for Women, and Asmita, a Hyderabad-based women's organisation, was never intended as a end in and of itself. The goal was to create a self-generating information network that could be passed on by word of mouth in the participants' communities. Therefore, women who had experience as a *dai* or who were recognised in their community as having some other kind of traditional healing knowledge were

given priority in the selection process. This was to try to ensure that the knowledge would not remain with a small handful of women.

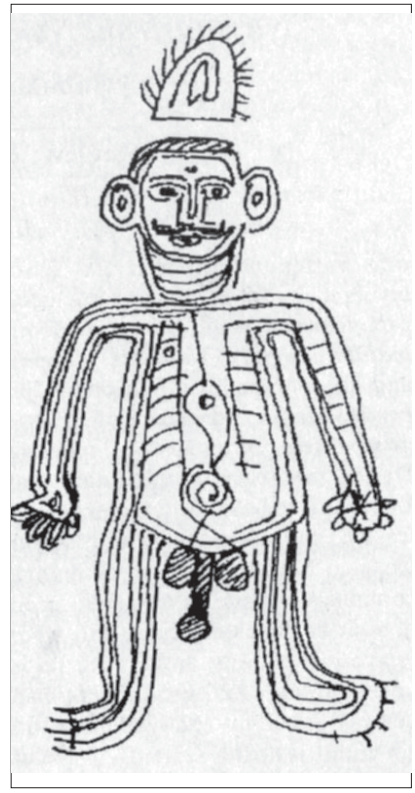
A follow-up period was structured into the programme to help sort out potential community conflicts that were likely to arise with the introduction of new and, in some ways, radical ideas**.** Using visual aids, role playing, and open discussion the authors promoted critical thinking about the relationship between health care and societal beliefs, including gender, caste, and class-based biases.

Throughout the book women's voices come through very strongly; their complaints are listened to and their ideas and life experiences are respected. The chapter describing the participants' backgrounds and main concerns is very useful for getting an idea about what kind of obstacles and pressing health needs these women and their communities are facing.

The youngest member of the group, Saroja, describes becoming suddenly widowed at age 15, after having been married for only six months, when her husband was attacked and killed by a bear while working in the fields. Though she was three months pregnant when her husband died, she miscarried. She spoke of being edged out of her in-laws home and forced to return to her natal home, but thereafter was expected to accept the restricted life of a widow. At the age of 18, she felt thwarted by the fact that in her community widow remarriage is banned, making motherhood or any type of expression of her sexuality completely out of bounds for her. "I want to have a son — tell me, how can I have a child? I want to get my property back. I do have sexual urges. Many young men get attracted to me. Why do people only look at me as a widow? Don't I have a future?"



The non-literate participants used bold colours and confident lines in their drawings of men's and women's bodies



Though the training programme was conducted in Telugu and most of the participants were non-English speakers, *Na Shariram Nadhi* ended up being published in English. The decision was left unexplained by the authors and brings up the important issue of for whom the book was written — whether their intended audience is English-educated activists or if the book was designed to be used as a practical guide for English-educated women. Considering the fact that the book attempts to open up discussion about the neglected health and social issues that face rural Indian women, the decision to publish in English is inconsistent and at least worthy of some explanation. Since it addresses local issues in such a clear and sensitive manner, *Na Shariram Nadhi* would have been a much more significant contribution to the existing body of writing in regional languages, since English readers already have access to a wide variety of material on women's health.

Bodily Visions

It was a bold move on the authors' part to bring women from such diverse backgrounds into one room for learning and discussion. Some participants were literate and familiar with modern medical notions of sickness and health, while others were illiterate and part of another tradition, in which beliefs surrounding the makeup of the body, its functions, illnesses and their treatment differ substantially. Despite these vast variances in the backgrounds and ideas of the participants, this masala approach resulted in some interesting exchanges between the participants.

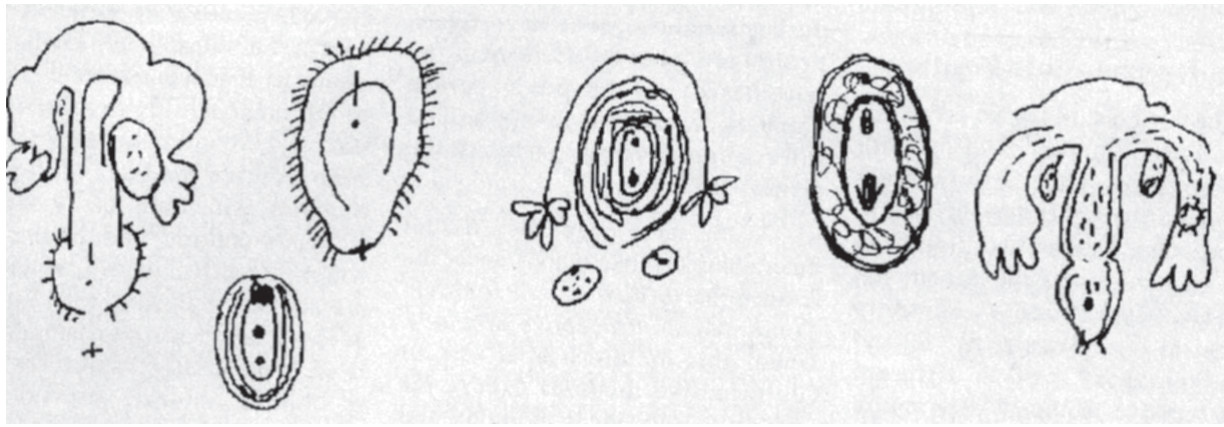
For example, when introducing an exercise exploring bodily perceptions

that consisted of drawing a man's and a woman's body, the authors were aware, from past experience, of the likelihood of the educated participants' drawings influencing the artwork of the non-educated participants. To take advantage of what could be learned from different perceptions of the body, the *sangha* women were separated from the educated women.

"It was very interesting observing the two groups. Without hesitating, the *sangha* women clustered into three teams of three partners each. Although they were new to this activity, they confidently took up the crayons over the paper. As they worked they discussed and argued about where the parts should be, and how they are related. They used the strong and bright colours confidently. In less than twenty minutes each of the three *sangha* groups had drawn out a female body. The male followed shortly after.

Meanwhile, for a long time the paper of three groups of project staff women were blank. They went looking for pencil and rubber. They prepared rough diagrams in their notebooks and were rigid about lines. First they drew a body outline. Two groups then put in breasts and vagina. The systems like digestive and urinary and lungs and heart got illustrated separately outside the body, trying to recall school textbook diagrams. Another group put clothes over the body and gave stress to extrinsic details like earrings and purses. They took three-fourths of an hour for this and did not feel free to draw the male body."

Upon bringing the group together again, the *sangha* women first displayed their drawings, which were brightly coloured with prominence given to the brain, heart, mouth, intestines, ribs, and male/female sex organs. They highlighted the parts that they felt were important, such as the ribs: "We often see our ribs. They stick out. Our children are thin. All we see are their bones ... we see and feel their ribs everyday." However, when the NGO project staff women showed their drawings which they believed to be technically superior due to a greater accuracy, tension arose as the *sangha* women teasingly laughed at one group who has clothed their female figure modestly in a *salwar-kameez* and launched into a critique of the drawings of "broken-up" bodies with floating parts.



"We gave them paper and colours and asked them to draw pictures of the *manam* (vagina) and reproductive parts, not as they might have seen them before in charts, but as they understood them from their cultural background."

Uncoding the Mystery

In the chapter entitled "Fertility Awareness and Sexuality", the authors demystify the reproductive process by teaching what they term as "body literacy", also known as natural family planning (NFP). By learning about fertility cycles, women were provided with a much greater awareness about how couples can space or prevent pregnancies. Understanding and dealing with possible causes of infertility, which causes emotional anguish for many Indian women and puts them at high risk for social ostracism and desertion, is another benefit of understanding female fertility patterns.

The simple method of observing bodily changes and using symbols to chart these patterns was readily accepted by the participants. Considering the high rate of untreated gynaecological disorders that has been recently documented, the ability to detect the difference between normal, healthy vaginal mucus and signs of infection is a particularly useful skill, especially since several of the participants had women from their

villages coming to them for advice on a range of gynaecological problems.

The participants felt an increased sense of control and confidence after learning this skill, as well as an understanding of the myths surrounding infertility. By the end of the 10-month training period, one participant, Nageshwari, had taken her acquired knowledge and was working with 20 childless couples to help them increase their chances of conceiving, as well as training *dais* and teaching sex education to boys and girls in her locality.

An Irresponsible Position

The most disturbing aspect of this book is the chapter dealing with contraceptives. It is also the only section of the book that dictates to women first, without any discussion with the participants about their own experiences and ideas regarding potential advantages and disadvantages of different contraceptive methods. The entire issue is obscured by the authors' political ideology and personal values, leaving no room for an objective presentation of women's options.

Only the risks and side-effects of provider-controlled and hormonal contraceptives are presented, without any explanation of the benefits of these methods or acknowledgment of the fact that many women have very valid and practical reasons for choosing these methods.

The authors introduce the subject of contraception by stressing the importance of women being able to control their reproductive lives. They then go on to discuss various methods that women have traditionally used to control the number of children they had, such as "... staying at one's mother's place, regulating diet, using

herbal or other remedies for preventing or aborting pregnancy, observing ritual abstinence from sex during certain seasons or festivals, prolonged breast-feeding, the withdrawal of the penis before ejaculation, and avoiding sexual intercourse during parts of the menstrual cycle."

On the same page, they list all other contraceptive options under the heading: *Invasive, Provider-Controlled Contraceptive Methods*. Under this ominous label fall all contraceptive methods except for condoms, traditional methods and natural family planning. By using such a loaded, negative term such as "invasive", the authors basically condemn all contraceptive methods besides condoms, abstinence, and the traditional methods listed above. Never mind the fact that none of the traditional methods fulfill the crucial need of year-round dependability, nor are most of these methods in a woman's control.

The luxury of going to stay at one's mother's place is not exactly available to most women, especially for periods long enough to make an impact on their fertility. Similarly, ritual abstinence for festivals or the use of prolonged breast-feeding, while effective, are limited in practical use. Withdrawal is extremely risky not only because it depends on the male partner's self-control, but also because it requires an agreement of both partners on family planning goals. Even when withdrawal is practised correctly, conception can occur by way of the small amount of semen that is released prior to ejaculation. Since there are no well-known foods or herbal concoctions that can be depended upon to effectively prevent pregnancies, it is a great loss that the authors casually mention such substances but don't provide recipes.

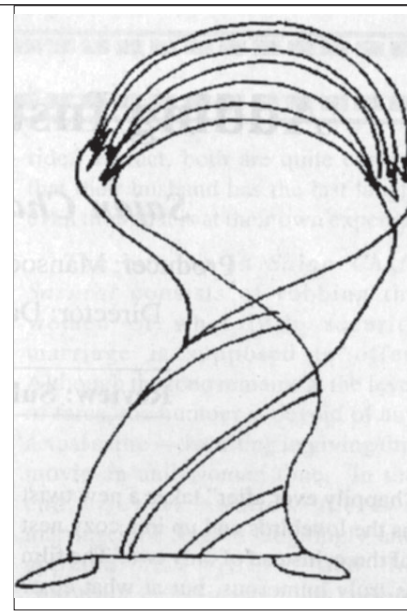
Sabala and Kranti don't directly promote all of the above traditional methods as effective forms of birth control, but rather freely list them as measures that women have used to control their fertility *to some extent*. But by dismissing all modern contraceptive methods (except for condoms, which are totally out of a woman's control, and diaphragms, which are difficult to use without privacy and adequate water supply) as either dangerous or unnatural, there is an implicit suggestion for women to choose natural, non-invasive methods instead. This would be fine if there *were* natural, non-invasive methods that were equally effective, convenient, and most importantly feasible for women to use. There is no doubt that practising natural family planning is a effective way of preventing conception if one has the final word *and* the desire to abstain from sex on all possibly fertile days of the month, but most women do not, so the usefulness of this method is severely limited.

The biggest objection I have is to this romantisised list of traditional methods, pitted against the evil, state-controlled technology, is including herbal and "other remedies" used to induce abortion within the realm of non-invasive methods of controlling births. Many common practices (that the authors acknowledge) such as

having twigs inserted into the uterus and using strong abdominal massages to induce abortions are known to be very harmful and dangerous. From a woman's perspective, though these techniques use "natural" resources, they seem much more bodily invasive than a morning-after abortion pill, which the authors firmly reject as too dangerous.

Where is the line drawn between what is acceptable and natural and what is unnatural and therefore shouldn't even be made available? And who will decide? The authors argue that tampering with a woman's natural hormonal balance by using hormonal contraceptives is both dangerous and undesirable: "They effect our whole body, and have varying degrees of side-effects, ranging from menstrual chaos to chemical and hormonal imbalances. Not only do they destroy or distort a person's fertility, but they may also affect the health and fertility of generations to come." This warning is a distorted exaggeration of what the average hormonal contraceptive user experiences. And when it comes to side effects such as "menstrual chaos", any women who is informed of the potential after-effects of a contraceptive method should be perfectly able to decide independently what risks are worth taking. For most women who either want to space births or who have achieved their desired family size, the issue of how to effectively stop having children is a much higher priority than whether the method is natural or not.

As health educators, the position taken by the authors is irresponsible. Their recommendations are likely to carry a lot of weight among the women that they work with, especially those who have very limited access to knowledge about reproductive processes. This sweeping



condemnation of almost all contraceptives dwells on the specific risks of these modern contraceptive methods while ignoring women's more urgent health threat of not having access to them, considering that the average risks associated with childbirth and abortion in India is many times greater than the chance of serious contraceptive side effects.

Rejecting Dependence

Outside of the discussion of contraceptives, however, Sabala and Kranti's emphasis on maximising women's autonomy in health matters is right on the mark. It is clear that *Na Shariram Nadhi* was born out of a genuine desire to promote an environment in which women can enjoy life within healthy bodies.

Emphasising cheaper, local alternatives to replace an unnecessary over-dependence on doctors is a very worthwhile goal that makes health maintenance more possible for regular people, especially in places where adequate health care is absent. Simple remedies such as the use of fresh neem leaves and garlic for treating gynaecological infections or using *methi* (fenugreek) for painful menses were tested and found effective. Efforts such as this counter women's alienation from their own bodies and the powerlessness that accompanies it.

The follow-up to the training illustrated that although the introduction of new information into the women's respective communities was generally accepted, it was not without difficulties. In one community the men objected to women's new assertiveness and didn't like them speaking to each other on taboo subjects, so they put a halt to *mahila sangha* meetings.

Sabala and Kranti were also not sure how to handle the dilemma of teaching women what nutritious food should be eaten during pregnancy and childbirth, when many women simply cannot obtain such nutritious foods due to severe economic hardship and unfair food allocation within their families. Though the authors are very aware of the inseparability of health and economic security, they found this to be an extremely difficult issue to tackle in all its enormity.

Na Shariram Nadhi is at its best when it goes lighter on ideology and focuses on explaining basic information and initiating participatory discussions. Despite the popular belief that Indian women are too shy and modest to discuss sexual issues, when given the chance to speak freely, the participants were more than willing to talk openly about sexuality and sex-related illnesses. Even when bringing up taboo subjects, the authors' frank, uninhibited style encouraged an excellent exchange of information and ideas. ❐