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The Women's Health Programme

Renu Khanna

The chapter describes how the women's health programme was initiated, the philosophy and the values that the programme attempted to evoke, the envisioned role of the Women's Health Workers and the kinds of preparation that needed to be done before the programme could start.

Beginnings

In 1986-87, when the drought was at its peak, and the chulha mistris (the stove builders) and supervisors were beginning to form an effective link between the rural women and the voluntary organisation, SARTHI started feeling the pressures of the local women's demands. SARTHI programme planners thought that it was time to develop more holistic women's programme responsive to the needs articulated by the local women. Women's depleted nutritional status, physical overwork at the relief sites, worry and tension about the children seemed to be resulting in greater maternal deaths and higher morbidity among both women and children. The women started suggesting that SARTHI start providing some kind of basic services for them. SARTHI, on the other hand, felt rather ill equipped to do this; it had no expertise or experience in health. Efforts were made to recruit doctors but after almost a year's search, the organization gave up; it was too difficult to attract doctors into a remote rural area, where they would be alone without the benefits of the company of others of their profession. In this situation, SARTHI's policy makers decided to start limited women's health programme: to train the traditional birth attendants, or dais as they are called, in aspects of maternal and child health (including conducting safe deliveries). This was somewhat unsatisfactory, as there seemed to be no recourse for referrals and secondary care. However, it was decided that for secondary care, links with the government's health structure would have to be forged and the government health system would be made to respond.

SARTHI, as could be inferred from the above, was a "traditional" development organisation, perceived by the people of the area as a giver, and provider of services. It was a situation prone to maintaining a certain kind of dependency. The Women's Health Programme has since then probably begun to make a change in this relationship, a change towards greater autonomy and assertiveness on the part of the women.

An important component of the health programme, as it was planned at that time, was a plan to study the existing health practices in the community namely, home remedies, herbal treatments, traditional healers' treatments, to mention a few. It was thought that wherever suitable, SARTHI's health programme would reinforce the "good" and effective practices; only where necessary SARTHI would add on new knowledge and skills to meet the health needs of the people.
Apart from providing the necessary services at the primary health care level, the emphasis was planned to be on education and consciousness raising with respect to health and peoples' rights.

The box "Women's Health Perspective" encapsulates the thinking underlying the Women's Health Programme at SARTHI.

Women's Health Perspective

Women exist within a social framework where they are primarily defined through their bodies. Their physique is assessed for the ability to work or to bear children, their appearances judged within the framework of traditional beauty, and their bodies restricted to satisfy the claims of ownership by man. Surrounded by and immersed in the stereotypical images of women - as mother, woman as sacrificing wife, woman as burden - there is little space for women to value their experiences and ways of being in the world, and through this, to take control over their bodies and lives.

Women's subjectivity, her experiences of existence are negated and rendered invisible, her body used as a battleground by the forces of both tradition and progress. Women continually face both external and internal, physical and emotional violence. This violence against women, their lack of control over and identification with their bodies become visible through the statistics rejecting women's poor health status, through deaths in infancy and at childbirth and through invisible but high Fevers of morbidity such as anaemia and gyneecological problems. Alongside the health problems women themselves face, is the role of women as career of the sick. Within the family context, a large amount of women's time, energy and resources are spent on tending those who have fallen ill, particularly children and old people. Yet again she receives little recognition for her input of physical, emotional and economic energy. In approaching women's health, it thus becomes vital to move away from the paradigm of issue-based health care inputs that focus primarily on Maternal and Child Health (MCH) and Family Planning (FP), developing instead a fresh conceptual framework. Working with women's health involves exploring and understanding women's experience of herself within society, her relationship to and control over her body. The layers of negation and devaluation need to be peeled off, so that women are empowered, their experiences validated and they are enabled to develop their self-image within a context where they can exert control over their bodies and recognize their intrinsic strengths, both individually and collectively.

From this will emerge a space in which women are then freer to define and work with what they perceive as health problems, definitions that may well include the components of MCH and FP, but have the potential to expand to issues of water and sanitation, physical work burdens, liquor and much else. The possibilities become enormous as the stereotypical, predefined barriers are broken and women come to see themselves and their potential to recognize and value their contributions to society.
In this context, development is seen as a process, which begins with the validation of the individual and encompasses the changing relationship and community of that individual in society, rather than being simply a set of targets to be achieved.
(excerpted from: Working Note On Sarthi's Women's Health Programme April 16, 1988)

Women's Health Workers (WHWs)

Having defined a perspective, the first stage was to identify twenty women who would form the foundation of the programme and who lived and worked within their own villages. We envisioned that whilst themselves going through a process of sharing, reflection and analysis of their own experience as women, they would initiate a similar process with women in their villages. Through bringing women together, they would be empowered to act, to work towards solutions for problems they faced, drawing upon their awareness of their own strengths.

Although the Government of India was seriously questioning the benefits of the village health worker scheme, our thinking was that the supposed failure was more a failure of the implementation methodology than of the concept itself. We firmly believed that women healers had a powerful role to play in promoting the health of women although increasingly women have been pushed into subordinate positions within the hierarchies of the health care delivery system.

Amongst the women initiating the programme were a number of traditional daises. Our attempt was to help create in the WHW a synthesis of the dai and the FHW with additional knowledge of modern gynaecology. Many women's health programmes had been focussing on the dai as a village level worker in view of her recognized role as a supporter of women during childbirth, the training enabling her to provide additional input in terms of western medical skills related to antenatal care, delivery and postnatal care. The dai was thought to be an invaluable resource in terms of her understanding of and relationship with women at the village level. However, in including dais within the programme, it was felt that it was important to explore the traditional value systems (as a supporter of women in childbirth) and those related to the status that goes with the modern medical technology and through understanding them, build upon

the positive, woman-affirming ways of being to expand women's health care. It was also felt important to include a number of younger women for training, those without the background of traditional dai work, both to offer a different perspective to the work and to support the tradition of older women/dais passing on their skills to younger women. Thus the final pattern that was sought to be established was that the younger women who came for SARTHI's training would work with the traditional dais in their own villages in an attempt to influence changes in their practices.

Role of Women's Health Worker

The role of the WHWs was envisaged as follows:

- To act as initiators of reflection amongst women at the village level, validating experiences, sharing a critical analysis of the position of women in society, and affirming women's positive self-image and power to act both individually and collectively to solve problems.

- To provide women with the space to explore the relationship between their bodies and society and to gain knowledge of and control over their bodies through such an exploration.

- To offer support services to women in pregnancy and childbirth, ensuring a woman-centered environment, a recognition of women's power and right, to determine the process of birth, whilst offering skills to ensure that pregnancy and delivery is monitored and safely conducted.

- To explore the broader range of issues of women and health in the field, through discussions with their village women, for example gynaecological problems, water, physical workload, child health care.

- To support women in their role as carers and healers.

- To work together as a team, in a spirit of collaboration so as to provide role models at the community level for people to come together on common issues affecting them.

Criteria for Selection

It was planned that from each of the four field areas in SARTHI's area of work, two traditional dais and two other women would be selected according to the criteria outlined below.

In keeping with the envisaged role of women health workers, the following criteria were outlined for their selection:

- A reputation for empathy and sensitivity: the women's health worker (WHW) or traditional dai should be a person who other women like to have around them in times of stress.

- Accessibility to a wide range of women, that is, the health worker should be able to work with women of all castes.

- Keenness and receptivity to equip herself for the role.

- A desire to work collectively with other women: to question, search and communicate.

- A relative freedom from domestic pressures so that she can give time for the work at hand.

- Mobility in surrounding villages.

Selection Process

The selection process consisted of informal "checking out" and identification by the field centre staff both male and female. In women's meetings in the villages, the local women's selection was obtained and the field staff's opinions were checked out. All the women listed during this process were interviewed as described in the following section. The selection was finalised thereafter.

Information Re-search Process

It was thought that before the women's health workers started working according to their planned role, they would need to be oriented and prepared for this role. The first phase of this preparation process was the sharing of their own life stories - the stories of their own experiences of their bodies, of child bearing, of their beliefs about themselves and of their relationships. The dais were, in addition encouraged to share about their work -their history as dais, their practices, the beliefs and rituals that go with their work, how they saw their role as dais, what they felt about being dais. This information, about their experiences of themselves, in relation to society, formed a foundation for a critical reflection. The process, it was hoped, would be a source of reinforcement and affirmation and an integration within themselves at a higher level. Also, the information about the dais' beliefs and practices gave the programme planners an

opportunity for understanding their deep-rooted traditions and for building up on whatever knowledge and skills they already possessed.

The information was gathered through a process of informal sharing and dialogue rather than through structured interviews. A climate of support was created with great sensitivity and the women were gently encouraged to talk about their own experiences of childbirth and other life events and belief systems related to being a woman in a male-dominated society. The facilitators in the interviewing processes were provided an orientation and practice for this.

A one-day orientation was given to the interviewing team. The contents of the orientation covered:

1. The contextual background including essential features of the programme as it was planned, the existing role of the dai and the emerging role of women health workers.

2. Introduction to the checklist for information gathering (see Annexure 1).

3. Interviewing methods and listening skills through role-plays and practice sessions in gathering each other's stories.

4. Establishing ground rules for information gathering.

The total period for data gathering and assessing the information collected from the potential trainees was between five to six days.

Other Logistics

Interviews were conducted by three teams of two persons each. The three women supervisors of SARTHI's field areas were the primary interviewers. They, as local women, were able to build a rapport with the traditional dais and the women health workers selected from their areas. The supervisors were supported by the "writers" who were in the background quietly noting down the essence of the interviews. The writers were Nirmalben, the Co-ordinator of the Women's Programme and two other volunteers from Baroda's women's groups. The three pairs interviewed all women who were selected to become the women health workers. Each pai r interviewed two or three women per day depending on convenience of the interviewees and the time available. The time and space factors for the interviewing were thought to be important, the time had to suit the woman being interviewed. The space had to be such that there was reasonable privacy to ensure that she was not interrupted frequently.

After all the interviews were completed, the entire group sat together and wrote these up in the form of stories of each woman (see Annexure 2).

Increase in our Understanding

Although the thinking among government health policy makers and planners was that village level health functionaries as CHVs (Community Health Volunteers) was not a workable scheme, several community health projects in the voluntary sector had a different experience. Because of careful selection, systematic training and continued field support, voluntary agencies had excellent results with the role of the CHV. We saw an added potential in the role of the traditional dai as a healer and empowered of women in her community. Because of her closeness, physical as well as emotional proximity to local women, we believed that the traditional dai could be further equipped and empowered to fulfil a crucial role in the community, that of a catalyst helping women to take charge of their lives. The interviews helped clarify their profiles.

Emerging Profile of the WHWs

Interviews with the women who were ready to work as health workers provided a wealth of information, which helped us, as programme planners, to increase our understanding of the local women's experiences of their bodies, of the beliefs and practices related to childbirth. It also provided a valuable basis for the training input. For instance, we learnt that all the dais massage on the abdomen of the women in labour in the belief that the baby will come out more easily. We also learnt that breast- feeding begins only between one to five days after the delivery. We learnt that while some nutritional practices - like eating ghee and gur during labour were good (as they provided energy), some others like restricting the lactating mother's diet to only rice and ghee in the post - delivery period needed to be improved.

The interviews with these women served another purpose: that of establishing a rapport and lessening their fears before they came for the training programme.

Life Background of WHWs

All the eleven women who were interviewed were married women with children. None of them had any formal schooling. They belonged to families who have small land holdings and subsisted off this land. Their families also needed to go for wage labour to supplement the income from their land. Two women mentioned that they were the main decision makers in their families. Sukhiben's husband had tuberculosis and Dhuliben's husband had been injured in an accident so the responsibility for managing their families rested on their

shoulders. Two other women were widows so they, too, headed their families. All the women were adivasis but belonged to different groups: Khants, Barias and Damors. Within the adivasis there is practically no social hierarchy so the women could have social access to different clans or groups. From amongst these eleven women, eight worked as independent accepted dais while three accompanied traditional dais as helpers or support persons.

History of Occupation

A majority of the women interviewed were traditional dais who had learnt the skills of the occupation by accompanying their sisters, mothers-in-law, aunts or grandmothers. They were initiated into the occupation by performing "helping" tasks and then over time they graduated to independent handling of deliveries. The motivation of becoming a dai seemed to be initially to carry on the family tradition or help the elder woman in the family in her work. As the apprentices learnt more and could handle the deliveries by themselves, they began to enjoy the special respect that they received within their families and in their villages.

Experience of Pregnancy

The women talked about their own experiences of pregnancy and childbirth. They knew that they were pregnant when they missed two or three periods and had feelings of nausea. There is no ritual or celebration when the women become pregnant. Work carries on as usual - they have to perform all their daily chores right till the time of labour. As Sumitraben put it, 'Who would do the work and what would we have eaten if I'd stopped work?" And Shantaben said: "I continued to work on the Patel's land right till the end. I used to travel a distance that cost three rupees by bus, dugout and carried the earth and built a boundary wall for the fields.' Some of the women recalled their craving for special foods but since they could not afford or had no time to pamper their desires, they just suppressed them. Kaliben of Gamdi was the only woman who could remember eating "methi ladoos" (fenugreek balls) for strength during pregnancy.

Antenatal care is not a part of the dais' work. If pregnant women have some special problem, bleeding or pain, they are sent to the hospital. Other discomforts they have to bear, the elders tell them that they have to bear these. Fuss over pregnancies does not seem to be tolerated. Many women said that the sex of the baby in utero can be detected. If the women remain weak and small during pregnancy, she will give birth to a daughter. If she becomes big and heavy she will have a son. Another opinion prevalent is that if the baby kicks to the right in the mother's womb, it will be a boy. And if the mother feels that the movements are on the left, it will be a girl. These beliefs seem to be supported by Ayurvedic literature. They also seem to be widespread in many rural and tribal

communities of Madhya Pradesh, Maharashtra and Orissa. (See for instance: Vaidya M Radhika & A.V. Balasubramaniam (Eds) Mother and Child care in Traditional Medicine Part I LSPSS Monograph No.3, Madras, 1990.)

About infertility, obviously women are very concerned. They go to holy men or holy places, for example, a dargah, and make vows, tie sacred threads and hope that they get pregnant soon. Otherwise their husbands take new wives.

Food taboos in pregnancy seem to be plenty. Pregnant women are not supposed to eat 'hot' foods like jaggery, bajri. They cannot have milk, curds or buttermilk as these are supposed to stick on the foetus and make the delivery difficult.

Deliveries normally take place in their natal homes, atleast the first ones almost always do. Deliveries of subsequent children may take place in the husband's home. When the water bag breaks or the contractions start coming at short intervals, the dai is sent for. All the female relatives and women from the falia gather around. The deliveries generally take place in the cowshed or a secluded back corner of the house. The woman is encouraged to walk around between contractions. Sometimes she is made to sit on her haunches, press her palms on the ground and bear down. She is generally given a mixture of ghee and gur to give her strength and energy. While the dai is the one primarily responsible for the delivery, the other women support her by holding her hand, massaging her back.

If there is a dai with an "evil eye" in the village, she is called too. The idea is not to offend her or she may put a curse on the mother and the baby.

Most of the dais appeared to be quite cognizant of complications that can occur during labour. If labour is too prolonged and sitting on haunches and the ghee gur mixture does not work, the dai may decide to either call the doctor or the nurse or take the women to the health care facility. Many of the dais mentioned that they had successfully managed breech deliveries. They could manueuver the position of the baby abdominally and deliver the baby safely. A couple of dais mentioned delivering twins successfully too. But the general impression that the interviews gave was that the dais were aware of their limitations and quite ready to take the woman to a referral centre for her own safety.

The traditional position for deliveries is the lying down position. The dais believe that the woman needs help in pushing the baby out and they generally use their hands to masssage the woman's abdomen to help the woman to ease out the baby. Once the baby comes out, the dai is the one who is supposed to catch it. The baby is cleaned. The mother is expected to hold the umbilical cord and the dai cuts it with a sharpened household knife. The cord cutting is done after the

cord is tied close to the navel of the baby with a thread or a piece torn off a cloth. The baby's cord stump is sprinkled with ash or kumkum (vermillion) to seal .it. The placenta is then forced out by massaging the woman's abdomen.

After cleaning the woman, a pad is put between her legs, her skirt stuffed between them, and her abdomen is tied up. The skirt is stuffed to "prevent air from entering her body" or to prevent her internal organs from failing out. The woman is given some dodi (Leptadenia Reticulata) leaves water to prevent dhanuri (tetanus) and she is given a hot meal of rice and ghee or gur and ghee and allowed rest.

While describing their own experience of childbirth, the women said that they felt as if their 'body was being torn apart" or a "burning sensation deep within my body". The most immediate feeling after the birth was one of relief that the pain had ceased. It was later that they felt happy and elated at having delivered a baby.

The placenta is buried by the dai in the cowshed. She digs a hole and places the placenta with some rice and grains and salt and covers them up with earth. The belief is that if animals eat up the placenta, the new mother will not lactate or that the child will die.

The baby is not given to the mother to suckle until the milk lets down, that is only on the second or third day. Till then the baby is given sugar solution or goat's milk.

Pollution

It is believed that the woman who has just delivered must not touch other people for fifteen days after the delivery. She is considered impure. So people come to visit her and see the baby but avoid touching her. After the first fifteen days, the first level of pollution is considered over and the woman can begin her chores like cleaning, etc. But she cannot cook for the family until 40 to 45 days after the delivery. She cannot touch any water source either - that is, she cannot go to the well or to the river in this period. After the pollution period is over, a purifying ceremony is performed. The purifying ceremonies can be either of the following two:

"Kundalo (swastika) was made on the ground with maize flour. A ten paise coin was placed in the centre. I had a headbath and took the child in my hands. A coconut was broken and placed in the kundalo with kumkum. I took some maize flour in both hands and sprinkled it on the kundalo. During the sprinkling of flour, the child remained in my arms. This way both of us, the mother and the

child were purified. The first thing I did after I was purified was to collect water from the well." (Shantaben : Village Movasa).

The other purification ceremony goes like this:

"Five to seven days after the birth some sweet was prepared. I had a bath and a kundalo was drawn on the ground. In the centre, a ten paise coin and some maize flour was placed. A diva was lit and a coconut broken and kumkum placed in the centre. I stood with the child in my arms and sprinked maize flour on the kundalo. The pollution period lasted for one and a half months. Because of postnatal bleeding, the mother is considered polluted for this period. After the pollution period a maharaj washes her hands with kumkum water and she is purified. After this, she goes and fills water from the well" (Shantaben: Village Simaliya).

Perceptions of their Role

Most of the dais feel that they are called by forces higher than themselves to fulfil this role in the community. Once they have done even a single delivery on their own, they feel that they can never turn down a request for help. They have to go whenever there is a call. Not only them, but even others in the village feel that theirs is a special vocation - a sacredness and a certain religiosity is attached to it. Generally dais feel that hospitals should be avoided.

"Home delivery is preferable to that in the hospital. Most women feel this, as in the hospital they are not treated properly and have to undergo painful treatment. They are scared of the internal (vaginal) examination in the hospitals" (Dhulliben: Lapaniya).

It is preferable to have deliveries at home, though at the hospital full medical care is given. Bid it costs money, which can be used to buy food, if the delivery is done at home. There is no emotional support for the woman in the hospital. The dai accompanies the woman to the hospital, but if she is uncontrollably in pain the doctor gets irritated and sends them back home' (Navalben: Muvasa).

"In hospitals, the woman is often slapped, her legs are held down and the woman is not helped during labour. She has to make all the effort herself. In hospitals the nurses do not allow anybody to touch the woman. If she needs to sit, or get up she has to manage alone. At home, atleast there are people who help console and reassure' (Chaturiben: Village Nanirel).

Despite the above sentiments, the dais do realise that hospitals and doctors have a place in the scheme of things. Several of the dais cited examples of times when

they decided that they needed to take certain women to the hospital and assisted the doctors in hospital deliveries.

Ways of Compensation

On the fifth or seventh day, after the birth, the dai is invited for a ritual feast in the house of the woman she helped deliver. After the meal, she is compensated for her services. She may be given a sari a few seers of grains and some money. Each family gifts the dai whatever they can afford to. The dai is supposed to graciously accept whatever she is given. In older times, whatever the dai was given went a long way in helping her support herself. It was as if they had a role to play and the community recognised this and took the responsibility for supporting her.

With the external recognition of this role, namely, the government's dai training and system of paying Rs.3/- for each delivery conducted and reported, the community has begun to think that the dais are government employees. People now are not assuming the responsibility of supporting the dais. The compensation to them has decreased in nominal and real terms.

Conclusion

Interviews with the women who were ready to work as the health workers provided a wealth of information, which helped us, as programme planners, to increase our understanding of the local women's experience of their bodies, of the beliefs and practices related to childbirth. It also provided a valuable basis for the training input. For instance, we learnt that all the dais massage on the abdomen of the women in labour in the belief that the baby will come out more easily. We also learnt that breast-feeding begins only between one to five days after the delivery. We learnt that while some nutritional practices - like eating ghee and gur during labour were good (as they provided energy) some others, like restricting the lactating mother's diet to only rice and ghee in the post delivery period, needed to be improved.

The interviews with these women served another purpose: that of establishing a rapport and lessessing their fears before they came for the training programme.
From these relatively modest beginnings, the WHW programme of SARTHI, went on to claim several milestones. Table 2.1 gathers these milestones at a glance. While we discuss these in the subsequent chapters, these milestones reveal the internal logic of evolution of the WHW Programme.

Table 2.1: Milestones of Sarthi's Women's Health Programme

Period	
Early 1987	Local women's demands for a health programme, search for doctors not successful
March to May 1988	Discussions on philosophy of women's health programme; gathering information from district and taluka offices; interviewing traditional dais and other potential trainees, preparing for training
July 22 to July 30, 1988	Planning Programme
Sept. to Oct. 1988	Trainees visit SEWA-Rural in two groups
Nov. 1988	Training on nutrition
Dec. 1988	CHETNA training on care of under-five children.
Early 1989	Discussions on need for research into Traditional Medicines.
Sept. 1989	Training on Traditional Medicines by woman doctor.
Dec. 1989	Death of Champaben 14 months after diagnosis of cervix cancer. Ayurved doctor's visit to local forests to collect samples for identification.
Jan. 1990	Meeting with Shodhini at Bangalore; decision to become part of Shodhini.
Feb. 1990	Evaluation survey of the WHWs
Apr. 1990	Second training Workshop on Traditional Medicines.
May - Oct. 1980	Collecting information on traditional medicines and preparing herbaria.
Oct. 1990	Anaemia Study
Dec. 1990	First Self-Help Workshop
1991	Self-Help Workshops continue each month.
April 1991	Cancer detection camp by a medical team from Civil Hospital, Ahmedabad.
Feb. 1992	Evaluation of Self-Help Workshop by participants.
March - April 1992	Discussions within SARTHI on future of the Women's Health Programmes. Bimonthly self-help workshops.
June 1992	Self-help workshop-visits to cottage hospital and State Hospital
Sept. 1992	Self-help Workshop - input on STDs