Chapter VIII

FURTHER EXPLORING HEALTH: WOMEN'S PHYSICAL ILL-BEING AND MENTAL STATE
Moving from women’s reproductive health experiences, this chapter is concerned with looking at women's perceptions and experience of their general health condition including their mental and emotional state. Such a separation does not presuppose a compartmentalised approach to women’s bodies nor to understanding their health. Rather, as mentioned in Chapter I, we advocate a holistic view of women's bodies, illnesses and health. The division is only for the convenience of analysis, a device for handling of complex and interlinked data. Our enquiry into women’s health was directed at exploring the relationship between reproductive health and general physiological, emotional and mental well being in order to arrive at a holistic understanding of women's experiences of ill health and their health status.

Against the background of the connections between environment and economy, gender division of labour and reproductive health that we have explored, we now focus on women’s physical and mental well being. The chapter investigates the experiences, definitions and explanations of women’s physical states and illnesses and the pains and sufferings that derive from them and their ameliorative efforts. Though we did not begin with the objective of systematically enquiring into mental and emotional well-being, but through the course of our interactions and observations were unravelled women's mental stresses and states and how they affected them independently and in conjunction with physical ill being. Women laid bare the tremendous psychological burdens that they carried along with physical malaise burden.

Going by women's own descriptions we focus on the following questions: How do women describe their physical ailments/afflictions? What view do they have of their causes? Which signs and symptoms do they consider important or unimportant? Do they see the link between their productive and reproductive function and general health? The first part of the chapter addresses these questions. The second part examines women's attempts at accessing treatment, both “traditional” and “modern” and restoring their health. What beliefs and practices do they adopt for treatment and alleviation? What are the conditions that improve chances for better health and what jeopardise them? Are they even more under-treated than they are for reproductive 'problems' and dangers? What constitutes 'good health' for them? The chapter is based on qualitative material gathered
from our interviews. As in the last chapter we will attempt to look for variations between women in terms of age, migrant status, economic status and caste.

WOMEN'S CONCEPTIONS OF ILLNESS AND HEALTH

Health and illness are conceptualised differently by different cultures. While we discuss women’s conceptions of illness in this section, the concept of ‘health’ will be discussed later as it is intertwined with the experiences of life and death.

The previous chapter has made brief reference to the dichotomous classification of sources of misfortunes and illnesses into *dosh* (affliction) and *bimari* (illness). The supernatural world is manifested in *dosh* or affliction. These afflictions are frequently traced to spirit possession - ghosts (*bhut*) and deities (*devi aana*), evil eye (*nazar lagna*) and spells cast by magic or witchcraft (*toonatotka*). As a result illness, especially fever, diarrhoea, blood dysentery (*kaath*) or sudden deaths are attributed to supernatural forces such as ghost, evil spirit, evil eyes, etc. Children are supposed to be particularly at risk of being affected by the evil eye. When medicines are ineffective (*dawai nahi lagi, doctor ki dawai bekaar li*), it is again perceived to be the work of the evil.

The supernatural world of affliction is juxtaposed to the natural world of illness called *bimari*. The origins of *bimari* are traced to bodily disorders attributed to the humours. Discernible symptoms like stomachache, boils, pain, swelling, cough, fever are often attributed to external, natural forces like excess of heat and cold, air, strong emotions etc. In local articulation, the word *bimari* is used for describing illnesses like T.B (tuberculosis), malaria (*jadu bukhaar*) as well as fevers, loose motion etc. *Bimari* is further bifurcated into *bari bimari* and *chooti bimari*. Women generally associate *bari bimari* (major illness) with serious conditions that takes longer to cure, is painful and affects output or work. *Choti bimari* as the name suggests, is illness that is less severe, can be cured easily and in short time and does not interfere with work.

Even though the etiological world of the villagers is broadly dichotomised at the level of the natural and supernatural, the villagers do not demarcate strictly between illness and other form of sufferings or miseries of life. Conventional ways of assessing states of
well-being include not only individual illness but also other non-bodily miseries that are cause for worry. Sufferings of the body are thus not clearly distinguished from those of the mind and there exists a conceptual overlap of body and mind. These conceptual perspectives in turn determine health behaviour.

Over time, with the advent of western medical services, the dominant traditional ways of making sense of illnesses gave way to new hybrid ideologies, knowledge, ideas, discourses and practices. A trend towards new (allopathic) treatment systems has set in but one is uncertain whether biomedicine is accepted as superior. There are some indications of changing beliefs. Most importantly indigenous forms of "germ" theory of bodily disorders have developed, which coexist with local theories of the 'violation' of body humours. In consonance with the multiple notions and beliefs about illness causation, a wide variety of healing systems/health practitioners have existed in the vicinity of Bunga and Daurn. These specialists, both men and women, greatly differ in terms of their methods of treatment and explanatory models. They provide cures for different types of ailments. Thus treatment is seen as a matter for negotiation and for other authoritative pronouncements, either by traditional healers or today increasingly by the 'wonders' of modern medicine. At present what we observe is that there is a mixture of healing systems with a clear preference for biomedicine in some illnesses. However majority of women resort to the entire range of practitioners, depending on the nature and severity of the illness. We describe the current situation in the section on women's access to healthcare.

**ILLNESS AND ILL-BEING: WOMEN'S SELF-PERCEPTIONS AND ASSESSMENTS**

In our interviews with the women, women referred to number of mild and severe ("choti" and "bari") and recurrent health problems that they suffered throughout their life span. Even though some of these ailments like chronic cough, cold, fevers and seasonal diarrhoea were common to women and men, women experienced longer and more severe occurrences. It indicates that women experienced a perpetual state / condition of ill-health. In this section we present the illnesses in order of the frequency of reporting by
the women. We present the data in terms of health problems as defined by and interpreted by the women themselves.

**Body Pain: A Chronic Experience Of Hill Women**

Body pain is a predominant problem. Women overwhelmingly and emphatically attribute it to the enormous, laborious and hazardous work that they do. Women suffer from a host of pains – headache, backache, neck ache, pain in the hands and legs, stomachaches and joint pain. Chronic pains disable their functioning intermittently or at times so severely as to handicap them.

Multiple types of heavy and strenuous work, which we have amply described in the previous chapters, are the direct causes of pains such as back pain and other musculo-skeletal pains. Young girls from a very early age are compelled to adopt postures that are detrimental to bone integrity, such as carrying heavy loads. The different types of agricultural operations also require sitting, standing or stooping for long periods of time. Such tedious and time-consuming work is combined with nutritional deprivation that begins early in childhood and is aggravated by early marriage. The lack of food and rest as a *buari*, compounded by early and repeated pregnancies and years of lactation ensure that women are afflicted by chronic pain beginning early in life. The structural pattern of work, types of work and nutritional deprivation brought forth a profile of 'body pain' morbidity.

**“Bai”:** joint pain

Chronic joint pain, locally called “Bai” was named as a predominant health problem of village women. “Bai” includes numerous symptoms and is associated in one way or another with particular kinds of work activity. Identified work-related patterns of symptomology-terms such as “bai knee”, “bai elbow”, “bai-hand” are often used to describe the effect of varying types of work upon muscles and joints. Explanations of these joint pains were mostly linked to “postures”, “lifting”, “carrying weights”, “bending” etc.
Women of all ages, starting as early as 30, suffered chronic joint pain. The lack of food and rest as a buari, compounded by early and repeated pregnancies and years of lactation ensure that women are afflicted by pain early in life. The most affected joints are of the knee, back, hips, shoulder, arms and wrists.

Five years back I started having health problems. My joints got affected with ‘bai’ and my back started to hurt. Every morning I was stiff. I am now unable to do strenuous work. Luckily my daughters are now old enough to should my burden. But despite that some work is inevitable. I relate my ill health to my life full of backbreaking work; I feel that work for Garhwali women is inevitable (Pushpa, 38 yrs, Brahmin Bunga).

Early and repeated pregnancies and several years of lactation are felt to further compound the situation. Conditions worsen with age, incapacitating many women above the age of forty.

I am suffering from persistent joint pain called “bai” since last 10-12 years. At times my pain increases tremendously and then I go to Rishikesh to buy medicine. I have also taken treatment from the “vaid” and “bakki”. I feel that “bai” is caused by the excessive work, poor diet that I have lived with. I have given birth to 15 children. Now my body is perhaps worn out. I have put on a lot of weight as well. The severe pain in the joints and body causes me a lot of discomfort. I am now not able to even do household work properly. Frequently my legs and hands get swollen up. Legs and hands also often become very weak – as if they have no strength. (Saraswati, 55 yrs, Lohar-dom, Birkatal)

Another woman now in her forties suffering from multiple joint pains and stiffness, identified having to work long hours in the fields and forests as the main cause of her condition.

I’ve worked in the fields and forest like this since I was 9 – 10 years old. My back, knee and elbow joints started to pain thirteen-fourteen years back. But for last three-four years, it has been getting worse. It is affecting my back, my leg - I’ve been walking up and down, bending and climbing, carrying head loads of firewood, fodder and other weights.... (Guddi, 39, Auji-dom, Bunga)

In addition to detailed descriptions of causal relationship between bai and labour, many women sum up the cause of bai as ‘wear and tear’. (“jor ghis jate hain; haddi ghis jati hai”) The elaboration of the concept of ‘wear and tear’ often drew women into more detailed reflections of how their bodies had to be ‘constrained’ by their working lives.
My health is failing because of the heavy workload. Now my joints, particularly upper and lower limbs pain a lot now. They are worn out- because of overuse I think. Our life and work in the hills causes our bones and joints to wear. With age it becomes worse. Look at me now. I find bringing water most troublesome. Weeding also aggravates my joint pain. While threshing and pounding the grains my hands become sore. (Kamla, 48 yrs, Gusai-Dom, Goddi)

Women felt “worn-out” while trying to manage these obligatory pressures in the context of growing pain. Women who have no help with agricultural or domestic work and bear the entire burden are worse off. Kapi who lives alone with her much older husband complained:

You have seen how far our water is. My knees are so badly affected by “bai” – I have severe pain and swellings. I find it difficult to go up and down the hill. I feel incapacitated in even carrying small quantities of water. Even though every day I carry only a small utensil filled with water, but still I feel I have too much work burden (Kapi, 69 yrs, Brahmin Bunga).

Saraswati echoed most old women’s problems when she said

Since I have “bai”, I have difficulty in doing work. It has affected my mobility. I just have to keep sitting while doing work. It takes so much longer to finish each task and that tires me out. But my bones just can’t take it anymore. (Saraswati, 55 yrs, Lohar-dom, Birkatal)

“Kamardard”: backaches

Backs are another great source of pain. Backache affects both young and old, though the pain differs in intensity. Older women complain of constant severe pain, while the younger women say that the pain increased with work.

Kavlo, described her “bai”- back as having severe nagging pain in her back and feeling of being drained out. She also felt that there was swelling on her back. She could hardly stand up; her whole body shivered. (Kavlo 40 yrs, Auji-dom, Bunga)

Bending at work – whether in the field or cutting grass – is perceived to harm the back.

It started from a back injury through a fall from the tree. After recovering a bit I carried on doing my routine jobs. It was the bending which hurt the most...cutting grass, harvesting.... my back really took a lot of pressure with regard to doing physical work. (Radha, 46 yrs, Rajput, Dawn)
Though both *bai* and backache are not considered a “threatening state”, they are experienced as nagging hurdles, which render difficult the performance of daily tasks and responsibilities. Pains aggravate during peak agricultural seasons, when women often work up to 18 hours. Women identified field labour of long duration, particularly during monsoon as “bad phases” when they suffered more pain. However at the centre of their explanatory framework were the constraints of their work:

*Farming itself is laborious. At present there is not much work. The workload of women increases five times during monsoon leaving them with body ache, joint pains and fatigue. At that time uninterrupted “gurai” (weeding) has to be done. Our hands ache and we feel very fatigued. But we have to continue the work – there is no way out. Yesterday I threshed and grounded flour in the “chakki” (stone mill). Today my hands are paining. But I still have to go and cut grass. What will my cow eat otherwise? Women have so much work – their joints get finished – we all end up with “bai”* (Guddi, 32 yrs, Auji-dom, Bunga)

Rains bring an exceptionally heavy and long workload of hoeing, weeding, planting etc. that causes physical exhaustion and stress. Women are in the field from sunrise and often until dark. Work is unavoidable and food is less during this season. It is also a season when women are more prone to infection and sickness. However illness and incapacitation have to be avoided at all costs. Women thus continue to work despite ‘unbearable’ pain, or even if they suffer from diarrhoea or skin diseases. Women reported pressures to “keep going” under extremely difficult circumstances.

*When we keep doing this hard labour throughout the years ... all the time, it’s bound to have some effect. But work has to be done. If we will not do the work, who else will do it?* (Sundari, 55 yrs, Rajput, Birkatal)

Thus the women’s descriptions of the relationship between body and social context calls out a complex representation of the nature of their occupation, the specific bodily movements the jobs required of them, their relationship to their various tasks and the way in which all these things had an impact on how they felt. What comes out strongly is that they have little room for manoeuvre in the deployment of their bodies in relation to work. In addition to the detailed description of the relationship between the “pain-morbidity” and the context of labour, their accounts were combined with the experience of not being able to stop, of having to go beyond one’s limits. Women protested and complained
explicitly about the kinds of intolerable conditions of work in which they were obliged to operate. But under the existing life conditions they were constrained, as work for them never really stopped.

"Kamzori": Weakness

Weakness (kamzori) is the second most strongly felt and reported health problem. Women would ask for takhat ki dawa – medicine to give strength. Women felt continuous fatigue – as if they were just dragging their bodies to function.

I feel tired and drained out. Sometimes I feel I will not be able to stand up. My knees become weak. My whole body shivers. I feel feverish and have a nagging headache. At times my head hurts as if it will burst. I never feel like getting up in the morning. I simply drag myself. I wish I could just rest. (Kavlo, 39 yrs, Auji-Dom, Bunga)

They routinely spoke of “incessant weakness” or feeling drained out. Few women also experience blackouts and fainting.

I have led a life of near starvation and deprivation and done a tremendous amount of work. Toady I am weak, and suffer from joint pains. I think I have no blood in my body. Just two weeks back when I went to cut grass for my cows, I fainted in the forest. Two women from the village had to carry me back. (Krapi, 69 yrs, Brahmin, Bunga)

Fever and headache aggravated these feelings. Women also complain of severe headache when they have to work long hours in the hot sun. They often describe their total body state as having fever in the bones viz. “haddi ka bukhär”. According to them this does not get recorded in the thermometer.

I am tired and drained out. I sometimes feel giddy. I get this fever – it is “haddi ka bukhär”. My body is cold, but I am very hot inside. I feel hot air coming out of my ears. When I get this fever, I just don’t feel like even getting up. (Kamla, 48 yrs, Rajput, Daurn)

The combination of fever and nagging headache, and a “drained-out” feeling was linked with laborious tasks. In particular, weeding and harvesting the crops or long walks into the forest and carrying head loads of fodder and fuel wood were reported as cause of this condition.
Older women attribute this condition to the inadequate food that they received as daughters-in-law, despite shouldering the heaviest burden.

_I feel weak and drained out. It's all the result of overwork and forced starvation I faced as a young buari. I got married at the age of 14. My mother-in-law was very strict and hard-hearted woman. She would make me do all the work except milking the cows. She feared I might drink the milk in the cattleshed itself. I worked for 18 – 20 hours a day. She would not give me food to eat or allow me to rest or even change out of the wet clothes. My poor health is the result of this kind of life. Today women get rest. In our time where we got any rest? Fields were many, animals many more. I remember even to fill my stomach I had to steal food. I used to hide “pindalo” (yam) in the “pinda” (cattlefeed) when it was being put to cook. When “pinda” used to get cooked, the “pindalo” also got cooked. I would hide and eat it in the cattleshed when I went to give the feed to the cattle._

(Shakuntala, 65 yrs, Brahmin, Bunga)

Several closely spaced pregnancies and deliveries are also seen to create conditions of chronic weakness by the older women.

_My body has become so weak because I had so many children. There is nothing to eat. I also had to do all the work. I definitely felt weak after giving birth to 10-12 children. Here work is enormous, diet is not sufficient and rest is minimal. Men do less work hence they are healthy. Bearing children, having nothing to eat and working endlessly I have become weak and feel my body has dried up. There is no blood in my body now._ (Jasla, 75 yrs, Auji-Dom, Bunga)

Women further associate their weakness with “khoon ki kami” an outcome of frequent childbearing and poor diet. To me as a researcher, anaemia seemed evident in their pale face, eyes, nails and skin and they had very low haemoglobin levels.

Majority of women appear to be undernourished, thin and having less body fat. As the earlier chapter has shown, women experience scarcity of food and poor diet even during pregnancy and lactation. Bodily stress and breast-feeding usually worsens conditions of weakness. Poorer women in particular suffer from ill health and malnutrition than the men. Thin and frail Kamla’s case described in the previous chapter tells the story of most poor women’s nutritional state.
The Accident Risk and Injuries

The close association between environment, work and gender is again brought out forcefully by reviewing cases of accidents in the village. Accidental hazards are high, resulting from working atop trees and walking with headloads over treacherous mountain terrain. Women frequently reported accidents while performing their work responsibilities. Mostly they alone are victims, since they traverse long distances and encounter risks while collecting fodder, firewood and water. Accidents that commonly occur are slips and falls from trees, rocks etc. or attacks by wild animals in the forest like bear or baghs (panther) etc. Women are also bitten by snakes while cutting grass.

Our household survey revealed twenty-four accident cases in the two villages. Of these twenty were females (see Appendix A8.1). Eight women fell from the tree while lopping wood, three fell off a cliff while collecting fodder, and another eight were bitten by snakes when cutting grass or weeding in the fields. One had died in a road accident.

Many women’s bodies are permanently scarred due to these accidents. The medical officer at the PHC, Yamkeshwar concurred that accidental injuries and deaths of children and men are fewer than those of women. Moreover since medical aid is not available immediately, the injury worsens and women may never completely recover. Susheela’s case reveals the general picture.

"Around 10 years back I fell from a tree and seriously injured my back. I was admitted in Safdarjung Hospital, Delhi (where my husband lived) for four-five weeks. I was told that my back had got injured and I must not perform heavy work or carry loads. After staying in Delhi for 3-4 months, I returned to Bunga. All this while my kin in the village had supported my family. Now I had to return to fend for myself. Life in village did not permit me the luxury to heed to the doctor’s advice. I resumed my daily chores- my back did not create trouble immediately. But after a month or so I started getting continuous pains. I went to Delhi again to a government dispensary and collected some medicine. But I did not get any relief. Later on insistence of my elder son, I also went to a private nursing home in Rishikesh. The doctor gave me injection for strength, few tablets and asked me to take rest and nourishing food". Susheela returned to her village and inspite of being aware of the doctor’s recommendation, she went back to performing strenuous agricultural, animal husbandry and domestic tasks. "What else to do. If I don’t work my children and my animals will starve". Pain in the
back and feeling weak are states that Susheela has learnt to live with. (Susheela, 42 yrs, Brahmin, Bunga)

Poor dom women who suffer accidents and incapacitation may face serious problems of daily livelihood. Saraswati's accident put an end to the prospect of securing the daily dadwar.

Eight months back I fell down while collecting some firewood, injuring my hip. I have not been able to resume my rounds with my husband who drums while I collect the "dadwar". With difficulty I manage to walk small distances. I am waiting for my death. I do not even look forward to my sons' visit. "If they come what will they do? They will give us few rupees and then leave. That's all." (Saraswati-2, 75 yrs, Dom, Birkatal)

Saraswati appears permanently disabled and handicapped as far as many of the female responsibilities are concerned. She is helpless and dependent on her husband and she feels miserable as he even fetches water! Saraswati manages to take care of domestic work within the home. She prays for death to relieve her of the pain and misery of such a life. Many such women are left at the mercy of their family or villagers for their basic requirements, causing not only physical but immense mental and emotional suffering.

Stomach Disorders And Related Illnesses

Stomach disorders and infections appeared to be rampant among women. Complaints of stomach-aches, along with indigestion, loss of appetite and dizziness are frequent. These greatly affect their functioning and undoubtedly exacerbate their overall conditions of weakness and under-nourishment. "Inability to digest much food" or "not feeling hungry" (khana hajam nahi hota or bhukh nahi lagti) was a complaint commonly voiced by older women. Goli Devi often said

I don't feel like eating. Even after eating a little I feel I have eaten too much. Food does not get digested properly. I have severe diarrhoea on most days. Earlier I used to eat a lot but now I can't eat. Because of not eating I feel this weakness has come. (Goli, 62 yrs, Brahmin, Bunga)

These symptoms may be associated with anaemic conditions, where due to a reduced oxidation of the body, there is a tendency to lose appetite. Or it could be a manifestation of long standing infections.
Many women like Kavlo have been experiencing symptoms of severe stomach pain. They describe it as “gola” or a ball in the stomach. Women believe lifting heavy weights causes this problem.

_Besides finishing my joints and back, lifting weights has caused me severe pain in my stomach. I feel as if there is a “gola” in my stomach, which sometimes rises up my chest. When I eat something hot or when I climb a steep hill with a big load on my head, I get a burning sensation in my stomach and severe pain. I went to a knowledgeable woman in Goddi who gave my some “jaribooti” (herbs) to grind and drink in hot water. I have not still got relief. I intend to go to the doctor in Binak for medicines now._ (Kavlo, 40yrs, Auji-dom, Bunga)

This again may be another case of long standing ulcer or gastric infection. But since there is no diagnosis, we cannot medically define her illness.

Large numbers of village women routinely suffer from stomach pain, diarrhoea, dysentery and gastric problems. These infections possibly water-borne in nature are a reflection of environmental conditions. The village largely does not have a supply of piped drinking water and hence have to rely on untreated natural water sources for drinking purpose. Most women stated that seasonal diarrhoea and blood dysentery (kaath) aggravated in summer months when the regular water supply dried up. People then were forced to use stagnant water sources or a small creek where the water was even dirtier. Sanitary conditions aggravate the situation. In the villages latrines are almost non-existent. The widespread habit of defecating in the open is perhaps the main cause of these ailments. Villages are situated on ridges and hilltops, so the run-off during the rainy season serves as natural disposal for excreta. This pollutes the natural water sources in the valleys and creates environments of greater exposure to infections.

**Eye Ailments, ‏_Shawas Ki Bimari_‏ And Skin Infections**

Visual disturbances especially “weak eyes”, "watering eyes" and “pain in eyes” are conditions that aggravate for women over forty. Cooking exposes women to high levels of smoke as the ‘chulha’ does not have a chimney and hence smoke stays in the kitchen. The situation is worse in the monsoons when wet wood is used in these open ‘chulhas’. In the winter season, people sleep in rooms with burning logs. This is no less hazardous to health. Women have not even heard of smokeless ‘chulhas’. Indeed most find no
association between the smoke and their eyes problems. On the contrary almost all women feel that smoke serves a positive function of keeping termites, woodborers and other pest out of their kitchens! Doctors at the PHC have noted vitamin A deficiency.

Older women suffer from a condition commonly called *shawas ki bimari* (breathlessness). Several women report getting breathless while walking and this condition worsens when they have to walk long distances, carry weights or climb to greater heights.

*I suffer from “shawas” and “bai” both. My joints get swollen and cause a lot of pain and I feel breathless doing any work. Even if I walk a little I pant. I cannot even climb 100 metres. Now I get very breathless climbing to Mohanchatty. Breathlessness and “bai” together makes this trip unbearable. (Susheela, 60 yrs, Brahmin, Birkatal)*

Chronic illnesses like “shawas” are clearly a part of a complex chain of cause and effect connecting the women's bodies to their circumstances. These conditions may also be related to the fatigue and strain involved in carrying heavy loads in the mountainous terrain and cooking on ‘*chulhas*’ in closed poorly ventilated kitchens etc.

Another common complaint is of skin infection. Rashes, boils, ulcers and sores (*daad, khujli, phoora*) afflict most women. Paucity of water and absence of bathrooms preclude women’s attention to personal hygiene. Women have to wait until late night to bathe in order to ensure privacy. Despite being relatively harmless, skin infections render women’s life further uncomfortable and miserable.

Other than these there are persistent gynaecological problems that women have learnt to live with, which have already been discussed in the previous chapter.

The foregoing description thus shows how the experiences of illness are embedded in everyday life. These illnesses relate to various components of daily life, in terms of both their significance and consequences. Women’s narratives have vividly revealed how the vicious circle of overwork – poor nutrition – ill health actually operates. Equally importantly is revealed how ill-health itself constitutes a debilitating condition of women’s work.
What Does Being Healthy Mean

Like illnesses, the women's conceptions of health too are borne out of traditional worldviews, diffusion of new knowledge and their experiences of illness and existing health services. Moreover women's culturally and socially determined roles, status and responsibilities in Garhwali society influence the way their health is conceptualised. "What does being healthy mean to you" yielded a range of responses.

- **Being fit:** "Can lift a lot of burden" "able to do all required work", "able to move freely", "does not get tired fast", "can do hard work".

- **Not being ill:** "does not fall sick", "is without diseases", "no disease can affect the body", "does not have any form of pain", "does not suffer from any big disease"

- **Feeling well:** "does not have worries" "have no tension", "does not have any anxiety".

- **Looking well:** "is fat", "has fat healthy body" "is fat and strong", "good strong body".

- **Is not weak:** "can do everything that a strong woman must do", "can fulfil womanly roles"

- **Other:** "one whose house is full", "one whose whole family is with him/her", "has a happy life with husband and children", "one who has no greed",

Though the absence of illness or disease was considered necessary to remain healthy, but the most predominant conceptions referred to the functional capacity of woman, and to a positive emotional and physical state (feeling and looking well). "A healthy woman is one who has no illness," emphasised the notion of an illness-free state. Given women's work context and the labour intensive agricultural economy, it is hardly surprising that dimensions of "work" and responsibility in particular capacities of fulfilling them entered women's definitions of health. "Being free of worry," reflected the importance of positive emotional and mental state. In addition, being healthy was viewed as a social obligation and those who could not live up this were viewed as failures. Illness is perceived as a
hurdle in fulfilling socio-cultural expectations. Prerequisites of good health were also related to wealth and good harmonious family relations.

Thus women's conception of health is linked to their day-to-day life and work. Since in this society women bear the primary responsibility and burden of agricultural, animal and domestic work, health is therefore mainly conceived in terms of their work responsibilities and is significantly influenced women's perception of their own health status. Poor health is experienced as a major problem and bimari troubled women primarily as a deterrent to work. Such a conception of health placed more emphasis on the utilitarian/ instrumental aspect of health i.e. the ability to perform necessary and required tasks rather than their emotional, social and physical well-being that was mentioned, but less frequently. Women expressed a genuine concern/ desire for good health and viewed it in the light of their constraints of daily life.

In conclusion we can say that women constantly related the specific features of their work circumstances and overall life to health, providing descriptions of the past and present as the contexts for making sense of their symptoms. What is striking is the strong perception of relationship between ailments and work, lack of rest/food and pressures of work. Women make references to the various losses as a result of life of hardship. Lack of proper and adequate food, lack of rest and subsequently slow loss of health following several poorly spaced pregnancies and long periods of lactation are well connected in women's accounts.

Almost all women of the two villages suffer from a combination of these heath problems. While responses of chronic illnesses/ problems are most prevalent and uniformly distributed across most women, it is the older who suffer more acutely. In the context of the women's lives, we found that several of these chronic health problems set in early becoming extremely severe and debilitating as life progresses. However as our narratives have shown among the younger age group, women from economically poorer households, especially the Dom (like Jasla, Saraswati, Kamla, Guddi, Kavlo) suffer more frequently and acutely. The range of problems that they endure is also much wider and serious. The constant exertion and heavy work that they carry out, along with their poor
nutritional status has a deleterious effect making them more weak and prone to illness. No significant difference in health conditions of migrant and non-migrant women is visible as both are subject to economic hardship, work pressures and gender discrimination with only marginal variation. It is only among the better off migrant households that younger women claim to be better cared for and healthy.

WOMEN'S WORTH AND THEIR MENTAL AND EMOTIONAL STATES

The multiple burdens of work, gender discrimination in food and care, economic deterioration and poor physical health has a tremendous toll on women's mental and emotional states. Living within large patriarchal joint family, the oldest women seem to have borne the brunt of these compounded effects. Women such as Krapi, Jasla, Saraswati and Susheela whose plight we have described in the chapters on work and reproductive health, also testify as stark examples of emotional trauma and mental oppression.

In my younger days my life was very hard. Not only had I to bear up physical violence; I used to be emotionally traumatised. In my natal home I had a stepmother who ill-treated me. In my husband's home too I had a step-mother-in-law who was also very cruel and treated me badly. She would make me do all the work. Sometimes while working in the fields I would fall asleep in exhaustion. Then my father-in-law and mother-in-law would beat me. My husband too was very cruel. He was like a wild animal. He would beat me and ill-treat me. I was frightened of his sight. When they all beat me a lot I would run away to Magatha village (natal home). There my sister-in-laws use to beat me up. I use to return back to my husband's place. I would get up at four. I would work more than even machines can run, but I was treated worse than animals. If I slackened, I was beaten. Sometimes I was beaten for no reason. At times my whole body was black and blue – one could not even find a small patch of normal skin. I never slept before 12 o'clock; I never rested in the daytime. My back, legs and hands ached. I never ate a full stomach. No wonder I am in such a condition of health today. Even now sitting here I can feel all pain they have caused me. After my children grew up, violence ebbed, though it did not come to a complete halt. When we separated from our in-laws, my husband did not get his due share. Our land was taken away by in-laws. Life was difficult still. We use to sleep on the floor. Had only salt and roti to eat. My husband did not earn well and whatever he earned he spent on drinking. I had to raise 9 children. Such hardships, lack of food, several conceptions and so much tension must be the cause of my poor health today. Today by God's grace we have enough to eat but now I am unable to eat. I don't feel hungry. I find it difficult to digest food. (Susheela, 62 yrs, Brahmin, Birkatal)
Children's deaths are the cause of permanent inconsolable emotional distress, which is suggestive of deep underlying depression and suffering in the form of 'nerves'. Deaths of young children have left deep emotional scars.

I have a lot of palpitations. Whenever I feel very restless - I go out and sit near the entrance of the house. My heart starts to palpitate especially at night when every one is asleep, its dark and very quiet. My dead (murdered) son's memory disturbs me. Today he would have been 24 years old. (Susheela, 52 yrs, Brahmin, Bunga)

Women's infertility continues to be another key source of mental agony and harassment. Young women are tormented today, as were the old ones in their younger days. Krapi, now aged 69, finds it difficult even today to come to terms with her emotional trauma and breaks down as she recalls the story of her ill treatment:

I was not able to save my children after they were born. I don't know why my fate was such, but they would die. My first-born was a son who died in few hours of being born. The next was still born. When my third son died during birth, my mother in law got so angry with me that she said, “Let her die too”. My heart was bleeding. But she did not see my pain. They abused me, beat me and sent me home. There we did “chal pooja” to calm the “dash”. After that I gave birth to two children – a boy and a girl. I still remember the pain and anxiety my in-laws caused me. I also still think of my dead children and my eyes become wet. Life was very hard. (Krapi, 69 years, Brahmin, Bunga)

Lakshmi's narration reveals that the stigma attached to childlessness continues to be strong and evokes harsh behaviour on the part of the in-laws.

I was married at age of 20. For 2-3 years I could not conceive. That became a point of conflict between my conjugal family and me. My mother in law stopped talking to me, but to other village women she would call me names. Even my husband got angry with me. I became very tense. They sent word to my father. Finally I was sent home and there my natal family performed some “dosh puja” but to no avail. Two years later I had my first child who was born with many big boils on his head. He died in 3-4 days. The next child was a stillbirth. My in-laws got very angry. This time I was even subtly denied food. Now my natal family was also worried. They again did “chal puja” as suggested by a reputed bakki. They also performed “jhar phunk”. The Bakki told them that because of some “dosh”, both the children died and this was essential. But on behest of my brother who was living in Rishikesh, I was also taken there for treatment. One and a half-year later, I delivered a healthy girl. Thereafter I gave birth to two more sons. Today I am bitter about my life. I worked hard in my in-laws house. Even though they also regarded me as a good worker, I was always treated as an outsider.
because I had so much difficulty with having children. I feel neither my in-laws, nor my husband even paid attention to my health or tried to understand my tensions or sorrow. They had no sympathy with my grief. (Lakshmi, 37 yrs, Brahmin, Bunga)

Women who are unable to conceive undergo a number of anxieties and fears. Apart from their own agony of remaining childless, they fear in-law harassment and some fear that their husbands might marry again. This is taken as a personal humiliation. In the words of Maheshwari:

I got married into a rich farming household at the age of 15, but for 8-9 years I could not conceive. My parents performed all kinds of dosh pujas, but to no avail. In the 9th year I gave birth to a girl child who died in infancy (4 months). She had high fever and loose motion and she died. My in-laws were very angry. When I could not conceive again for two years, they got their son married to another woman. I lived a miserable life with a "saut" (Maheshwari, 53 yrs, Brahmin, Bunga)

Both miscarriages and deaths of infants caused untold suffering. Women struggle with their own sorrow. In-laws are no source of succour or support; rather the women are blamed for premature infant loss and may be ill-treated for this mistake.

Out of the 13 children I gave birth to, five children died in infancy, of which four were sons. I was 14 years old when I had my first child. When I had my first child he died immediately. What happened and how it happened, about this my mother-in-law alone knows. At the age of 15, I became pregnant for the second time. He also died after delivery. At the age of 16, I became pregnant for the third time. He died after 5-6 months. After this at the age of 23 I had given birth to a girl and she also died when she was one month old because of cold. Then I had a son from my second husband who died in two three day's time. After birth he kept crying for 1-2 days and next day at 9 o'clock in the morning he passed away. Deaths caused me a lot of pain. It angered my conjugal family. Each time I was pregnant I was afraid. Each death was followed by more ill treatment. (Saraswati, 55 yrs, Lohar-Dom, Birkatal.)

Physical abuse by in-laws has relatively reduced today, but there are still cases of wife abuse. Thirty-eight year old Pushpa’s is a typical case. She is married to a migrant car mechanic who is an alcoholic and wife beater.

After my marriage I was living with my husband in Faridabad where he was working in a garage. I delivered three of my children also there. At that time my husband was earning properly and I stayed with him there. Six months after my
third delivery, my husband said that he is going abroad to work and therefore he left the children and me in the village. But soon he returned to the village – not only he did not go abroad, he also lost his job in Faridabad. He turned into a drunkard, left the family and started living in Haridwar where he would on and off pick up a job at some garage. For more than ten years now I have been living with my 88-year-old father-in-law, somehow seeking out a living in the village. My husband comes once a month, usually very drunk. He fights and beats me up. Because of his beating I have been hurt many times. I have often bled profusely, sometimes from the nose, sometimes from the head. Many times I have severely hurt my back. When his drunkenness is over, he apologises to me. But what is its use. I fear his coming. Now I am married for almost twenty years. But I have spent most of my life in sadness and in pain. Five years back I started having “joint-bai” and my back started to hurt. But worst was when one day after chopping wood I had severe chest pain. I thought I would faint. After that many times I get this pain. I feel tense and my heart feels heavy. I started the rounds of doctors in Diuli and even few in Rishikesh. So far I have been to all doctors nearby and they have not been able to find out what my problem is. (Pushpa, 38 yrs, Brahmin, Bunga)

Middle-aged group of women also gave vent to the mental stresses and strains inflicted by husbands and in-laws though the severity seems to have declined with early break-up of families and male migration. Their lives are also beset by several new worries and tensions. Shortage of food, children's especially boys education and economic future in a declining economy, domestic isolation and loneliness, sicknesses of children, over work caused by new agricultural tasks including the tiresome management of hired male field labour are problems that cause a lot of mental stress. Deaths of young children have left deep emotional scars.

The poorer and low caste women amongst them are plagued by family hunger, insecurity of wage labour and income and about feeding the children. The struggle is exhausting physically and emotionally. The experiences may instil in the women a sense of despair and desperation, which may even make them nostalgic about the older times when work at least carried a minimal compensation of a modicum of food security. Overall, the economic hardship, instability and insecurity of contemporary times are hardly conducive to mental peace.

As we saw in the earlier section women express their health problems in very general terms relating to pain (“dukh-dard”/“dukh-pira”), discomfort (“pareshani”) to a convey
sense of physical ill-being that also encompasses their psychological/mental state and pain. Women stated that this combined suffering is reflected in symptoms of 'uneasiness', 'heart beating fast' and 'anxiety attacks' that they often face. Thus dukh-pira may be seen as a cultural idiom, which reflects the relationship between women's material-social circumstances and their construction of health. Such articulation suggests that women perceive their illness as sometimes related to causes lying outside the purely physiological domain.

Women's narratives about their work and the new division of labour are full of the multiple and new kinds of stresses that they have to undergo. Physical strain, social stress, increased levels of responsibility, growing workload, pressures of time, lack of resources, violence, chronic poor health and dwindling capacities have a cumulative impact that is physically and mentally stultifying. They express incapacity and helplessness to change their situation. Statements such as "we are nobody", "nothing is in our hands", "there is no one to share our trouble", "we have to bear all responsibility alone", highlight the stress and strain felt in relation to difficult situation. They reflect perceptions of women's declining value in the society and 'unequal worth' in the family.

Women from migrant households may face an acute sense of 'being alone' and a 'sense of increased responsibility'. Equally however, there were wives who also perceived a sense of relief that they were free of wife abuse and control. Non-migrant household women face threat of both mental and a continuing physical violence. Violence, which involves severe 'battering', is not rampant, but neither is domestic violence uncommon. The situation has changed from collective violence of in laws to beating by the husband alone. While the immediately battered women's wounds may be only too visible, the long-term insidious effects of violence are manifested in women's expressions of 'anxiety', 'helplessness', 'unhappiness' and 'stress'.

In the context of change some women suffer complex psychological effects. For instance city-bred Shakuntala who wished hard to get out of the stranglehold of traditional rural life, in which she was caught, could never reconcile to her confinement. This has caused
her great mental and emotional distress, damaged her self-image besides ruining her physical health.

I had spent my childhood in Delhi and came to live in the village only after marriage. Despite pleading to my parents they married me into a Brahmin family living in a village. Being city bred, and educated (class 8 pass) I could never adjust to life in the village. Though my in-laws and my husband were very nice to me, their poverty disturbed me. I was also expected to work a lot – if I got tired and was unable to work everyone would taunt me. I did not conceive for many years after my wedding. I had two spontaneous abortions. My mother-in-law use to say “neither is she good at any work, nor does she have good fate”. But after many “dosh puja” that were performed in my natal village I conceived. I gave birth to six children. But I could never really adjust to working in the village. Even today I know most women mock at me. They tell my husband that why does he feed me as I do not do any work? It hurts me very much. No one sympathises with me or tries to understand my pain. As a child I was beautiful and healthy and never fell sick. Throughout my married life I did not keep good health. I did not have any serious health problem, but I was always unwell. I would have severe headache, felt weak, almost always had fever. I went to several doctors, took all kinds of medicine, even went to the Bakki and did “devi poojan”. But I could never really feel well and healthy. Since last few years I have chest pain and acidity. I have poor appetite and flatulence. Around eight months back I went to a Charity Hospital in Rishikesh and got admitted there for three days. Doctors could not diagnose my condition, so I returned after taking few “taaquat ke injections” and medicine. On some days I am very down – then I just lie huddled in my home throughout the day. I cannot even get up to have my food.

(Shakuntala, 50 yrs, Brahmin, Bunga)

If certain women suffer as some do, the cumulative impact of several types of distresses is devastating. However it is important to state that the coping capacities of women are very high and that obvious psychiatric health problems were not evident. Yet the women reveal immense stress apparent from enormous demands for aspirins for headaches during the researcher’s stay. This high level of stress and anxiety often gets translated into bitterness, resentment, anger, sadness, depression and helplessness that found no space for expression in their social existence.

Local Perception Of Changing “Health Risks”, Illness And Dependency

Significantly the concerns about the changing quality of environment, new health risks and shifting vulnerabilities in the village were central to the narratives provided by women. While women’s interpretations centred on individuals and families negotiating
for a way of life in an environment threatened by various factors, they also addressed larger concerns of health and social change. They drew connections between the various aspects of their rapidly changing reality and several causal factors. Women's understanding of health risks thus were broad, drawing from their own worries and struggles to sustain families in a tenuous environment and under shifting and changing conditions of production and control of and access to resources.

Local accounts of health trends are undergoing subtle redefinition as women draw comparisons between the past and present situation. All agreed that there is a higher standard of living, increased educational levels and easier access to market products because of improved transportation networks. Even medical facilities are now more accessible and medicines can be purchased from local shops in Rishikesh. Yet, there is a strong expression of cynicism with regard to impacts of these larger changes on their long-term health and well-being. 85 years old Darshini commented:

_Roads are there. There are schools. We even have electricity and many new hospitals have opened up in Rishikesh. But then in the olden days there were not so many diseases. Those days were good. No doubt there was no "angrezi dawai" (allopathic medicines) or "doctors", but there weren't so many diseases. Now there are plenty of diseases, many very fatal - and there are plenty of drugs. Now I hear there is some nurse from the government hospital who goes door-to-door, weighing and examining babies! She also carries medicines for treatment and distributes them. It's strange but that with so many doctors, drugs and hospitals - we still have so many diseases spreading rapidly. (Darshini, 85 yrs, Brahmin, Bunga)_

Changes in local diet brought about by the encroachment of the market are looked upon as a causative factor of poor health. Today dalda and vegetable oil brought from the shop is used as substitute to “ghee” (clarified butter) and local mustard oil. Tea and biscuits are now commonly consumed and served. Older people regret not having enough mandua, jhangora and home-grown wheat and rice. Women have various opinions about changes in health and disease. Several women felt that locally grown food was healthy and full of strength (“taquatwar”). Contrasting with locally grown food, grains and spices purchased in the “bazaar” (market) are commonly perceived as inferior in strength and nutritional value. Imported wheat and flour, pulses, rice called “dukaan ka” (from the shop) were
deemed inferior. Shakhambari Devi spoke of these changes, which reflect attitudes about influence of rural dietary habits:

In the past we ate everything that grew in our fields. We ate more of mandua than wheat flour, jhangora than rice. Our oil also came out of mustard from our fields. Many roots, leaves from the forest were a regular part of our diet. They possessed unique disease preventing qualities. We ate pure food. Today few women even buy powdered milk. Any case who can drink milk nowadays - most of us have black tea, and more and more tea only. (Shakhambari, 64 yrs, Rajput, Birkatal)

Women also bemoaned greater consumption of and dependence upon market products because this compromised larger community values which discouraged buying and selling in the market. Thus tenuous circumstances and needs, which compelled bazaar purchase, were regretfully perceived as signifying the breakdown of traditional food security systems and associated with deteriorating household health.

While some regret the shortage of nutritious foods for household consumption, others look at local markets and easy access to food grains as a security available against seasonal scarcity which the many households earlier faced. The majority view however is expressed by Guddi:

Before people lived off what they grew. They would store the grains for the following year. They would store all kinds of food grains and cereals. If say I did not have enough rice, but my neighbour did, then I would go to her house and trade some of my potatoes for her rice. These way things worked. No one went hungry. We all ate grains, vegetables, and pulses grown in our own village. But now we bring everything from the “dukaan” (shop). Then also there is shortage. What is strange is that this “bazari” (from the market) food just sits in your stomach – you feel so heavy. And you may eat lots, but you will not have the strength that older people have. Look at Govardhani chachi – she must be above 80 years. But even today she can work longer, lift more weight than her young grand daughter-in-law. She has eaten good “khet ka khana” (from her own fields), while these young girls today just got dukaan ka. (Guddi, 32 yrs, Auji-Dom, Bunga)

We observed that the outward and stated connections between deteriorating diets and food quality and poor health are indicators of deeper worries. Women are concerned and troubled by maintaining a certain quality of life and set of social and cultural values that their communities have lived by. Through these narratives women express their concern
about the nature of social and rural transformation and the fundamental changes it is bringing out in household status and standards of living.

DEALING WITH ILLNESS: WOMEN'S APPROACHES TO TREATMENT AND CARE

In the context of their many sufferings and the availability and access to different types of treatment systems, we now examine how and when women define themselves as ill enough to seek treatment. Which symptoms do they perceive as demanding treatment? What kind of treatment do they opt for in what kinds of symptoms? What is their overall frame of reference while dealing with ill health? After a brief introduction to prevalent systems in their pure and hybrid forms, we move on to understanding women's contemporary conceptions and practices of treatment and care.

The Plurality Of Healers And Healing Systems In Present Times

The first group of healers consisted of those who associated illnesses to the realm of supernatural - the bakkis, jagris, tantrics, toonatotakas, jharphunck and even baman (Brahmins) who performed “ritual actions”. Next, there was a group of specialists who handled many diseases and everyday aches and pains. Their common explanation of causation grew from a humoral theory which symbolically connected “hot” and “cold” types of food and environmental exposures to subsequent illness. This included (i) specialist like vaids who were generally exceptionally knowledgeable Brahmin and Rajput healers; (ii) Dama and tala healers (who used hot iron rod in a process which involved “firing by use of iron” in cases of strains, swelling and rheumatism); (iii) local herbalists and (iv) “dat” / “byahs” who intervened in abnormal cases of delivery particularly cases of displacement of the womb (“pet dolna”) through skilful massaging. Moreover there were many older people in Bunga and Daurn especially the women, cutting across caste, who possessed an incredibly detailed practical knowledge of herbal remedies. This knowledge largely makes up the realm of domestic medicine.

In the early 1950s and 1960s, the Primary Health Centres (PHC), its dispensaries and sub-centres were the sole local sources of modern medicine. However this began to change with the state constructed motorable road links to Kotdwara and Rishikesh. This, along with the starting of bus services significantly increased the transportation access for
Private practitioners in Rishikesh, Kotdwara and other nearby towns could now be more easily accessed. These private service more than the government rural health care facilities provided direct biomedical treatment. Moreover the integration of these villages to cities has hastened the emergence of this new circuit of practitioners, through whom western medicine entered isolated villages such as Bunga and Daurn.

Further more in the decades of 1960s and 1970s a new group of practitioner popularly called “doctor” also made an entry into the existing plural medical system at the village level. These makeshift doctors (mostly untrained) have in the past several times rented room in village Magatha (Pipal Dali) and practised modern medicine for short durations. They were usually outsiders, with little known about their training, but they generally administrated allopathic drugs in treatment and made use of non-traditional means for treatment, more specifically of thermometer, stethoscope etc. in diagnosis. Their tablets (“goli”) and injections (“sui”) capsules, tonics etc. were popularly consumed medicines.

The villagers of Daurn and Bunga recalled having several such varieties of healers in their vicinity. Two vaids lived in Bunga till three decades back. Nearby villages of Umrauli and Kheda Talla also had widely reputed (“nami”) vaids. A villager from closeby Bijni village practised “dama and tala” treatment while an old Dom woman in Goddi was known to possess knowledge of local herbal remedies for several ailments. Villagers also recall a “gaon ka doctor” – a Bunga resident, who after working for several years in a Rishikesh clinic, returned to the village to practice. Till his death almost fifteen years ago, he reportedly practised a combination of allopathic and ayurveda. The doctor seems to have been very popular with villagers since he administered injections. But most popular today is a travelling doctor from Rishikesh.

Dr. Rawat comes riding on his scooter to Bhirgukhal from Rishikesh on two fixed days. On the way he halts at the roadside bus stop of Binak and Pipal Dali. Patients or relatives who need to see him or buy medicine await him here on scheduled days. Seeing a crowd, the ‘doctor’ halts. He examines the patients and dispenses medicine. The medication is kept in a small vinyl suitcase. He also carries also has another bag full of bright yellow-red and red-black antibiotic pills. The pills are usually sold separately and at reasonable price though credits are also extended. On request, and after due negotiations of the fee, the doctor may oblige to trek to the village for a home visit. His charges are Rs. 150/- per
visit. Earlier posted at the Mohanchatty dispensary, the doctor is now on a transfer. He claims to have started this mode of operation in response to the felt need of the people and has practised his trade in this manner for the last three years. He is popular, despite being expensive and ill tempered and is well regarded for his experience and effective treatment. He has a guaranteed market in the region with almost every villager having sought his treatment, sometimes at any demanded price. Each trip along this route is estimated to fetch him two to three thousand rupees.

Thus both doctors and villagers easily intermixed biomedicine with other types of healing and even today there exists a plurality of medical system in use and practice.

Treating Illness: Women’s Conceptions And Approaches

Women’s contemporary approaches to dealing with their illness reflect the existent plurality of treatment systems. While there is no fixed pattern followed by women, certain specific healers are preferred for certain conditions. For instance, women believe that for ailments like stomachache, boils, pain, swellings, fevers, cough only and rituals like jhaad phoonk, doodh phool ki pooja, and can be used. While some problems are thought to be amenable to direct treatment either with herbs (jaaribootis) and dietary restrictions (perhez) or with incantation by minor specialist, a class of specialists called jharnewala (practitioner of jharna, stroking or brushing), gifted pandits, and healers with tala and dama skills. This last group of healers usually treats afflictions characterised by some external, visible symptom such as sores or swelling (e.g. boils, scabies). They also treat “gout”, upper and lower limb pain, mumps, headache, stomachache, sore eyes, snakebites and spider bite. All these practices are aimed at restoring the balance between the humours, through which it is believed that the illness will be “cut off from its roots”.

In cases of illnesses being equally attributed to germ and not merely body humours, allopathic medicine may be combined with above stated types of treatments too. In fact only snakebite is believed to be cured by “jharnewalas” alone.

There are several afflictions which are perceived by women as symptoms of “dosh”\(^1\). These include conditions like recurrent or prolonged fever accompanied by convulsions and blood dysentery (“kaath”), measles (“khasara”), leprosy (“kushta rog”). Apart from

\(^1\) Afflictions by conditions associated with ghosts, supernatural beings, sorcery or black magic.
these, women include in this category certain conditions, many of which appear to be of a psychomatic nature such as sudden starting ("jhapeta"), shaking or crying incessantly, trembling, stammering, inability to talk etc. (skin rashes and boils ("khaur")). Where "dosh" is implicated as the cause, prescriptions for cure normally involve a ritual or a set of rituals. These are in the form of "paying fine", "making vows", "tying charms" etc. aimed at appeasing the infuriated supernatural force and dispelling its effects. The "Baman" or pandit and "bakki" are basically "diagnosticians" and prescribe sacrifice, rituals, trying charms or amulets as therapeutic modes. Women strongly believe that there is no way of curing a person of "dosh" except through the performance of spells, prayers and offerings. They also believe that western medicine is ineffective in such cases. As a form of preventive measure against the "dosh", a black spot is usually marked with "kajal" (lamp black) on children’s foreheads. Special and expensive food items, particularly fruits and sweets, which are rarely available in village households and hence may be a cause of envy are never kept in view of visitors.

Things seem to be changing however as a result of the growing influence of modern medical ideas. In an increasing number of actual illness or disease cases, it is observed that dosh and bimari are often lumped as possible causes. The emergent, widely held belief is to first calm dosh and then only attempt treatment of the bimari. The persistence of the old system is evident in the view that a dosh may aggravate bimari but never vice-versa. It is increasingly common to find women too resorting to both allopathic medicines as well as to the bakkis and other traditional healers. Though many secretly question whether all illnesses are caused or cured by supernatural or magic, they cling on to supernatural when seeking cure. In general, women also vouch in unison about the efficacy of these methods.

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2To cure a person of evil eye pandit who has special knowledge of mantra is called to rid the afflicted of the effect of this evil eye. The pandit usually performs a small pooja called the dudh phool ke pooja where he chants some mantra over some sugar, and gives it to the patient to eat. The pandit may even spell charms and blow on ash and give the same to the victim to keep (called rakhauli). Some pandits may do the same with mustard seed and hand it to the afflicted to wear round the neck. Or sometimes he may chant mantra and give a black thread to be tied round as an amulet.

3Bakki is also primarily a diagnostician. Villagers go with a handful of rice, turmeric and Rs.1.25 as offering to the bakki. With his innate powers he is able to diagnose the persons suffering and prescribes a "ritual action" ranging from private ritual like "jagar" to bigger rituals involving sacrifice, "mantras" (spells) and possessions ("dhamt")
The treatment is seen as a matter for negotiation and for authoritative pronouncements, either by traditional healers or today increasingly by the "wonders" of modern medicine. At present what we observe is that there is a mixture of healing systems with an emergent preference for biomedicine in some illnesses. But most women resort to the full range of practitioners, depending on the nature and severity of illness.

While explanations are grounded in a range of material and supernatural factors it is divine intervention, which is finally believed to determine the eventual outcome.

_We can only say that God has caused the disease. We know overwork, poor diet due to scarcity are the causes for women's illness. Unhappiness also causes diseases. But it is our fate. God makes us ill and He can only cure us._ (Saraswati, 55 yrs, Lohar-Dom, Birkatal)

People in general have grown to be dependent on allopathic medicines. However, local villagers have to go out of the village even for basic medicines and basic services such as blood and urine tests. The PHC at Yamkeshwar or the SAD at Diuli is not the preferred choices. The state assigned resident physician (ayurvedic or allopathic) is almost never present at the PHC or at the Ayurvedic Dispensary at Binak. Months pass between the departure of one and the arrival of the next. Moreover the perceived level of care offered by the public health facilities is lower than the private. Thus those who can afford the higher fees and transportation costs prefer to attend private clinics at Rishikesh. No villager would venture to do so unless they have at least Rs. 200 on him or her. People are aware that the more advanced the medical treatment, the more money required.

The RMP in Duili village is the other available option. The costs are comparatively lower at Rs. 20 per head for transportation. RMPs charge between Rs. 25 and Rs. 40 to the patient per visit for the medication and injections that they provide. Besides lack of money compels villagers to turn to the local bakki or vaid. This medication is also not cheap, but payment can be made in kind (usually a chicken and some liquor).

A serious illness requiring hospitalisation would be a major setback for a common family. Even a series of short illnesses in a family push men to migration in order to meet the need for cash. For instance Damu who sustained severe internal injuries after a bus accident and had to be hospitalised. His wife was forced to sell all the cattle and even a
piece of land, to pay for medical costs incurred. Damu recovered, but they still have
debts. He left the village for Haridwar where he works as a roadside photographer. His
wife is engaged in working on others fields for a small amount of grains!

The popularity of “Dr. Rawat” mentioned earlier is a clear indication of people’s need
for medical care. Because of the inaccessibility of PHC and its state of affairs, the
‘doctor’ need only wait on the roadside for patients to arrive. This successful
entrepreneurial initiative in a hitherto neglected region must be linked to people’s
practical efforts to access modern medicine. The researcher herself was flooded by
requests for medicine and was compelled to respond notwithstanding the limitations of
her knowledge.

As mentioned by Susheela and observed by us, most households keep their own stock of
medicines and are hesitant to share this with others. As Sudeshi explained:

_I will not give any medicine to any one. One can be jailed if someone died of his
or her medicine. Even if you give good medicine, some women blame us for giving
wrong medicine. I also will not take medicines from anyone. It could be expired
or it may have it own side-effects_ (Sudeshi, 30 yrs, Rajput, Birkatal).

An old villager of Bunga Sohanlal _dadaji_, disburses medicines and also gives injections.
He is not educated, but his uncle was once the village doctor. Sohanlalji feels he has
some knowledge of medicines because of this association. Most villagers doubt his
knowledge, but resort to his treatment when desperate.

Rishikesh market to this day remains the nearest important source for proprietary drugs
the antibiotics, injections, etc. sold at the chemist. Today, small shops in Duili, Binak
and Magatha sell routine medication along with other general merchandise. The routine
stock consists of a range of painkillers, paracetamols, antihistamines and antacids like
Crocin, Baralgon, Brufen, Lomotil, Saridon, Digene, Disprin, Coldarin, Vicks etc. which
people purchase for self-treatment. The shopkeepers rarely have greater knowledge than
their customers about the medical effects of these products. The transaction takes place
with the tacit understanding that the customer purchases at his / her own risk. Villagers
seem to be familiar with these medicines and confident about their usage. They freely
bought and consumed the medicines without fear.
The medical pluralism, which we observe, may be interpreted as multiplicity of choice being available to women confronting ill health. However, as we shall see, a true choice or option seldom exists.

**Gender Difference And Discrimination In Health Belief And Practice**

A “rational” account of good health has always existed in the village health culture. Thus women perceive good health to be secured and maintained by proper diet, proper behaviour, along with factors such as having proper morals, avoidance of prohibited environments and regulations of passion. It is also believed that women should take care not to allow their body to become hot or cold, wet or dry or indulge in any acts that might cause their families or themselves to be visited by disease. Villagers believe that God uses affliction for multitude of purposes—and women may be a preferred medium as they are more vulnerable to evil spirits than men. In particular, unmarried women, new brides, pregnant and postnatal women are said to be highly susceptible to the attack of evil spirit.

Recognising the gendered dimension of health belief and practice, elderly village women recall that death was a familiar and expected outcome of illness especially for women and infants. It was natural to think of death for oneself and ones children. If the well-being of the family large was seen to be threatened by an affliction (*dosh*), the family head would consult a “big healer”. For women they relied on herbal remedies procured from some local *vaidya* or performance of a small ritual. Thus health interventions are gender discriminations hinged on the differential perception of women's health needs as compared to men or male children.

The situation began to change, around the eighties, when women who accompanied their migrant husbands for short durations were able to access modern health care and realise its benefits. For example Susheela now 52, went to Kanpur in the 1980s, was able to get treated for “white discharge” at the private doctor. Such cases however remained few and far between. Treatment too was sporadically availed, linked to women's short stays with their husbands.
Basic cultural attitudes, which view women's illnesses as hurdles in fulfilling duties, are slow to change. The woman is by and large expected to bear the discomfort and carry on "normally". Women are themselves unlikely to access medical care and often do so only when the illness becomes serious. They may not get adequate medical attention because they have less access to cash, or because they do not readily admit to being ill. They have too much work, or at times they feel shy to admit an illness. Moreover, a woman who keeps admitting to illness is often portrayed as a malingerer and lazy.

Women generally do not seek any medical help till condition deteriorates. This is because no facility which is easily accessible. Going far involves expenses and money in scarce. Hence only when condition worsens usually they have to be taken to doctor. Moreover in earlier time and even now women are always over burdened. They carry on working despite small health complaints. Only when a woman feels incapacitated, or her suffering is unbearable and visible, is she taken for treatment. Even when she is herself responsible she avoids as long as she can. Health care involves cost and time and both are scarce for her - or so she believes. Money can be put to so many other uses and hence even now even if she can, she generally avoids going to a doctor. (Susheela, 52 yrs, Brahmin, Bunga)

Some women like Sundari feel that older times were better from the point of view of accessing treatment. Vaids were more easily available.

In earlier times vaids used to visit the village-hence people could seek their help. Nowadays no doctor of any kind comes into the village hence it's often impossible to get any treatment closely. It is most difficult for women. Men go to the bazaar and to the town and it is easy for them to accommodate a visit to the doctor or buy medicine for themselves. Women are dependent on others to find some healer. (Sundari, 70 yrs Rajput, Daun)

'Health care' practice of village households follows a typical pattern:

Most families keep some medicines at home – like for fever, cold and cough - crocin, painjon, baralgan, disprin, anacin. For minor ailments people take medicines on their own. They borrow it from each other too. People hesitate to share medicine, but in emergency they relent. If after 2-3 days, there is no improvement they attempt to visit the doctor (RMP) at Duili. Some who have more energy to travel will go to the doctor at Mohanchatty. Sometimes if the patient is very unwell and cannot walk, the doctor from Mohanchatty is called to the village. He is an ayurved who works at the ayurvedic dispensary there but gives "angrezi dawa" (allopathic medicine). Only in emergency villagers go to Rishikesh, Dehradoon or Delhi. But only those villagers went to Delhi who have some family member or relative staying there. The decision to go is dependent on
cost and very few women go. Even sick women can go if some one is ready to take them. They have to be carried to the roadside and then taken on a bus to the city. Rarely do women in this condition get taken. (Susheela, 52 yrs, Brahmin, Bunga)

For smaller ailments, particularly if they haven’t taken too severe a form, women go to the ayurvedic dispensary at Pokharkhal to collect free government supply of ayurvedic drugs. The frequency of visit to this dispensary depends on whether it is manned by the appointed doctor. If he is available, villagers definitely frequent it. There is always the probability of getting some allopathic medicine. The compounder too dispenses a few allopathic medicines, on payment. Occasionally a few women also go till Magatha village (Pipal Dali) to procure medicines from the travelling doctor - Dr. Rawat. However men always outnumbered the women in the crowd awaiting Dr. Rawat’s arrival.

Women revealed that each family spends a sizeable portion of its income on health care, as sickness is widely prevalent. There is always a chronic shortage of the drugs at the government health centres and the treatment provided is of poor quality. Many women have never themselves visited a doctor; their sons or husbands may get medicines for them based on symptoms descriptions. Only a few younger, educated women routinely attend a doctor’s clinic. Women in general however do not use the government facility – ayurvedic or allopathic is not the preferred choice.

The doctor is rarely always there even in the dispensary at Mohanchatty. We go all the way and return without seeing him. Due to these delays out health deteriorates. Then we are forced to go to Rishikesh which is so far way and is costly. But I feel its better to go to Rishikesh. Despite being a government dispensary, we have to incur a lot of expenditure even at Mohanchatty. If one clinic is closed in Rishikesh, many will be open. Spending a little more can save life atleast. (Sudeshi, 30 yrs, Rajput, Birkatal)

Sharp and systematic gender discrimination exists in the provision of modern medical treatment to women. As against the men who look after their own health needs, most women are simultaneously dependent on as well as neglected by their husbands. In-laws focus on the health of men and children of the family, while women's health gets nil or last priority. The following two cases reveal the cruel extents of physical suffering and medical neglect that even very sick women must bear.

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Neither my in-laws, nor my husband paid any attention to my health. Now I have nowhere to go. I keep so unwell. I can barely see with my eyes. The "bai" has affected my joints. I have problem walking. My husband does not bother about me. Nor does my son. Till our village doctor was alive, he use to give me medicines and injections whenever I fell ill. In 1999 first time I saw a hospital when I had fallen severely ill. I had high fever for two weeks. I was vomiting and shaking. When my husband refused to take me to the hospital, I went on my own to Rani Pokri (near Jolly Grant) to my sister’s place. There I got my treatment done at Jolly Hospital. But even before treatment was over, my husband came and brought me back to the village. He himself has no money for my treatment and when my sister was taking care of me, he forcibly brought me back (Kraji, 69 yrs, Brahmin, Bunga)

Since the last 17-18 years I have had problem of white discharge. I did not have the courage to tell my mother-in-law about the problem. My husband is not bothered. I do not have enough information to go to hospitals in Rishikesh. I am not confident of doing it alone. In the nearby dispensaries there are no lady doctors. Even in my young days I have never gone anywhere. That is why I do not know anything. Mohanchatty is far and the path is winding and steep. It takes 2 hours to climb up and 2 and 1/2 hours to come down. Usually a patient has to spend approximately Rs. 100/- for his treatment on medicines alone there. Even this I cannot afford. (Maheshwari, 53 yrs, Brahmin, Bunga)

While Maheshwari is seldom taken to the doctor her husband Govardhan visits the doctor every week for treatment of “shawas ki bimari”. Even for simple problems like cold, cough and fever he prefers to visit the doctor. He either goes to the private doctor at Duili, or Mohanchatty or even as far as Rishikesh. He has got his urine, blood examination and chest X-rays done several times in Rishikesh. By his own admission, he has consumed medicines worth Rs. 3000-4000.

Despite greater availability of cash and greater family expenditure on health care, especially in migrant households, first of all their women do not get much attention, leave alone equal access. Access to cash incomes is indirect through reliance on male kin. Secondly, there are strong social pressures that deter them from paying attention to their illness. Only when ill health reaches a level where they are absolutely unable to work, is some action taken.

In 1998-99 Sakuntala needed hospitalisation and underwent two operations (probably uterine ulcer as apparent from her description). She was ill for almost a year. As during that year the family were unable to cultivate at all, her husband migrated for work just to earn enough for buying food grains. They borrowed
money to pay the hospital charges and large debts are still outstanding. Despite her difficulties however, Shakuntala does not evoke much sympathy from other women in her neighbourhood. She is considered lazy and not a good homemaker because of her frequent complaints of illness. She is mocked for not putting in enough work on the fields and at home. (Shakuntala, 50 yrs, Brahmin, Bunga)

Only in extreme illness is a woman worthy of attention. Even when their lives are in danger as was Sunanda’s, it is not easy for women to claim treatment. Natal family members, parents or brothers may come to women’s rescue. Such family support often proves crucial to women’s health and their very life.

As a young bride who suffered during a difficult pregnancy and delivered a dead child several hours later, Sunanda was lucky enough to convalesce at her natal home. For her second delivery her in-laws did not consider it necessary to take precaution by reducing her agricultural work. She was not taken to a doctor either when she felt unwell. She became seriously ill on a visit to her natal family. Prompt action by her family members saved her life. However her second child too did not survive. Her husband’s family not only never offered to pay the medical expenses but also complained bitterly that Sunanda’s parents had acted hastily and failed to consult them in the matter. They thus blamed the parents for the loss of the child. (Sunanda, 35 yrs, Rajput, Birkatal)

Munni’s story throws up the poignant contrast of the treatment received at natal and conjugal homes. Munni’s brother escorted his sister to the doctor and also bore the medical expense.

I married Roshanlal at the age of 15. It was a big extended family with large fields, many domestic animals. I arrived in the family and immediately got drawn in its endless work. For six years I did not conceive. I was sick. My back use to hurt severely. My in-laws use to curse and ill-treat me. On hearing about my plight, my brother called me to Kotdwara. There they did “devi poojan” and “dosh pooja” and my brother also got me treated for 3 months in the government hospital. But I still did not conceive on returning. Now my mother-in-law got very angry. I was sent back to Kotdwara. I had a small operation. Then my brother came to drop me back. Then after one year I had a son. After that I had 5 more children with a gap of two years between them. But after each delivery I felt very weak. I could not eat any food. Weakness crept in my body.

After 6 months of my third delivery I fell very sick. I could not make out whether it was day or night. My chest use to pain severely. When the pain came I became almost lifeless and I would fall anywhere writhing in pain. If I were in the field or forest, I would just fall there. My nephew visited me. Seeing my state he said, “You will die if you remain without treatment in the village.” My father-in-law was a kind man. He had been trying to get me treated by local vaids and also by
doing some “dosh pooja” but that was not helping. On behest of my nephew he took me to his daughter’s place called Haripur. There it was diagnosed that I had severe jaundice. I was so weak that I could not even stand. I would just fall unconscious. On hearing about my bad condition my brother came to see me. He took me with him and got me treated from a Vaid in Dehradoon. I stayed there for a month till I felt better. My brother has really helped me. If it were not for him I would be dead long ago. (Munni, 48 yrs, Brahmin, Bunga)

Phuphu is a woman who was divorced because of her ill health. Her husband’s family refused to bear the costs of her treatment and also provide subsistence to a sick woman. Divorce was the punishment she received for falling sick and being incapable of work.

Phuphu was compelled to leave her husband. He re-married on the excuse that she was always falling ill and was unable to work hard enough. She was sent back to her aging parents. Today Phuphu’s son has grown up and has migrated to Delhi where he has set up an independent household. Since then Phuphu has gone twice to Delhi – once for a gall bladder operation and once for hysterectomy. Her fortunes have now changed. (Phuphu, 43 yrs, Brahmin Bunga)

Women, who have sons in a city may have hopes of treatment, often the best possible under the circumstances. Sons take their mothers to private doctors or to the big hospitals, meet the cost of treatment, and house them till they recover.

Thus we find that while there is definite gender discrimination in access to health care, women are accessing both allopathic doctors and traditional healers. Also women’s overall preference for modern medicine suggests an erosion of faith in the total effectiveness of traditional treatment. Gradually modern medical treatment has been incorporated into their lives and is often accessed along with indigenous healing methods.

To conclude, the negative association between women’s lives, work and health is deeply embedded within the women’s economic and cultural life in this region. Thus many of the physical, somatic and psychological disorders are a product of this association. Women’s illness narratives brought out implicitly or explicitly the perceived links between work, environment, food and socio-economic locations and the sufferings of illnesses. The most significant causes perceived by women were environmental damage, under or malnutrition, quantum and conditions of their work, numerous pregnancies and deliveries and even the supernatural, which cut across major types of illnesses suffered.
Women's explanations of illnesses also reinforce the interplay of these factors which influenced health seeking in complex ways.

While there is undoubtedly perceptible gender discrimination in access to health care, women within the existing constraints attempt to avail both indigenous and modern cures. Hence while modern medical treatment has been included in the treatment seeking practice, it bears emphasis that biomedicine has not displaced or subverted the local healing system. It still has not replaced the work of religious healers, bakkis, vaidas etc. It has however, transformed local patterns of help-seeking and healing. Biomedicine is thus diffused across the plural healing system, but without subordinating traditional healing to its hegemonic control.