Chapter – VI

Discussion and Conclusion

The thesis discusses the relationship between relation of production and reproduction in the context of adivasi society. Related to this it seeks to chart out the social and economic structure of the society and its influence on fertility practices. Secondly, it also aims to throw the light on the issue of reproductive labour – dais, ASHA workers and Aanganwadi workers, etc, birthing practices and examine the response of the state. Thus, these objectives are framed by using the concept of “structural inequality” on one hand and taking the methodology of stand point feminism especially subaltern scholarship on the other. Standpoint feminism emphasise the experiential reality of women as the source of knowledge and indicate double marginalisation of women from deprived communities.

Keeping these in mind, the thesis is divided into six chapters. The first chapter introduced the subtle gender differences that are observed in relative egalitarian adivasi society in the sphere of work where women’s work participation is little higher than the men in addition to the household responsibility and highlighted the complex character of reproductive health especially when it is given a space symbolically - in folk culture and given the weak welfare programmes including health programmes and structural inequality. On the other hand, Dai’s have certain set of medical expertise which commensurate with folk culture but ill-equipped to deal with emergencies/obstetric care in a context where anemia among women is an ordinary scene. Although dais were interested to be part of public health care system in the course of training, recently state de-recognised their work and instead inducted another set of health workers i.e. ASHA workers and Aanganwadi workers. This not only created conflicts and competitions among grass root health workers; but also changed the work pattern and brought confusion and chaos in the society. Concurrently, these women workers too tried to critique state’s policy. In tandem with this, Indian state’s exclusive focus on family planning and deaths related to sterilization further dissociated adivasi women from public health care.
Introduction chapter too justified the paucity of ethnographic studies with regard to research on dais and reproductive practices and care in adivasi set up compared to caste and agrarian society where the norms related to purity and pollution and hierarchy are very strict. It also discussed research questions and objectives and theoretical framework.

The second chapter which is entitled as “Researching Adivasi Women: A Note on Self-Reflexivity” focused on the methodological experience particularly reflected on using feminist methodology, engaged with question of ethical values, issues encountered while carrying out field study as an adivasi educated women and study restrictions. Generally, a lot has been written on the way researcher who seemingly from a non-adivasi condition shapes the very progression of data collection and analysis of methodological thoughts and discussions in the chapter. In fact, Spivak challenged some of the critical assumptions of feminism in universals and instead argued that all women are not the same and there are a lot of variations active even among women with view to class, colour and faith. The will and aspirations of the European women are completely diverse from the women of the Asian Continent. She suggested that feminism needs to concentrate on this variation that exists among women and help them to achieve their private goals. With this focus, I narrated the experiences of researching the intimate lives of marginal groups i.e. adivasi women in which the original impetus came from my own personal experience. Being a Bhil adivasi woman, I encountered twin problems i.e. patriarchal and caste pressure which was discussed through my inter-caste marriage (with upper class and caste Kunkana adivasi). Class is also another axis which shaped up my individuality. Secondly, class inequality was elaborated through the encounter with the police with regard to not allowing my parents and co-villagers to do community farming in the Forest. I not only discussed how my own subjectivity influenced the research and but also the consciousness of changing of my identity over the course of time which generated important questions from the respondents. Inversely, I recognized how field work experience and respondents’ questioning and comments affected the research process, positioning of the arguments and findings.

The third chapter appraised the significant scholastic work on birthing and reproductive labour and tried to review some of the literature on adivasi women. This chapter was divided into five sections wherein the first section contextualised the issue of reproduction and put into historical backdrop in order to highlight how shifts in the birth control discourse took place which blamed
and controlled third world, poor and women of colour as responsible for all social problems instead of addressing structural problem. It also documented the different radical articulation of birth control by non-Brahmin social reformers for the emancipation of women. The second section dealt on the write up on Marxist perspective (Qadeer, Rao, Bang and Bang, Jeffery et al, Radhakrishna) which underscored the structural factors like legislations such Criminal Tribe Act, unemployment, weakening of public health care and promotion of private medical care, etc are responsible for malnutrition among adivasis and affecting reproductive health. Scholars in this paradigm contributed in making conceptual distinction between women’s health and reproductive health and then reproductive health and family planning programme. Third section discussed feminist critique especially radical feminist framework through the work of Firestone and discussion on female child deficit through the work of Visaria and Menon. Fourth section discerned post-colonial feminists’ (Sarah Hodge, Maya Unnithan Kumar, Cecilia Van Hollen, Wendy Harcourt) deconstruction of indigenous health practitioners and population control programme which are designed on third world women and fifth section focused on the scholarship on anti-caste feminist approach (Sarah Pinto and Gopal). Pinto underlined the fault lines in the Dai training programmes.

In the next chapter, socio-political and economic history of Gujarat has been described through its historical trajectory. Initially it discussed the state formation i.e. unification of three distinct regions namely British governed erstwhile Bombay Presidency that is south, central and north Gujarat. Some of these regions were under the rule of Maratha Dynasty and later British Gujarat, secondly, formerly princely states – Saurashtra regions and Kutch region bordering Pakistan, the social context/reasons for which the state was formed as well as the demographic profile. The second section described the economic and social profile of the state which unraveled the contradictory nature of state’s development record such as high growth but insufficient and low income particularly among marginalised sections, skewed sex ratio, high maternal mortality especially among adivasis and Dalits. In addition, it explained the social structure of Gujarati society through caste hierarchy like how traders and financiers, not its royal officials, nor its chieftains, nor even its Brahmans, set the tone of society in Gujarat, inter-community conflicts (Patidar vs. Kolis and Patidar vs. Bhils), economy etc. in order to depict the marginalisation of adivasis and women in particular. With regard to the former point, it underlines how economic growth does not go hand in hand with the social development unlike in pre-independence period.
particularly the interventions of Maharaja Sayaji Rao III, Gaekwad of Baroda in terms of compulsory and inclusive education, outlawing child marriage, to name a few. This aspect is particularly of importance as suffering related to reproductive health is linked to the discrimination and disenfranchisement of adivasi women. While analysing the state, it examined the initiatives taken by the ruling class for upliftment of weaker sections and social development and its challenges; for instance marginal women, like adivasi women. Simultaneously, it sketched the various social movements propagated by various communities for social equality and secularization such as Kshatriya Sabha, KHAM experiment and Dalit movement in Gujarat was to improve and promote the Dalits, and Bariyas, Thakardars and Bhils, the lesser castes in the Kshatriya fold. However, there were also backlashes through state policies during pre-Independence as well as post-Independence (such as abolition of Jamindari system, introduction of Indian Forest Act 1878 and amendment of Industrial Dispute Act which benefited the Patidars to acquire land in adivasi area and criminalised the Bhils and decimated their claim to the Forest resources on the other) as well as parallel conservative religious movements like Swaminarayan movement and Swadhyyay movement which created setbacks for these activities. It argued that though the entrenched inequality triggered social movement and secularisation initiatives, simultaneously these were backlashes from the upper caste which resulted in caste and communal violence. Another important point it underscored that in these movements adivasis too were culturally appropriated and most crudely seen in Hindu right wing activities and sensitization processes.

The third section outlined the politico-economic condition of Dangs which unequally disadvantaged adivasis and in this connection it outlines the social conditions of adivasis in general and particularly doubles marginalization of adivasi women. In this direction, it depicted how on one hand, adivasis are both included (like used in communal projects) and excluded by dominant sections and state machineries (job creation and poor implementation of the Scheduled Tribes and Other Traditional Forest Dwellers- Recognition of Forest Rights- Act, 2006) on the other. In this region and mainly adivasis living here succeeded in maintaining a position of semi-independence well into the nineteenth century. Only gradually one finds economic distress and adivasis were subjugated as share croppers and tenants by penetration of caste Hindus. Consequently, in this region tribal emancipation movements also arose. Coming to double marginalisation of adivasi women, it is discussed through the introduction of Koyta system
which creates a kind of bondage system and influence underage *adivasis* for early marriage. Among the Bhil *adivasis* early marriage is not part of cultural attitude rather it is strategized in order to overcome economic insecurity where state failed to provide aid to disempowered people. Marriage entails pairing which facilitate them to earn money and help family for maintenances. Varghese discussed about the *Koyta* system under which *adivasis* from Dangs are employed through a *Mukkaddam* and are trapped into exploitative chain. In this system, not only there is low wage and higher working hours but also local *adivasis* end up into a debt system.

In continuation of the previous chapter, fifth chapter entitled “Reproductive Labour and Health Care in *Adivi* Setting” tried to situate *adivasi* women of Dangs and delineate their health care needs and specific reproductive issues as well as involvement of *adivasi* women in health practice. It highlighted the specific health needs of *adivasi* women in relation to the broader socio-economic conditions and mapped the role of the state and discussed what citizenship means in the case of *adivasi* women. The chapter contained four sections. The first section provided the process of making Dangs as a district - which threw light on poor public facilities like roads, housing arrangements, dismal functioning of AWCs, Mid-Day Meals, MGNREGA, Indira Awas Yojana, etc, and paradoxical nature of gender equality wherein sex ratio is positive towards female child while simultaneously under age married girls have increasing work burden. Socio-spatial configuration of *adivasi* villages such as intra community rivalries and status differences between *adivasis* and non-*adivasis* in Dangs has been also described. It also discussed the slow penetration of Hindu radicals in terms of organizing *Kumbh melas* in Shabridham, Subir which was unknown to the *adivasis* and disturbed the peaceful coexistence of plural religious communities like Christians, Muslims and Hindus.

The second section explained the specific health care requirements of *adivasi* women and its interlinkages with broader socio-political situations and cultural contexts i.e. varied birth practices. It argued that while women actually work more hours than men, their work is subsumed under household income or are given wages not individually but through family income especially under *Koyta* system. When underage *adivasi* women are made as pair not only they do heavy work on par with men in Surat and other places, due to their early marriage they also experience pregnancy quite early. This increases their reproductive health risk which is again magnified along with insufficient rest and nutrition. So from this logic, their public health
The third section dealt on the reproductive labour/work and explained how daisies legitimize their status. Suvarins discussed about the wrath and humiliation inflicted by state authorities against them for continuing home deliveries and in the process recruited ANMs by providing incentives to them and pregnant women to mobilise them for delivery at public hospital. While suvarins were asserting their legitimate work status, it is seen that given the image of Indian state’s involvement into family planning and non-availability of basic facilities like water actually emboldened the suvarins’ point. In addition, they too highlighted the requirement for fundamental structural change like revolutionise economic policy. Field instances discussed not only the gaps in the services of ANMs but also how conflict and competition is brewed between the former cadre of workers and suvarins by the state. Suvarins expressed how ANMs cheated them. While going deeper into the difficult questions raised by suvarins, the idea was to encapsulate how traditional health practitioners claim their legitimacy by pinpointing the state’s failure to provide public health services. Additionally, it pointed to the fact that suvarin’s work cannot be put under the lens of tradition vs. modernity debate as field notes showed that suvarins too are interested in training
whereas state is in back foot in terms of earlier provided limited training and later on stopped the Dai training programme especially after NRHM programme. Fourth section, diagnosed the role of the state and the relationship between adivasi women and state. It showcased how state treated women differently according to their social standing, where women become both the object and subject of reproductive programmes. While the previous section discussed about competition between ASHA worker and suvarins, this section explained how at some level these different cadres of grass root health workers share equal relationship with the state. This is best captured by discontent against the state for offering limited salary and demand for ADHAR card, etc as told by ASHA workers and AWWs.

In short, it explained how Indian state included adivasi women – become the target for family planning, dais training previously- as well as excluded adivasi women in the sense that there was no substantial health care for pregnant women and no meaningful training for dais in terms of citizenship. Additionally, it attempted to encapsulate how state treated subaltern women in a peculiar manner which eventually back-fired the state. Subaltern women especially who are involved in reproductive care were entrusted too much work load while simultaneously denying their work status by terming it as “voluntary” and rationalised their limited salary in neoliberal era. This became also the reason for these health workers to defy state’s nomenclature that is, seva. Ideally, there should be a balance between maintaining the specific cultural practices and the public health care. However, as the field insights showed, disruption of adivasis’ cultural practices coupled with apathetic attitude and negligence of hospital staff as well as structural barriers made the reconciliation between cultural uniqueness and public health needs a difficult task. In this scenario, services offered by suvarins attracted the adivasis for reproductive care.

Sixth chapter is the summary and discussion.