Chapter I

Introduction

Adivasi\(^1\) society is known as relatively progressive in terms of providing freedom to women as opposed to the Brahminical\(^2\) society (Xaxa 2007). For instance, in the matter of women’s sexuality, they are not strictly controlled as it is found in upper caste Hindu society. In adivasi society women chose their marital partners, girl child and male child are equally valued and hence female foetocide and infanticide rate is significantly lower (Morish 2014). Further, Kumar (2014) writes that among the Kolams in Maharashtra, a woman is not subjected to violence in case of pre-marital or extra-marital pregnancy as she might have to face in mainstream Hindu society. She is either married off to the man who is responsible for the act, or the man is heavily fined if he is found guiltier than the women. The child, however, will bear the name of the biological father whom the mother identifies and can claim a share in the father’s property when s/he grows up, even if the mother is not married to this man. At least, this is accepted in principle, though the Kolams being a property-less group, the question of asking for a share in family property

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\(^1\) I have used the term adivasi instead of tribes and vanavasi due to numerous reasons i.e. political and ideological. Adivasi means first inhabitants or nations and here it implies the communities’ assertion of their right to own the space. Adivasi word is made up of words i.e. Adi and Vasi. First word Adi which is erived from Adikal, implies before or earlier. Second word Vasi, which is derived from vasnar denotes occupant, staying, inhabitant, etc. Earlier “tribes” were known as “aboriginals” by anthropologists and “backward Hindus” by caste society. The word “scheduled tribe” was used for the administrative usage by colonial government. Author has used the term “adivasi” while following the arguments of Hardiman, Xaxa, and Bindu and so on. The term “adivasis” [means first inhabitants or nations] is an early twentieth century word that emerged as a result of attempts to describe “tribes” in a non-derogatory manner or backward mode of production or emanated from resistance movements to reclaim their hold over the land and resources when they were alienated from it. Also, now tribal describe themselves as adivasis. However, Omvedt (2005) have a different point of view namely suggesting referring them as “Santhals” or “Bhils” like any other communities.

\(^2\) Braminical word was used by Sharmila Rege’s article (2000) “Understanding Popular Culture: The Satya Shodhak and Ganesh Mela in Maharashtra” to imply the domination of upper caste tradition in Hinduism.
does not generally arise. In some cases, the adult children from such a sexual liaison have chosen to ignore their claim to property (ibid: 80).

Significantly, food is equally shared among all members irrespective of their gender as opposed to Brahminical society. Another contrast is seen in terms of respecting and valuing female medical practitioners or healers i.e. suvarins3 (dais or traditional birth attendants) and other elderly man and woman. To put it straight, dais’s works are stigmatised in Brahminical Hindu society (Pinto 2006 and Gopal 2013) whereas dais’ works in adivasi society are valued. Even if their work is associated with the dirt and impure work, dais are not looked down by adivasi villagers unlike Hindu society. Likewise, adivasi society is healthy society especially in the matter of maintaining hygiene (Bang and Bang 2010). Elwin (1986: 235.36) makes a similar observation with regard to the Baigas when he says that the women enjoy an excellent position in Baiga society. They enjoy freedom and authority, play a leading part in marriage ceremonials, and have a reputation for practising witchcraft. Among the Baigas, there is no clear division of labour between men and women (cited in Xaxa 2004: 347).

Xaxa (2004) writes it succinctly how the gender egalitarian structure in one sphere is offset by unequal structures in other realms in adivasi society, “Earlier, they (tribals) were portrayed as having a better status than women in caste societies, with physical mobility, choice in marriage, divorce and remarriage, access to property and resources. Such assumptions were based on an examination of the literature available in monographs with reference to rules of inheritance, right to property, share in the decision-making process, etc. In short, these hinge on the one hand on rights and privileges these women enjoy and on the other, on the kind of role assigned to them by virtue of belonging to a particular gender. Consequently, adivasi women were invariably depicted as having higher social status than their counterparts in caste society. However, the economic burden and workload of adivasi women as well as their access to education,

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3 Suvarin implies traditional midwifes in Dangi dialects and Gujarati language, they are referred as dais. Interestingly, Dangs suvarin’s work is done by woman and man. Therefore, it is not considered as exclusively feminine labour. Neverthless, it is seen that women are mostly involved in suvarin work than the men.
food and nutrition, modern occupation and political participation, especially in the modern context, has not been given the kind of attention it deserves. Hence, rather than talking of high or low social status, it is more pertinent to talk of inequality of gender. In the latter case, one can examine the relative position of women and men in relation to their access to equal opportunity, both formal and substantive (ibid: 353).” To illustrate, a study of the Bhils by Mann (1987) shows that as high as 99.09 percent of women participate in agricultural activities and 93.64 percent in livestock rearing. Furthermore, Mann’s study discusses the shift in sexual norms and regulations through the penetration of dominant/hegemonic Hindu culture. Mann explains the sexual regulation of adivasi women through the influence of Sanskritisation. The freedom of a Bhil woman in the sphere of premarital sex, marriage, divorce, access to decision-making bodies, etc. is being gradually curtailed with Sanskritisation. The Bhil woman is already adversely affected in terms of her freedom to select a male and to elope and marry. Among them, the purdah system has also been adopted from caste Hindu society (ibid: 155). She privileged the customary practice of bride price than dowry which was brought up recently through Sanskritisation as it provides more security and rights to women.

Interestingly, Jeffery, Jeffery and Lyon (2002) observe that in rural India, the pregnant woman and the newly delivered mother are simultaneously workers and the bearers of the next generation of workers. Same is also found in adivasi society where pregnant women too work till the time of delivery. The crucial point that can be underscored here is that this unequal economic burden is not limited to economic domain, it spills over and affects other activities like health. It is important to recognise the fact that maternal mortality and infant mortality are very high in adivasi areas. These social factors along with other issues i.e. economic insecurity due to dispossession from land or displacement which cause malnutrition, exacerbate the problem. For instance, maternal mortality is very high in adivasi society due to unavailability of delivery services as well as lack of access to nutritious food.

Kumar (2002) refers from Rozario’s (1988) study which suggests that the midwives actually have serious deficiencies in terms of delivering effective health care, both in their knowledge and capabilities as well as by being compromised by the cultural and
material situation in which they work. This reinforced Kumar’s own observations of Nagori birthing and healing practices (ibid:125).

**Statement of the Problem**

There is abundance of literature available on reproductive health and especially the critique of family planning programme in India. Recently, two controversial episodes like use of unsafe IUD devices for family planning and death of *adivasis* and *Dalits* in Chattisgarh (in 2014) due to mass stérilisation programme resurrected the interest in the dimension. Reproductive health has been studied from various paradigms like politico-economic, feminist and post-colonial angles. Notwithstanding the contribution of post-colonial feminism on the subject of reproductive health, there is very little scholarship related to reproductive health care experiences of *adivasi* women. Likewise, even if *dais* are studied overwhelmingly in critical studies but specific social location of *dais* in *adivasi* society is very rare. Reproduction has symbolic or cultural significance and it is always associated with economy/production. In *adivasi* context, reproduction not just signify sexual relations, it is enmeshed with production or economy. Feminists’ interrogation of the dichotomy between public and private sphere represented by production and reproduction respectively by mainstream economist is pertinent in *adivasi* society. Women’s fertility is accrued to enhance land productivity. For instance, mother-in-laws in *adivasi* society are of the opinion that if women will conceive more children their land will augment its productivity. Field insights during my M.Phil. work revealed that *adivasi* women are averse to institutionalisation of deliveries and suspected that hospitalisation of child-birth deteriorated women’s health and eventually their performance in field. However, this opposition cannot be simply, termed under tradition and modernity binary. Rather, it is related with the issue of “structural inequality” experienced by women in hospital set up. Considering these angle, reproductive health in *adivasi* set up is much more complex and needs an ethnographic focus. In this circumstance, they value *dai/suvarin*s work. 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 anaemia among women is a common sight. Even though they show the interest to be part of public health care system through
training, recently state de-recognised their work while inducted another set of health workers i.e. ASHA workers. This not only created conflicts and competitions among grass root health workers, it is interesting that these workers too subverted their image by questioning state’s policy as well as exposing the mundane violence that takes place in hospital set up.

So, the research question arises in this context include how do adivasi women understand reproductive health in their mundane life. This will examine the inter-relationships of women’s experiences of work and child bearing. Whether Bhil women have choice or constrain on the matter of reproduction, sexuality etc. in a relatively equal society? This aspect will explore the different nature of patriarchy exist in seemingly gender neutral society. The last important question is how to address the reproductive health needs without eliminating cultural specificity of the society. This will entail how to reconcile the conflict between community’s cultural orientation and reproductive health needs. Ethnography on reproduction in the context of adivasis will encompass both socio-cultural aspects, notions of patriarchy, economy, etc. rather than just public health need. So far, tribal studies has been limited to focus on the nature of subsistence economy, gender relations, ethnicity, kinship structure, healing culture, traditional birth attendants [dai/suvarin] and so on. Ethnographic work on reproduction in the adivasi social setting has not been done except few like Kumar (2002) and Visaria [1999]. However, Kumar’s description on reproduction is limited to the practice of dai/suvarin i.e.from the perspective of female healers. Visaria’s work examined the quality of reproductive health care and service of female health workers available in modern medicine. Furthermore, it did not evaluate critically state’s notion of welfare i.e. family planning.

Objective:

1. To explore the connections between relations of production and reproduction.
2. To understand everydayness of state through its health programmes and underline how it creates differences among women.
3. To map adivasi women’s experience of reproduction in the day to day life.
4. To examine the concept of “work” in the context of reproductive health and problematize state’s notion of “work”.

**Theoretical Framework:**

It primarily draws from standpoint feminism, particularly experiential realities of subaltern women. In this context, it tries to situate *adivasi* women and underline the double marginalisation of *adivasis* from being *adivasis* as well as women. Structural inequality is also analysed through looking at caste and class differences.

**Chapterisation:**

Considering the above research problem, this thesis is divided into six chapters. The **first chapter** introduces the complex character of reproductive health in *adivasi* set up and discusses statement of the problem, research questions, and objectives. The **second chapter** i.e. *Researching Adivasi Women: A Note on Self-Reflexivity* focuses on the methodological experience especially reflecting on using feminist methodology, engages with question of ethics, issues encountered during field study as an *adivasi* educated women and study limitations. The **third chapter** attempts to outline the review of literature. Specifically, this chapter tries to review feminist scholarship on health in the context of *adivasi* women and Bhil women of Dangs. In the **fourth chapter**, the discussion is on *socio-political and economic history of Gujarat*. It discerns the contradictory character of Gujarat in terms of high growth without substantial development among weaker sections like *Dalits, Muslims* and *adivasis*. It highlights that though the entrenched inequality triggered social movement and secularisation initiatives, simultaneously these activities invited backlashes from the upper caste which resulted in caste and communal violence. Second section focuses on the politico-economy of Dangs District and briefly discusses how social and economic marginality adversely affect *adivasi* women which has implication for reproductive health. **Fifth chapter** entitled “*Reproductive Labour and Health Care in Adivasi Setting*” attempts 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 tries to highlight the specific
health needs of *adivasi* women in relation to the broader socio-economic conditions and map the role of the state and discuss what does citizenship mean in the case of *adivasi* women? **Sixth chapter** is the discussion and conclusion.