New Reproductive Technologies, Subjective Women's Experiences and the Discourse on Modernity in Rural South India

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Abstract

The modern biomedicine as an agenda of modernity has been a major source of concern for both the academics and the common men alike. Medicalization is the process through which the agenda of modernity is accomplished. Simply put, medicalization refers to the way in which the jurisdiction of modern bio-medicine has expanded in recent years and encompasses many deformities and problems that were not formerly defined as medical. However, this development needs to be located within the broader discourse of modernity in order to have a better perspective on the challenges facing us today, especially in health sector. The major driving force behind medicalization, at more operational level, has been the power and control exerted by the medical profession within the domains of health and illness.

Keeping in view the above argument, the present paper tries to signify the role of new reproductive technologies in the development of the discourse between modernity on one side and the subjective indigenous perceptions of women affected by reproductive contingencies on the other. In fine, the author tries to focus more on the interaction between women and the medical personnel wherein the former are more dependent on the latter vis-à-vis medicalization. Normally it has been observed that, modern occupational patterns, education and healthcare itself have affected the way of life at the grass roots. However, there are very few studies to illustrate the mechanisms through which the indigenous beliefs and practices in turn affect the above stated domains. Therefore the central thesis of the present study is that, modernity is an extraneous phenomenon which is being planted unevenly across the globe. And to view it as a singular one way process would only lead to unrealistic conclusions. The paper therefore adopts a qualitative approach towards the problem in question.

Keywords: Agriculture, Family structure, Healthcare facilities, Modernity, New Reproductive Technologies.

THE PREMISES: SUBJECTIVE EXPERIENCES OF WOMEN'S REPRODUCTIVE LIVES.

Health refers to that aspect of human condition which is a critical constituent of an individual's capabilities and which is valuable for more reasons than one (Sen 2002). It is as much a cultural phenomena as it is biological. Health and well being represent that unified whole which we call human existence, where both the cultural and the biological are not only intertwined, but are in fact indistinguishable in both thought and action (Wagstaff and Cleason 2004). It is in this sense studies reveal that, lack of health causes burden of death and disease, and has different outcomes for different kinds of people, both in terms of their socio-economic status and gender. Today we have a large body of evidence

that demonstrates a direct relationship between socio-economic status and disease, but however, the gap that exists between the various sections of society is widening day-by-day. (Black et. al. 1980, Whitehead 1992, Kreiger et. al. 1993, Davey Smith et. al. 1994, Acheson 1998).

The subjective reproductive experiences of women especially those residing in the rural locales need to be put into perspective by adopting a life-course approach that is more holistic and comprehensive in bringing out the problems faced by women today. The life-course approach is effective in locating the specific instances of indigenization as well as medicalization through the process of "place making" wherein the women are facing new and impending realities that they had never heard of before. The reason behind such state of affairs is the rupture that has occurred in the cultural-temporal sequencing of the reproductive lives of the women wherein they are forcefully brought in contact with process of medicalization as an agenda of modernity. This phase can best be described as the "liminal space" in the lives of the women wherein the reproductive career itself undergoes an abrupt change. And this change is co terminus with the process of modernization .

Women's health in general and reproductive health in particular is one of the most neglected areas of international health in this regard (James L, Sandra Laston et. al. 1998, Pachauri 1994). Motherhood is often perceived as a virtuous experience that gives status to women in a society, but at the same time it is also associated with pain, suffering, fear and even death. This gets manifested in an abnormally high rate of maternal morbidity and mortality caused by haemorrhage, infection, high blood pressure and obstructed labour, which is in turn symptomatic of highly inaccessible health care services (WHO 2010). In 1995, 515,000 women died during pregnancy or during childbirth, out of these only 1000 were in high-income countries and rest were in the developing world (UNICEF 2001). 5.6 lakh women die every year during pregnancy and childbirth of which 1.17 lakh are from India (Sule 2009**).** 99% of all maternal deaths in 2008 occurred in developing countries with Sub Saharan Africa and South Asia accounting for 57% and 37% of all the deaths respectively. This is owing to the fact that only 50% of women avail skilled delivery care and the other 50% do not take assistance or do not have access to such skilled care (Idris, M.W., Gwarzo et. al. 2008). The situation in India is even more dismal. A recent 2000, World Health report-WHR chronicles a glaring and massive deterioration of reproductive health situation of women in India.WHR puts India on the 51 'slow progressing' countries with respect to infant, child and maternal mortality. According to the report, in India, virtually every five minutes a woman dies of complications related to pregnancy and child birth. By this, India has gained the dubious distinction of having the highest estimated number of maternal deaths in any country during 2000, that is, 136,000 deaths in one year. It is reported that more than 100,000 women die each year in India of reproductive health related causes. Maternal Mortality Rate-MMR in India is 407 as against 60 in China and Sri Lanka. In India, over two-thirds of women give birth at home. This is close to 85% in rural areas and 95% in remote areas (Frontline 2005). Efforts are still on to biomedicalize the reproductive health care services provided to women by promoting

the option of home delivery with an accessible and skilled care (Huque Z.A., Leppard M, et al. 1999, Geefhuysen C.J., 1999 cited in Blum, L.S.,Tamanna S et. Al. 2006). However, there is little qualitative evidence to compare the indigenous home-based reproductive health care services with that of the biomedical care provided in the hospitals. This is the reason as to why the objective of 'Safe Motherhood' that forms the corner stone of a nation's population policy is still a contested phenomenon. Studies on home-based delivery care have largely focused on the biomedical orientation of traditional birth attendants, and very few attempts have been made to understand and bring to the fore the indigenous beliefs and practices that ultimately account for safe-motherhood (Sibley L, Sipe T .A. et. Al. 2004, Bergstrom S, Goodburn E 2001).

The facts provided so far are just a tip of iceberg of the overall health scenario, either at the global level or within India. Then,

Why this dismal state of affairs?

What has gone wrong?

Where to point the finger? and

What does the situation entail?

Researchers working on health policies and programmes, both governmental and non-governmental, put the onus on the perspective and approach that is being adopted to tackle the problems of health and disease. And this is the approach 'bio-medicine'. The biomedical approach runs as a common thread cutting across all the levels-policy formulation, designing of health programmes, execution, information dissemination (IEC), and even monitoring and evaluation.

Biomedicine both in its form and content is culturally and historically western in its orientations. It depends on static taxonomies and epidemiological categories of individuals that are rarely context sensitive. In bio-medicine, both society and culture are regarded merely as extraneous residual categories notwithstanding the fact that they may be as critical as the human biology when it comes to the study of disease etiology. Transmissibility and prevention takes precedence over helping the people from getting affected by diseases owing to the innate body-mind dichotomy of the biomedical approach. Consistent with this paradigm, the practitioners of bio-medicine treat patients as having 'conditions' rather than as humane and complete individuals. The approach is therefore found to be narrow, target driven, top-down and wanting in user-perspective. However, we also need to take into account the antecedents of such an approach. From where does it emanate and how does it shape and gets shaped by the existing cultural contexts? Speaking from a macro level bio-medicine is *not* a monolithic entity (Lock and Kaurfert, 1998: 16). As reproductive health becomes increasingly biomedicalized throughout the globe, the researchers cannot assume that this process is singular and one way in both its cause and effect despite the fact that the initial thrust came from the west during the colonial and post colonial periods. This uneven transplantation of bio-medicine through the process of globalization has had a negative impact on the women's control

over their reproductive health. Ginsberg and Rapp have cautioned against adopting unidirectional models of the relationship between indigenous perceptions and globalization observing that,

> While our work calls attention to the impact of global processes on everyday reproductive experiences, it does not assume that power to define reproduction is not unidirectional. People everywhere actively use their local cultural logics and social relations to incorporate, revise or resist the influence of seemingly distant political economic forces (Ginsberg and Rapp 1995: 1 p)

Thus, it is evident from the above discussion that, we have definitely fallen short of taking into account certain critical aspects of those disadvantaged and marginalized sections of society viz. women and their reproductive health. It is only by giving special considerations to these areas of heath research by keeping in view the above given perspective that includes both the processes of indigenization and globalization, that we will be fulfilling our ethical imperatives of 'equity' with 'distributive justice' (Oliver and Pearsman, 2001). In spite of India being a signatory to the 1978 Alma Ata Declaration of 'Health for All by 2000' we have hardly met the target. In fact, the target has been pushed to 2020.

Therefore, the central thesis of the paper is to try and examine the aspect of contemporaneity of three different strands of reasoning namely, the altering of the cultural-temporal sequencing of the women's reproductive careers, the rupture in the rural-urban continuum and the role of new reproductive technologies as a manifestation of the modernizing process.

METHODOLOGY

The present paper is derived from an ethnographic research conducted in a village called *Nigadi* which is situated in a rural setting of North Karnataka, India. The research project focused on Reproductive Health Care and Gender Relations, and was funded by Indian Council of Medical Research, New Delhi. The findings are based on first hand intensive field work carried out for one full year during 2007-2008. Research strategy was basically qualitative in nature and was aimed at gaining subjective as well as interactionist insights into women's reproductive experiences. Information was gathered through structured and unstructured interviews with over 70 women in their reproductive period (15-49) and their families, in their homes and in the public amenity buildings of the village. Quantitative information relating to delivery and delivery care was collected from 125 women who were in their reproductive period (15-49) using simple random sampling method. The village under study bears a caste stratified society characterised by elaborate kin groups and an agrarian way of life.

INDIGENOUS PERCEPTIONS OF MODERNITY

From a macro perspective, the people of the village follow two distinct patterns of child birth ; home and institutional. The women belonging to younger generations perceive pain, suffering and danger to their life when confronted with home deliveries as they foresee complications. 49 (39.2%) of the total women interviewed gave birth to their children at home, either natal or conjugal. 75 (60%) of the women gave birth in public hospitals, one of the women gave birth on her way to health facility. It is evident from the above data that there are more number of women giving birth in hospitals than at home. One of the reasons behind this kind of a shift in the place of delivery is the breaking down of the extended family households-*koode irodu* into their constituent nuclear family households-*byare irudu* where in only husband, wife and unmarried children reside. Under these circumstances, the parturating women are denied of support systems of all forms including physical, nutritional, economic and emotional. With the change in occupational patterns, fast depleting lands for agriculture due to large-scale commercialization and industrialization and lack of proper education, both men and women are forced to work outside their traditional set-up to earn a living for their households. In such a situation, even if the women desire to go in for home deliveries they are confronted with new and impending complications. As an outcome they have no choice but to go in for institutional delivery. The following is a case of one such woman which exemplifies the role of changing family structure in determining the place of delivery.

Susheela Mohite is mother of three children belonging to *Maratharu*[3] caste of the village. She is 30 years of age. She has completed primary level of education and her husband has completed secondary level. They do not own land therefore work as agricultural labourers on others' land. They are separated from their ancestral home and are residing in a nuclear family household. *Susheela* says, it is for this reason that she gave birth to all her three children in a government hospital in a nearby town. For all the three deliveries she had been to her natal home as there was no one in her husband's place to take care of her during the delivery. There was nobody at her husband's place or in her natal home from where she could get skilled delivery care as it is traditionally done in this village.

These existing childbirth related practices of the villagers further shape their perceptions towards the newly emerging reproductive exigencies at various stages of their lives. According to the villagers, the women are facing new kinds of complications that can be categorized as *BP* (variation in blood pressure), *pits* (convulsions) and *margakke bandilla* (obstructed labour) which they had never heard of in the past. The following is the case study that brings to the fore the influence of these new complications that have changed the way people look at home deliveries.

Ningappa is an agriculturist belonging to *Dasankoppa* lineage of a *Panchamsali* caste of the village. He was living with his wife and two daughters in a nuclear family household. As his wife conceived for the third time, she was taken for an ante-natal checkup to civil hospital where she was diagnosed as being normal. And one day when she got labour pain her husband called for *soolagitti* (traditional birth attendant)

from a nearby locality in the village. But to the surprise of the *soolagitti* (traditional birth attendant), the delivery had become complicated because of *hur*i *suthkondithu* (umbilical cord was around the baby's neck) and *Ningappa'*s wife started getting *pits* (convulsions). At the end of delivery both mother and child had died. *Ningappa* is now married to another woman and has a child. This incident has created a sense of fear among the villagers regarding the home deliveries. The people now say they are scared to go in for home deliveries as they say *soolagitti* are not trained to handle such complications.

The most widely shared belief among the people which has given rise to these kinds of complications is lack of *kasu* (physical strength) in the present day women. The two main reasons that account for loss of strength are, the change in type of food consumed and the nature of work they indulge in, prior to childbirth. The food that is consumed by the women itself lacks strength because it is made of food grains that are produced using chemical fertilizers and hybrid seeds which was not the case earlier. The very cropping pattern has undergone a change owing to the advent of commercialization of *kamata* (agriculture) to serve the needs of market economy. The large scale mechanization of agricultural food production has lead to the change in nature of work and daily chores of women. The women have started leading a more sedentary lifestyle, which people believe will lead to complications during delivery. And it is for this reason they are not able to induce pain during delivery which at times leads to fatal consequences. These conditions make way for the medicalization of childbirth practices among the people, and the first casualty is the dislocation of place of delivery. One such measure adopted by the doctors or nurses in hospitals to overcome these complications is *byane injection* (injections to induce pain) which connotes easy delivery to the people of the village.

However, one thing that needs to be stressed in all these instances mentioned so far is that, women of the village prefer to give birth at home if everything is *sarala* (goes on well) without any complications. This further connotes that, if the delivery takes place at home, the *soolagitti* (traditional birth attendants) will not use abusive language and misbehave with the woman during delivery as it is most often done in the case of hospital deliveries. They are also scared of the unruly behavior of the medical personnel who ill-treat them during the process of delivery. The women of the village reported that the *sistergalu* (nurses) at the hospital even beat them if they do not follow the medical procedures during childbirth. Apart from this in hospitals they do not get hot water. The women of the village consider that the care they receive both during and after the childbirth is critical for the well being of the mother and the child and therefore of the whole family. At home, hot water bath is given immediately after delivery by applying *bevina tapla* (neem leaves) and *arshina* (turmeric) paste mixed in *kobbari yenne* (coconut oil) which helps in reducing the body pain and keeps the body warm, *alavi* (juice made up of pulses) is given to *bananti* (delivered woman) to regain the lost strength. But in case of hospital deliveries, such care is not possible, instead they are given *kavina injection* (painkiller injections). But, the people believe that *kavina injections* (painkiller injection)

are only a temporary relief and the neem, turmeric paste and hot water bath will be helpful for the woman for their life time.

It is more out of helplessness and inconvenience that the women go to hospitals for delivery. They do not appreciate the care given in the hospitals. In fact they consider hospitals to be most uncomfortable places for conducting deliveries. The following is a case study of a woman which brings out the attitude of the caregivers in hospital settings.

Manjula Basavan Gowda Patil who is thirty years of age, went for her second delivery to a public hospital in the nearby town at around 8 O' clock at night. As it was night time the doctors were not available. The *sistergalu* (nurses) checked her abdomen and told that she cannot have a normal delivery. They told her parents that *Manjula's* case is complicated and the doctor will perform the caesarean in the next morning, therefore they gave her a bed and asked her to stay back on that night in the hospital. The nurses later did not turn up to see her. In the mid night *Manjula* got severe labour pains. When her mother went to call the *sistergalu* (nurses) they said, they will be coming in the morning to examine *Manjula*. By looking at her pain and suffering one of the elderly women who had come to hospital for her daughter's delivery came forward to help *Manjula*. The elderly woman conducted the delivery in the night and *Manjula* gave birth to a male child and it was only then the nurses turned up. The elderly woman told *Manjula* that the baby had come out even before the nurses checked her at the first instance but they could not notice it. This clearly indicates the quality of reproductive care that a pregnant woman gets in the hospital settings.

CONCLUSION

Thus from the above discussion it is evident that the agricultural food production, family structure and the health care system are the domains under which modernity and traditional practices of childbirth interact to create new and unforeseen reproductive realities for the people of the village . The shift that can be seen in all the above three domains of people's life has severely altered the reproductive health seeking behaviour of childbirth marked by dislocation of the very notion of place of delivery as seen from the traditional point of view.

Apart from taking into account the impact of modernity on child birth related practices, the present study has the potential for the reconstruction of gender roles within the context of maternity. The new reproductive technologies introduced as a part of medicalization have shaped the existing notion of womanhood. However, the critical question that needs to be answered is whether medicalization has curtailed or enhanced the reproductive status of women in the rural areas. But as of now the women are torn apart from their existing cultural-temporal sequence of the various stages in their reproductive lives owing to the compulsive interference of new reproductive technologies in the form of assisted pregnancy, child birth and child care. An effort has been made to study the discourse between knowledge and power at an operational level and thereby arrive at the inter linkages at a more macro level.

References

Acheson, D.1998. *Independent Inquiry into inequalities in Health report.* London: The stationary Office.

Bergstorm S,Goodburn E.2001.The role of traditional birth attendants in the reduction of metarnal mortality. *Studies in health services organization and Policy*. Vol.17.pp.77-96.

Black, D., Morris T., Smith C., and Townsend P.1980.*The Black Report*. London: Penguin Books.

Davey, Smith G., D.Blane and M.Bartley. 1994. Explanations for socio economic differentials in mortality. Evidence from Britain and elsewhere. *European journal of Public Health*, 4(2).p.p.131-144.

Frontline (2005), Saving Mother and Child, The Crucial Comments, UNICEF's interventions in West Bengal, Frontile, May 6th, 2005.

Ginsburg, Faye D., and Rayna Rapp (Eds.). 1995 Conceiving a New World Order: The Global Politics of Reproduction. Berkeley, University of California.

Huque ZA,Leppard M, et all 1999, Geefhuysen CJ, 1999 In Blum S Lauren Tamanna S et al. 2006.Attending Home vs Clinic-based delioveries: Perspectives of skilled birth attendants in Matlab, Bangladesh. *Reproductive Health Matter*. Vol 14.No 27.pp 51-60.

Idris S,Gwarzo M D.et al. 2006.Detrminants of place f delivery among women in semi urban settlements of Zeria,North Nigeria. *Annals of African Medicine.*Vol.5.2.PP 68-72.

James L. Ross, Sandra L. Laston, Kamrun Nahar, Lazeena Muna, Papreen Nahar and Pertti J. Pelto. 1998. Women's health priorities: cultural perspectives on illness in rural. *Health..2(91).*

Kreiger, N., D.Rowley, A.Herman. 1993. Racisism, Sexism, and Social Class: Implications for Studies of Health, Disease, and Well being. *American Journal of Public Health*, 83(1), 82-122.

Lock, Margaret, and Patricia Kaufert, 1998. Introduction. *In* Pragmatic Women and Body Politics, Pp. 1-27, Cambridge, Cambridge University Press.

Pachauri, S. (1994). Women's reproductive health in India: Research needs and priorities. In J. Gittelsohn, M.E. Bentley, P.J. Pelto, M. Nag, S. Pachuri, A.D. Harrison, and L.T. Landman(Eds.), *Listening to women talk about their health:Issues and evidence from India*. New Delhi: The Ford Foundation.

Sen, A.2002. "*Why Health Equity?*" *Health Economics* 11(8):657-666.

Sibley L,Sipe TA et al.2004.Does traditional birth attendant training improve referral of women with obstetric complications; a review of the evidence. *Social Science and medicine*. Vol 59.No 8.pp 1757-1768.

Sule, Supria. 2009. To translate promises into action. *The Hindu*, Friday, July.10th.p.p 8.

Oliver, Sandy and Peersman, Greet (eds).2001.*Using research for effective health promotion.* Buckingham: Open University press.

United Nations Children's Fund.2001.*Progress since the world summit for children: A statistical review*. New York: UNICEF.

Van Hollen,Cecilia. 2003. *Birth on the Threshold: Childbirth and Modernity in South India.* University of California Press.London.

Van Hollen,Cecilia. 2003. Invoking *vali*: Painful technologies of Modern Birth in South India. *Medical Anthropology Quarterly*.Vol 17.No.1.pp 49-77.

Wagstaff, A., and M. and M. Cleason.2004.The Millennium Development Goals for health: Rising to the Challenge. Washington, DC: World Bank.

Whitehead, M. 1992. *The Health Divide*. London: Penguin Books.

http://www.who.int/reproductive health/publications/monitoring accessed on 06/10/2010.