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NEGOTIATING REPRODUCTIVE HEALTHCARE: STRUCTURE, RESISTANCE, AND AGENCY AMONG THE WOMEN OF RURAL NORTH KARNATAKA

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INTRODUCTION

The following paper is based on ethnographic research carried out for a period of one year in 2007-2008 and 2010-2011. The article examines the plight of the women residing in the rural locales of North Karnataka, and the process through which they go about their reproductive decisions during pregnancy, child birth and child care. By doing so the author tries to bring to the fore, the complex web of formal and non formal factors which influence these decisions. The researcher puts forward basically four set of factors which inform the decisions of women: 1) the institutional public healthcare of the state and the international funding agencies which implement RCH programmes at the grass roots. 2) the self-help groups that are run by governmental and non-governmental agencies which cater to the needs of rural women for their economic empowerment. 3) the support group organizations or the "networks" that help women with reproductive health problems like the TBAs, ASHA workers, and other elderly women of the village. 4) the cultural constructions of gender and the self, particularly the centrality of motherhood as well as the women's own kinship network viz. inter-spousal relations, natal-conjugal relations, inter-caste relations, localized patrilineages and patron-client agrarian relations. These factors actually provide the women with a framework which enable them to make informed reproductive decisions. The article therefore focuses on the how women pragmatically negotiate these various factors as they engage in reproductive decision making. Women's decision to accomplish the state of motherhood is not the outcome of favouring one factor over the other, but rather, their own synthesis of coexisting structures and discourses.

THEORETICAL UNDERPINNINGS OF THE STUDY

There has always been a dearth of theoretical and empirical attention being paid to the influence of the asymmetrical gender relations on women's ability to take informed reproductive decisions at various stages of their life cycle. Instead, it is blatantly assumed that even in societies where men are overtly dominant, like the ones in rural North Karnataka, women's decisions concerning

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reproduction and their subsequent accessibility to healthcare are made by women themselves. But the fact of the matter is that, the actual circumstances under which the women interact with their male partners and other actors, in matters relating to reproduction - or even subordinate to them - have rarely been considered in an in-depth and qualitative manner, at least in the Indian context. In many societies, including that of rural North Karnataka, control over the means, goals and consequences of reproduction are critical to the decision making process wherein individual actors participate in a kind of dynamic "structuration" ordained by the cultural constraints of their own. Thus, the contexts within which these reproductive relations operate are characterized by conflict, consensus or an eclectic mix of both, and these contexts have been seldom subject to systematic investigation. The reason for this, to a large extent is that the academics in social sciences including the anthropologists have historically seen reproduction as "women's topic" as women's body as "site of reproduction".

The present paper is based on the theoretical construct of Cambridge Sociologist Anthony Giddens called "structuration" which accounts for both the "strategic conduct" of the agents, that is, the individual actors resulting in potentially transformative action *and* institutional structures that reproduce social systems simultaneously (Giddens 1979). Following this development, Social Scientists in general and Medical Anthropologists in particular have tried to achieve a balance between the typically structuralist approach put forward by Levi Strauss and the functionalist stand taken by Malinowski.

REVIEW OF LITERATURE

There is an assumption in the west and elsewhere that women in India are subjugated and have little or no control over their reproductive lives, the implication being that Western women have substantially more decision-making power and act as free individuals. Much has been written about the interests that are served by such ''othering'' discourses regarding ''Non-Western'' or ''Third World Women'' (see Mohanty 1991 and Raheja and Gold 1996 on South Asia; see Abu Lughod 1993 on the Middle East). I recognize that the reproductive decisions of the women I met were constrained by social and cultural structures, including gender inequality. This is true of women everywhere. But using Laura Ahearn's (2001:54) definition of agency as ''the culturally constrained capacity to act,'' I draw attention to women's agency as they frame their decisions in response to the above-mentioned set of factors.

Since the 1990 s, feminist anthropology has highlighted the ways in which women around the world exert their agency in the face of local and global structures of patriarchy (MacLeod 1991; Abu Lughod 1993; Raheja and Gold 1996; Mankekar 1999; Ahearn 2001; Seizer 2005). For example, MacLeod (1991) challenges Western assumptions that unequivocally equate veiling in Muslim societies with the control of women. She describes the new veiling practices that

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emerged in Egypt in the 1970s as ‘‘accommodating protest’’ because the Egyptian women whom she met experienced them, simultaneously, as confining and as a means of engaging in protest. In a similar vein, through an ethnography of television viewing in North India, Mankekar (1999) stresses the importance of ‘‘foregrounding women’s agency’’ as a counterpoint to Western stereotypes of Third World women. She defines agency as the ‘‘ability to actively engage with, appropriate, challenge, or subvert the hegemonic discourses’’ while, like MacLeod, reminding us that ‘‘resistance and compliance are not mutually exclusive’’ and that women may, in fact, exercise their agency so as to participate in the construction of hegemonic discourses . Ahearn (2001:55) echoes this point when she writes that agency ‘‘may also involve complicity with, accommodation to, or reinforcement of the status quo.’’ Also articulating the links between resistance and accommodation, but coming at this issue from the opposite angle, Seizer (2005:325) states that ‘‘all too often, compliance is the most effective way to resist an oppressive power.’’ The present paper intends to contribute to these poststructural feminist studies of agency and structure.

Feminist Medical Anthropologists and Historians engaged in the study of reproduction—particularly the medicalization of reproduction have similarly shifted their theoretical attention away from earlier feminist approaches, which foregrounded the links between medicalization, biopower, and the control of women’s bodies (Oakley 1984; Martin 1987; Jordan 1993), toward documenting how women actively engage with new forms of medical science and technology in complex, context-specific, and sometimes contradictory ways (Lock and Kaufert 1998; Ragone 1994. As Margaret Lock and Patricia Kaufert (1998:2) wrote in the introduction to their edited volume, *Pragmatic Women and Body Politics*, women’s responses to medicalization ‘‘may range from selective resistance to selective compliance, although women may also be indifferent.’’ Ultimately, they suggest that ‘‘ambivalence coupled with pragmatism may be the dominant mode of response to medicalization by women’’. Given the fact that the women in my research were engaging with the medicalization of their reproductive processes, indifference was never a response that I encountered. But ‘‘ambivalence coupled with pragmatism’’ perfectly characterizes the nature of these women’s responses and decision-making processes. It is precisely this point that I intend to convey through this article.

THE PROBLEM

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

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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 RATIONALE

The facts provided so far are just a tip of iceberg of the overall health inequalities, either at the global level or within India that continue unabated in spite of the efforts put in to bridge the gaps. Then,

Why this dismal state of affairs?

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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 of 'biomedicine'. 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 biomedicine, 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 biomedicine 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.

The biomedicalization of pregnancy and child birth in the West is not as uniform as critics often make it out to be. For example, the way in which birth is managed varies on the basis of race, ethnicity, class, gender, and region. The same technological intervention may be interpreted, experienced, and acted on in different ways within the West (Becker 2000; Martin 1987; Rapp 2000). Researchers dispute how one's socioeconomic status will influence the process of medicalization. There is also a great deal of variation in the dominant models of birth throughout the so-called Western world. Brigitte Jordan's seminal comparative study showed variation in modern obstetrics in three different western nations: the United States, Sweden, and Holland. However, we also need to take into account the antecedents of such an approach.

Biomedicine is not a monolithic entity (Lock and Kaufert 1998:16). As reproductive processes become increasingly biomedicalized throughout the globe, researchers cannot assume that this process will occur in a uniform way despite the fact that the initial push behind the trend came in part from Western nations in colonial and postcolonial contexts. Ginsburg and Rapp, somewhat like Jordan, voice their concern that unequal relations of power in the process of globalization impact negatively on women's agency over reproduction, leading to what they describe as the "stratification of reproduction on a global scale" (1995:12). Yet, at the same time, they caution

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against adopting unidirectional models of the relationship between structure, resistance and agency in the context of reproduction, 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:p1).

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 which actively incorporates the "structuration" aspect of decision making, that we will be effectively 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.

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 CONSTRUCTIONS OF REPRODUCTIVE HEALTHCARE

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

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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. This is the main cause of their loss of agency in attaining a better reproductive health status in the village as whole. 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 structure in determining their reproductive decisions.

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 constrain their decisions in the case of 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 check-up 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

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surprise of the *soolagitti* (traditional birth attendant), the delivery had become complicated because of *huri 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 very notion of 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 led 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 care of mother and the new born. 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. This, in a sense provides the people of the village with an out let an agency no matter how discomforting and painful they perceive it to be.

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 behaviour 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

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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

The healthcare system, self-help groups, informal networks and the social construction of gender are the structures under which modernity and traditional practices are negotiated by the women of the village leading to creation of new and unforeseen reproductive realities for them. However, this dispensation of structure and agency is still proving to be disadvantageous as it has altered the reproductive health seeking behaviour owing to the compulsive and the overwhelming medicalization of their reproductive cycle.

Apart from taking into account the impact of medicalization of reproduction 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 within the broader agenda of globalization, have shaped the existing notion of motherhood. However, the

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critical question that needs to be answered is whether medicalization has curtailed or enhanced the agency 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.

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