WOMEN'S STUDIES CELEBRATION
Women's History Month 2005

NOMINATION: Papers and projects done in completion of course work for Spring, Summer and Fall 2004 eligible for nomination. Students do not need to be enrolled Fall 2004 or Spring 2005 to be eligible. (Students are encouraged to identify works they would like nominated and approach their professor to initiate the process.)

Instructor: B. Jill Smith Dept. Geography/ Anthropology

Course Number and Name: Directed Studies 493 Semester completed Spring 2005

Title of Nominated Work Women's Health in India: A Student's Perspective

CATEGORY:

Sampson:		
Undergraduate Research Paper	XX	**See** ___
Undergraduate Project	X	**Olson** ___
Graduate	___	**Kessler** ___
		Turell ___
		Belter ___

STUDENT INFORMATION:

Name Anna Nummelin

Email NUMMELAK Year/Major: Junior / Nursing

Local Address: 459 Governors Hall-North, 640 Hilltop Cr.

Local Phone: 855-4423

****WHY DO YOU, THE INSTRUCTOR, RECOMMEND THIS AS AN EXEMPLARY STUDENT PAPER/PROJECT?** (Attach a separate sheet.)

As the nominating instructor, please notify the student and ask them to turn in the paper, or attach to your nomination form.

Awards are sponsored by the UW-Eau Claire Foundation, Helen X. Sampson Fund, and by private individuals. Research involving human subjects must conform to the guidelines given by the Institutional Research Board. Contact Research Services, 836-3405, with questions.

Submission deadline is February 11, 2005.

Nomination for Anna Nummelin for the *Donna C. Turell Award*

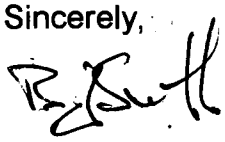
There are times when the students you have known the least amount of time impress you the most. While I have never had Anna in my classes as an anthropology student, she asked to take the canceled *Global Issues In Women's Health* class as an independent study. She initiated the effort, and followed through. On a whim, she asked me to read the paper she wrote to complete her International Studies Semester abroad in India . I was very impressed. In all honesty, her insights and experience in health care delivery among the poor in a developing country put my own international experience to shame.

She demonstrates the best of student growth and insights when faced with experiences well outside the range of her normal life. The manner in which she analyses the world she confronts in India, her attempt to be objective about the difficult world women in India experience, non-judgmental, yet deeply moved by the experiences of both the patients and the care-givers is well beyond most experienced adults. I am deeply impressed.

While I was not Anna's major professor for this international experience, and we have had a very short time to work on this paper, I would like to nominate this paper for the Turell prize for the 2005 Women's Studies competition.

Thank you very much for extending the deadline for us.

Sincerely,



B. Jill Smith

Anna Nummelin

India ISP Paper

Spring 2004

Women's Health in India: A Student's Perspective

To the Western eye, dowries, the caste system, and bride burning all appear to be blatant examples of women's oppression unique to India, but for the most part, the problems that Indian women face are universal; the same problems of all women in developing countries and of all women world-wide. Malnutrition, poverty, misogyny, illiteracy, lack of political representation and lack of control over their lives are just a few of the countless factors contributing to women's subordination and poor health. Indian women, though constitutionally guaranteed equal rights since soon after India gained independence from the British in 1947, are still suffering and will continue to live in oppression until those constitutional rights are acknowledged which will be difficult granted they have never been publicly accepted or enforced.

This paper is largely based on my own personal experiences and the interviews I conducted in India and can in no way claim to be representative of the experiences of all Indian women. India is a vast and diverse country with one hand reaching out towards development and modernization and the other firmly grasping its rich tradition and history. Each woman's story is so widely different from the next, yet within each one exists similar themes which tie all women together in their struggle for happiness, safety, freedom, health, respect and love. These are the hopes and longings of women all over the world, the same hopes that should be guaranteed to all human beings regardless of sex, gender, age, race, religion, physical and mental capability, sexual preference, or economic and social status. Sadly, what should be is not, and because of such severely entrenched political corruption, poverty, tradition and firmly established patriarchy, the realization of these dreams may only be accomplished after much work both on the part of India and the world. As a result, this reflection concentrates on how the many facets of an oppressive society effect the health of women in India and addresses many health-influencing topics relevant to an Indian woman's experience as well as relating my own experiences.

Many scholars and students of medicine (I believe that anyone in the field of health care never ceases to be a student) have attempted to define health, and although it can be described as

simply the absence of illness, there are so many other facets that constitute a healthy being. For the intents and purposes of this paper, health is defined as something that permeates every fiber of our being and every aspect of our lives. Health is being able to feel safe, to feel joy, to be without feelings of fear, worry or anger and to be in both a physical and emotional state that facilitates the realization of a person's full potential. Anything that does not contribute to these criteria is therefore defined as destructive to physical, mental and spiritual well-being.

In the months leading up to my arrival in India, I tried to look for reading material about the experiences of women in India in order to better acquaint myself with some of the issues they face, but I found nothing. Even my searches for writings about nursing or healthcare in India turned up dry. It wasn't until after I got there that I found the types of articles and books I was looking for. Since my arrival, I was able to find articles in the *NY Times, Frontline*, and *India Today* as well as books and studies done regarding the status of women in India, most of which include some reference to the effects it has on women's health. But unless you know where to look for the information, it is largely inaccessible. Not only is the amount of writings minimal, the data is either incomplete or nonexistent. For many reasons, accurate statistical information for developing countries is next to impossible to attain and what exists is not representative of the population. On the other hand, it would almost be impractical to try to keep track of all the births, deaths, illnesses, and patients in such a populous, diverse country with a large sphere of remote and often subsistence-level villages and city slums. By sharing what knowledge I've gained I only hope to offer a small glimpse into some of the issues and atrocities women in India face and how daily, they endure.

I lived with the family of an Ayurvedic doctor for four months in the world's oldest living city, Varanasi. The majority of the city is very traditional with many of their practices dating back to 5,000 years ago when the city was first built. The majority of people live very simply and even though my family was of a higher class, they were no exception. We pumped our water every morning, had little electricity throughout the day and slept under mosquito netting on the roof at night when the weather became too unbearable to stay in. While I was there, I worked in both a leprosy colony and a Mother Theresa hospice both about a twenty minute bike ride from my house. I say I worked there but really, I learned much more than I was able to contribute.

Trying to adjust to such culture-shock proved to be both mentally and physically exhausting as I spent one of my first nights in Varanasi sick next to the hole on the bathroom floor. My group of fellow students and I quickly learned the rarity of a good solid poo and that it was something to be celebrated especially after eating foods from street vendors. Between the 120F degree temperature, strange food, city water, and questionable refrigeration, our weak stomachs suffered considerably.

Every day I was met with situations that seemed so incredibly backward from the ways in which my mind was accustomed to thinking and it took the entire first month to get used to this dusty, chaotic place. After seemingly endless days of grappling with language and trying to decipher societal norms and taboos I was eventually able to relax, fully take in my surroundings and in time, actually go about life without a second thought as to how foreign it was. One particular afternoon I was walking home through the market and happened to weave my way into the middle of a herd of water buffalo in order to avoid the rickshaws and cars speeding by when I had to do a double-take at not only how normal the act seemed, but the security I felt there among the buffalo. Neither did I give a second thought to going two or three times a week to the one-room leprosy clinic to cut parts of people's feet off. Sitting at the bottom end of the table with a scalpel in my gloved hand and sweat dripping from my forehead, I learned how to lance and drain an infection beneath the nerveless skin. I would apply ointment and then attempt to wrap bandages, awkwardly at first, but even the patients who had lost their fingers helped to direct the cleaning and wrapping. The resident doctor and I would alternate cutting, and I was often able to observe the facial expressions of the patients as he operated. For the most part, they were expressionless faces and had most likely sat on his table many times before, but every so often he would cut a bit too deep and open a new wound, filled with nerve endings. I wondered if we were even helping when all we seemed to be doing was creating another area for infection. I still marvel at how much trust and patience everyone had as the inexperienced American nursing student tried to help them.

I pulled my bike up the stairs to the Mother Theresa hospice as the sun rose on the ghats one morning, casting its glow on each step and all the people gathered to give morning puja (prayer). With only two hours before yoga class, I was eager to find a Sister to put me to work and knew that when I entered the large stone building much of it would have already been

finished. I had only to clean the beds, lay the urine-soaked quilts out on the roof from the night before and help with feeding before I could assist Sister Rosemary as she brought her medical kit around the hospice. After a few weeks, I was able to administer care as well.

Once, I followed her to where a thin woman with a bandage wrapped around her head was sitting and she asked me to hold her box of bandages while she worked. I watched as she unwrapped the gauze unveiling a lump on the woman's head and another small piece of gauze laying on top of sparse hair. As we sat in the open courtyard, women were washing dishes, painting toenails and swatting flies. Down below the men sang and splashing water could be heard as they cleaned the floor. A merciful breeze floated down from the roof and rustled the canopy of leaves over the courtyard providing a little relief from the sun on my back and thick smell of iodine and infection. I felt a bit woozy to begin with, but I was completely unprepared for what happened next. Sister Rosemary clamped her metal forceps over the piece of gauze damply stuck to the woman's head and lifted it up. As she pulled, I could feel my stomach turn and my knees begin to fail me. The gauze continued to lengthen and the lump grew smaller as she pulled what I assumed was packing out of a rather large, oozing hole within the woman's scalp. Since no one at the hospice spoke English and I did not want to bother anyone with my endless questions, I never really found out the specific reasons the women were there. In this particular case I remember hearing something about a dog attack, but could be mistaken.

While the tireless work of the Mother Theresa nuns is inspiring, perhaps the most amazing part of their ministry the way in which every volunteer finding themselves at their doorstep is welcomed with open arms. The volunteers are both long-standing community members and foreigners passing through on a weekend vacation. Some are doctors, some are housewives, and some just know how to play the guitar. There is a place for everyone to help just as there is a place for anyone who needs it and many times, it is the patients who live there that help each other the most and who really run the show.

INITIAL FINDINGS:

* Name has been changed

Upon interviewing various Indian women in the health care profession about what they thought the greatest health concern for women in India was, I received a range of answers

varying from specific diseases to larger faults in the societal structure. These are a few responses: Auntiji*, a self-trained rural health care worker in the Assi and Nagua communities of Varanasi, felt that the main reason for women's illness is that they don't get enough nutritious food at home. "They also don't have the time to take care of their health," she told me in a translated interview, "their houses are not clean and they have to sleep there. Most of the time they have to work outside all day and when they get back, they don't have enough food, time, or energy to take care of themselves.

"Women get so tired when they come home from work and then have to work more. They only think about the children and their husband. This is the main reason for the sickness."

One privately practicing female gynecologist I interviewed believed that on the surface, the main health problem among women is pelvic inflammatory disease because of unsanitary conditions. But in her eyes, lack of education is the root of the cause.

Another 'female doctor' employed at Banares Hindu University (BHU) felt the biggest health problem that women face here is unsupervised deliveries and social dependence. "The women just don't have any say in the family, no power in deciding if they want to limit pregnancies, utilize family planning or even decide what doctor they want to go to. If the husband or mother-in-law says they should have the baby at home, then they have the baby at home."

I received these and many other reasons why the health status of women in India is so poor, but the fact is that all methods of oppression women face are so deeply integrated into their daily lives that it is impossible to separate or identify one single cause without acknowledging the others. I went to India intending to study the health problems and issues surrounding health problems that Indian women encounter, but instead found that writing a paper solely addressing the health aspects of women in India was impossible. The illness is only a physical manifestation of the unhealthy environment in which many of these women subsist.

POVERTY AS A HEALTH RISK:

Doctor and cultural anthropologist Paul Farmer states in his book Infections and Inequalities: the Modern Plagues that poverty, above all else, is the biggest health risk for women. He wrote that the reason why diseases exist in some parts of the world and not others is more

aptly attributed to socioeconomic status rather than to climate or region. My findings only reinforce that poverty, among many other things, is a major determining factor in the health and well-being of women in India. An Indian woman living in poverty often doesn't know where her child's next meal will come from. She has no other choice but to work all day and then come home to care for her husband, his extended family, and her children. What earnings she does make, her husband might spend on alcohol or gambling and when all is said and done, she has little energy to spend on herself. When she doesn't have the knowledge or means of acquiring adequate contraception, clean water, or healthcare, her own health is one of the lowest items on her list of worries and unfortunately, undernourishment is one of the primary health concerns among lower-class Indian women even today. One female gynecologist at a local hospital reported that most of the pregnant women she examines suffer from anemia due to undernourishment. With fertility rates high and nutrient intake minimal among lower class women, maternal anemia and small maternal body size are major risk factors of pregnancy and childbirth.

When I talked with another female gynecologist about women's nutrition in India she told me that it used to be that girl babies were severely undernourished in comparison with boy babies. Families would save the ghee (purified butter) and other nutritious things only for male children. Even as a daughter in a comparatively more affluent family, the doctor had not been exempt from this treatment. But she was an assertive child and whatever her parents wouldn't give she would just take for herself. In most households, the women do the cooking and feed the men first, then they take the leftovers; which I experienced even in the family that I stayed with. The situation is improving overall, but even the work of women's organizations has barely touched the country's strong preference for male babies. This is largely because males are still given the responsibility of being primary breadwinners and inheritors, providing for their parents in old age, and lighting the fires on their fathers' funeral pyres.

Because of this gender preference as well as many other reasons, the male/female ratio is on average, 927 girls to every 1000 boys based on the 2001 Census figures, and the gap continues to increase every year. Malnourishment, abuse of the elderly, sex-specific abortion, and female infanticide are just a few of the reasons why fewer and fewer females are surviving being born

into Indian society. Female infanticide and female abortion are still practiced at a rate that may soon top China's despite government efforts and NGO (non-governmental organizagion) work.

The 1994 law banning all sex-determination tests has been weakly enforced and is available almost exclusively to upper class women. For the lower classes, female infanticide has been the fallback method. Health experts say that even rising educational levels have not decreased the rate of sex determination tests and it is actually the rich that are creating the highest demand for them. Easily accessible technology, poor implementation of laws and the new middle class consumer mind set have "trapped even the educated element" according to Sushma Swaraj, Union Health Minister. A 2003 "India Today" article reported that the effects of these current trends could have serious consequences especially for India's population stabilization program which requires a balanced gender ratio and a limit on the number of children born every year. This might put even more pressure on parents to produce a son, but population growth is a huge problem that needs to be put in check as well. "It is a major social flaw in a society that claims to have made progressive strides....Female feticide will disempower Indian women. As sociologists stress, it is only empowered women who raise similar children and nurture strong families. Fewer girls will also mean that their childhood, their marriage and their future will come under a variety of social and physical threats, where only those who have power, wealth, influence and are male will dictate their choices in life" (India Today). India's missing girl population is a frightening reality and everywhere the result is readily apparent, but it is most clearly visible on the streets.

One of the first things I noticed upon arriving in India was the scarcity of other women out in public. As a white female, I felt so alone and even threatened at times in the midst of so many men. There are very few women out on the street during the day, even fewer out at night, and virtually none traveling alone. Women are usually discouraged from leaving the house after dark, but being a student and a foreigner, I was often caught out in late-night traffic going to and from lessons and performances. After the first attempt at coming home from a flute lesson after dark, I soon understood why my Indian sisters stayed behind their iron gates and deadbolt locks.

Public places seem to be free reign for any male to assert his hormonal urges and ample opportunity to validate his masculinity by violating any female who is not accompanied by a man. Through a series of ridiculous, absurd and perverted actions he can vent his sexual frustration and prove to himself that yes, he is male. Boys on bikes swerve and gesture, men stand in front of

shops to leer and occasionally call out, and sometimes in heavy traffic, there's no way to tell who grabs who and nothing one could do about it in any case. Some women have so much frustration built up that they outright slap the perpetrator, attempting to retaliate for the humiliation and violation. But little else is done about sexual harassment. It seems to be the case in India, as in countless other countries, that when dealing with abuse or violence against women it is the women who are blamed and who even blame themselves for encouraging it. Responsibility is placed on women to prevent, defend themselves from, and deal with sexual harassment. Indeed, the open streets are a frightening place if you're female, but the most shocking and terrifying acts of violence occur behind closed doors.

'Dowry deaths,' one of the most horrifying forms of domestic abuse, is a result of what happens when a once well-meaning practice becomes corrupted and the meaning of dowry today is a far cry from what it was originally intended to be. Girls are still looked upon as burdens or pieces of property (a liability that has to be unloaded for a price) passing from one family to the next. An Indian woman really doesn't have anything to offer her husband's family except a dowry compensation consisting of possessions ranging anywhere from large sums of money, to appliances and TV's, and in some cases, motorcycles or cars. Men that are well off or are educated often demand even higher dowries, sending a bride's family deep into debt sometimes for the rest of their lives.

Most deaths among new Indian brides may be associated with dowries that the in-laws deem as insufficient, thus coining the name 'dowry death.' The deaths are routinely blamed on 'stove accidents' or suicides, but such large numbers of similar occurrences suggest differently. A little kerosene and a match is all that is needed to start a woman's long hair and saree on fire, after that, very few survive. Those that do survive wish they were dead and police say that the low survival rate helps to make the practice a popular form of murder.

There have been many differing reports on the statistics of dowry deaths including one from *Time* magazine which said that the number has increased from 400 deaths a year in the 1980's to close to 6,000 deaths a year in the 1990's. Some groups claim that the number is rising because more cases are being reported due to the increased activity of women's organizations, but others still insist that the increasing importance placed on dowry is causing more deaths.

In 1995, India's National Crime Bureau reported approximately 6,000 dowry deaths a year and a police report from 1997 states that dowry deaths had risen by 170 percent. But one article written by Himendra Thakur in 1999 estimated 25,000 deaths every year with many more left unaccounted for (Hitchcock, wsws.org). In 1961, anti-dowry laws were enacted but not enforced, and it was not until 1983 that domestic violence became punishable by law. But in actuality, the laws have done very little to deal with the issue of dowry or dowry-related violence since women often times do not feel as if they can go to the police, who have a history of turning their heads when confronted with violence against women.

Dowry was originally seen as a way to help a couple start a new life by collecting wedding gifts but now, it has become more of a way for the groom's family to elevate its economic status and is another form of women's oppression. Some liberal families have resisted societal pressures and do not demand dowries any more with the belief that the value lies within the woman. One can only hope this will be an ongoing movement in the future.

Many of the women I talked with, young and old alike, felt that if a woman accepts her place in the home, stays quiet even if she is unhappy or if she is treated badly, and "worships her husband like a god," she will soon know the happiness of raising a family. Surprisingly, many women eventually resign themselves to their position as housewife and find contentment. As one young Indian woman put it, "for women in India, ignorance is bliss" and many relationships exemplify the phrase 'blind devotion.' If Indian wives do not have anyone else to compare their husbands to, they are convinced that he is the best. Many women feel that since their husband provides for them, they are duty-bound to love him, an idea very different from the Western ideal of passionate, romanticized love relationships. Moreover, these women are aware that most often the best option is simply to adjust to their new life as there is a great stigma against a divorced woman. She will be blamed or perhaps called 'crazy' if the marital bond is severed or even if there is apparent marital tension.

GETTING HEALTH CARE/FINDING PATIENTS:

Varanasi is divided into specific communities and depending on which one a person is from and what last name they have, it is easy to recognize what caste they belong to and therefore distinguish approximate familial affluence as well. The Assi and Nagua communities where I

worked were associated with the lower classes and communities such as these seldom have access to health care, let alone affordable and quality health care. The services that are available are difficult for women to utilize. Even with a free clinic at BHU hospital, most women don't go there for treatment or to deliver their babies. One of the reasons for this could be the absence of decision-making power in a woman's life.

Either her husband or her mother-in-law decides if she needs treatment, where she should go, and what kind of treatment she should receive. One problem here is the considerable knowledge gap between the mother-in-law's generation and current medical knowledge. While a mother-in-law may know more traditional forms of medicine, she is most likely uneducated and not up to date with emerging technology and new information. Other reasons women don't go to free medical facilities could be because of lack of education and also because of sexism and discrimination within the hospitals themselves. In Varanasi, most of the Nagua women prefer to be treated by Auntiji rather than go to the free clinic at BHU. In Auntiji's own words:

"(translated) Mostly the women want me to treat them. When I take them to the hospital it's because they don't have any knowledge about how to go to a check-up or how to visit a doctor. I explain things to them and help them go to the hospital. Very few women can go without permission from their husband or family. Usually the women first come to me; they don't need to get permission for that. I give them the information about the illness or tell them where to go and what doctor is best for them."

A female gynecologist at BHU told me that usually a woman holds no power in the family. It is not uncommon for a new wife to be treated like a slave in her husband's home, often suffering abuse from other female family members and made to cook and clean for the entire family. She is confined to the house for much of the time and must give up her social and personal life in order to care for her new in-laws. If her husband's mother decides she should have ten children, there is little she can do about it and the effects of repeated pregnancies, constant nursing and caring for children, extended family and husband take a huge toll on a woman's body. Between home and family responsibilities, illiteracy, and lack of decision-making power about when and where a woman can receive health care, lower-class Indian women often don't receive the health care they need.

For these women, it is not only difficult to find health care, but it is also difficult from the other end of the spectrum as health-care providers must go the extra mile just to find women to give health care to. Whether operating independently or within an organization, knowledge of female health care practitioners seems to spread most effectively by word of mouth. But for many reasons, even then, women will not come forward to ask for help; they need someone who will reach out to them. Auntiji's work is exactly that.

AUNTI JI:

Even though she has no formal training and often claims to have very little knowledge, she is a dedicated woman with a big heart and unbending constitution. She can be seen walking through the streets with her umbrella in the late-morning sun and no matter what problems appear in her life or how she is feeling, she never misses her biweekly walk through the Assi and Nagua communities along the Ganges River to check on the women. She is the bridge that connects available medical care and information with the women who need it. I was able to accompany her most mornings and in order to reach these women and their families, we would walk through the back streets, along the river bank, through fields and even climb over brick walls, Auntiji in her saree and sandals.

Auntiji began her work seven years ago after her husband died of Tuberculosis and now supports the two sons she adopted from the community, one whose mother died while giving birth to him. Since she began, she has vaccinated many of the local children for TB and Hepatitis and continues to reach out to increasing numbers of lower-class families. Her time is spent gathering information from the families, counseling, advising and educating them on health matters, and making sure that their prescriptions and treatment are followed accurately. Auntiji says that unless someone's condition is serious, they generally do not come to her; she has to go ask about their health. When women do come to her, it is usually only to ask for medicine and if she is to find out about the nature of their problems, it is only after examining them that they open up to her.

> "(translated) They just come and ask for medicine and don't tell. That's why I need to talk a lot with the women and ask about everything in detail. I first examine them to find out what problems there are. Then I ask the women and they tell me everything. I spend a

long time listening very carefully to them; as much time as it takes. I have to speak softly with every woman."

She is an insider and female, two attributes that work to her advantage in a society where women will not talk about their health problems in the presence of a man. The women know when she comes around and they do not hesitate to grab her attention for a few minutes to share anything from local gossip to introducing a friend who needs help. But her well-established trust with the community was not easy to come by. It was only after talking with many of the women, sharing the story of how she suffered and listening to their stories that she was able to begin helping them. Although she maintains a good relationship with the families in the community, sometimes she needs to take the initiative when it comes to the health and well being of children. In the poorer areas of the city often times both parents are required to work outside the home and many young children end up fending for themselves during the day. Auntiji waits until the parents leave for work and then goes into the house to clean up the children and if needed, take them to the hospital.

Other female health care practitioners also employ some covert ways of finding and caring for their patients, such as one woman who would wait outside Durga temple to see if she could spot any families with mentally handicapped children. When she found one, she would follow the family home to see where they took the child and then would pursue the situation from there. For other doctors, a more indirect approach to persuading women is frequently more effective than a straightforward explanation for instance, when educating Muslim women about contraceptive use, one particular doctor realized that if she wanted to sway a woman towards using a contraceptive, she would have to convince her of its appeal. She said that the Islamic religion pushes women to have more and more children and if you try to tell a woman that one child will be far easier to afford an education for than fifteen, she will just tell you that her religion says to have many children and will not understand the benefit of a smaller family; i.e. that fewer children will ultimately help India to rise out of poverty. So instead the doctor might tell this woman; "Fifteen children? Oh, you'll [look] very old by the time you're thirty" and the patient's immediate response might change to "oh, doctor, what can you do to prevent this?"

KARMA:

Other Indians use religion to explain issues such as poverty, mental retardation and leprosy, passing these off as 'bad karma' or the consequences of wrongdoing in a past life manifesting in this life. Approximately 70 % of India's population is Hindu, 23% Muslim, and the remaining population is a combination of Buddhists, Christians, Jains and many other religions. The concept of karma is of Hindu origin and maintains the idea that people deserve what they are getting and are being punished or rewarded according to the way they lived earlier in this life or in past lives; if they live this life well, they will be rewarded after reincarnation. This method of thinking contributes to the current health status of people living in poverty, aiding in relieving members of the upper classes from a sense of responsibility for the poor and also creating a certain resignation and even helplessness among the poor people themselves. They feel that they have no control over their lives and their only choice is to make the most of their current condition. This perpetuates the notion that poverty is a private affair and also that mental retardation and leprosy are simply byproducts of bad personal choices.

LITTLE KNOWLEDGE OF BODY: PID

One of the foremost gynecological problems that poor women in Varanasi suffer from is Pelvic Inflammatory Disease (PID) caused by unsanitary conditions and lack of knowledge regarding adequate personal hygiene. A woman is particularly at risk during menstruation because she will "use anything to stop the bleeding." It is difficult when women know so little about the natural functions of their bodies; menarche, menopause, pregnancy, family planning, puberty, sexual urges, or about physical and emotional changes. The lack of knowledge transfer between generations is in part because women in poverty do not have access to the sources of medical knowledge but also because mothers are uncomfortable talking to their daughters regarding these issues. Instead, girls learn from the media, from friends and from school; girls who have a higher education and are exposed to some health classes also have a heightened sense of bodily respect and awareness. But even then, the health classes provide rather minimal information and even a university education doesn't guarantee safety from the consequences of insufficient knowledge.

In a conversation with a female gynecologist in Varanasi, I was told about a woman who was 'forcefully taken' by her husband upon the first night of their marriage and who then became pregnant. Although the percentage of Indian women who remain abstinent until marriage has declined significantly over the past few decades due to modernization and western influence, a large number still have no idea what to expect on their wedding night. This woman was so traumatized by the experience that it was impossible for doctors to examine her and they even had to perform a Caesarian section when it came time for the delivery of her baby. This woman had earned her PhD from the university, which alone qualifies her as one of the few people in the world to have that much education regardless of gender. Yet the culture dictates that while a woman can earn her doctorate, it is taboo for her to hold a conversation with her own mother about the experiences in a woman's life. Sadly, her experience is not uncommon among Indian women, and the consequences resulting from generations upon generations of silent mothers and fathers are far-reaching and long lasting. By simply shifting the focus of education to include more health and sex-related topics, many of these situations could be prevented.

This would require early education of girls as well as boys. But in order to make any impact, it would also mean that first; more children need to be attending school regularly and second, that the principals of those schools recognize the necessity in teaching children, especially girls, about normal body physiology. Only then could a sense of respect for their own bodies as well as each other's bodies be instilled. The importance of women doctors providing such education should be at the forefront of education because given India's traditional cultural values regarding such topics, regular teachers cannot be relied upon to provide the information objectively even if they receive teachers seminars in preparation.

EDUCATION:

I was privileged to meet one doctor in Varanasi who had established a hospital to help those in need. He organized aid to children, lepers, sex workers and those suffering from mental disability. His hospital set up schools, clinics, and other educational programs all needing volunteers and so a few other students and I showed up on his doorstep one afternoon to give our time and abilities to helping in whatever way we could. I ended up teaching at a small school for underprivileged children in the Gangotri area and created a full-day class on hygiene complete

with songs, games, dances, and relay races involving good hygiene practices. There was no lack of enthusiasm, participation or want of materials, and I only ran into a few cultural differences.

Schools like Gangotri are a gift to the community and a gift to India because education is one angle at which women can be empowered and can make a difference. First they are the students, then they are the teachers, they are the care givers, they are the organizers, they are mothers. And if these small organizations are making such a difference, imagine if the government gave full support to educational programs, especially to women's education. Even if the government has not been successful in implementing women's programs, the grass-roots organizations, NGO's and the women themselves are the real power force behind this movement. Women's programs are at an all time high and because of incredible dedication and vision, women in the upper classes are experiencing more freedom than ever before. These programs are also helping disadvantaged women and creating consciousness about women's status and rights. All over India, women are quickly rising to new levels in every profession. They are even exceeding the capacities of their male co-workers and female students at BHU are now surpassing boys in every subject.

It used to be that if a woman was working, it was because her husband failed to make enough money for her to be able to stay home and enjoy the idleness of prosperity. But now, many women are working and are enjoying their jobs. Parent's ideas are changing and they are taking pride in their daughters' education. If you take a look at any Sunday personal ad. section of a Hindustani newspaper, you'll find that educated women are in high demand. But regardless of the existing desire to educate their girls, Indian girls increasingly entering the educational system could mean the end of some of the very ideals India holds dear.

India has a long and glorious history, and its cultural values are something which its citizens take pride in. Many would argue that because India has a much lower divorce rate than the United States, that Indians have higher ethical standards. The strong cultural emphasis on familial stability is one reason India could be viewed as morally superior, but now that women are just beginning to understand their rights as citizens, they are putting off family life until later and opting for an education in pursuit of their own dreams. Educated women also tend to be less inclined to remain in bad marriages. As more and more girls are advancing in education, many people associate it with the increasing divorce rate and the dawn of the infamous 'Delhi girl,'

identified by her disobedience, pursuit of freedom, and attraction to alcohol and dancing. But these fads could just as easily be associated with globalization and western influence and only time will tell if they are more permanent additions to Indian society.

While women's liberation could be detrimental to the well-established Indian values in the long run, wasting intelligent minds by keeping women bent over the stove does far greater damage for both short and long term national development than any amount of well-behaved girls could ever compensate for. Furthermore, nothing compensates for the damage created in the lives of the women themselves.

MODERNIZATION / INDUSTRIALIZATION:

Both modernization and traditional views in Indian society increase women's dependency on men. As India continues to grow and become a more significant world competitor, development encroaches on women's livelihoods and poverty, exploitation, and environmental degradation impact the health and well being of women and children as well (Kim et al. 2000). Trying to survive among urban poor is much harsher and much more difficult when families have to leave the countryside in search of jobs in the city.

Although development has its benefits, it still hurts women in poor countries all over the world. Industrialization cuts women off from access to the land, creates more work for women to do when husbands leave to find work in the cities and one income is no longer sufficient to support the family. Families then need to work to be able to afford the food and medicines they once grew independently and because generally women do not have the same training or education as men, women become increasingly dependant. Due to rapid urban growth, the number of single-mother rural households is rising while family income continues to drop.

INDIAN GOVERNMENT:

A wide variety of women's initiatives could benefit greatly from aid provided by the Indian government. In recent years, the programs designed to promote health were well thought out and had great potential to impact society if it were not for poor implementation. Motivation and resources are also abundant, but the organization and distribution fall short in so many ways. The original philosophies of dowry, the caste system, and the Indian government as a whole were