NÄ SHARIRAM NÄDHI, MY BODY IS MINE: THE URBAN WOMEN'S HEALTH MOVEMENT IN INDIA AND ITS NEGOTIATION OF MODERNITY

KALPANA RAM
Research Fellow, Anthropology, School of Behavioural Sciences, Macquarie University, Sydney, NSW 2109, Australia

Synopsis — This article explores the Indian women’s health movement for productive insights into current debates on the “travelling” meanings of modernity. Taking the feminist demand for bodily autonomy as a starting point for the exploration, the article traces the trajectories described by some of modernity’s central concepts: choice, freedom, autonomy, rights, and [developmental versions of] progress. The journeys described here take place not only between the “global” and the “local,” but between metropole and colony in the colonial period, and between the nation-state and the women’s movement in the postcolonial period. As the case example of the controversy over amniocentesis (used in India in the identification and abortion of female foetuses) illustrates, terms such as choice and development have become central to contestations between the women’s movement, the state, and the professional middle classes. © 1999 Elsevier Science Ltd

INTRODUCTION

Perhaps because it is so closely connected to Western ideologies of universal development, modernity serves ill as an analytic tool for grasping European expansion, most of all from the vantage of the colonized. Still . . . the term itself has come to circulate, almost world-wide, as a metaphor of new means and ends, of new materialities and meanings. As a (more-or-less) pliable sign, it attracts different referents, and different values, wherever it happens to land. But everywhere it speaks of great transformations that have re-shaped social and economic relations on a global scale; transformations, indeed, that have made the very idea of the “global” thinkable in the first place. (Comaroff & Comaroff, 1993, pp. xii–xiii)

Nä Shariram Nädhi: the title of this article comes from a women’s health manual by Sabala and Kranti (1995). The manual is based on an innovative programme in training women in self-help techniques. Like the programme itself, the language of the title builds on more than a decade of campaigns and publications by women’s health groups in India. These publications include Hamara Sharir, Hamara Haqq [Our Bodies, Our Rights] (Virdi, 1986); In Search of Our Bodies. A Feminist View of Women, Health and Reproduction in India (Bhate et al., 1987); Sharir Ki Jankari [Knowing Our Bodies] by the Women’s Development Program Workers of Rajasthan (1989); and Our Lives, Our Health (Karkal, 1995).

It is to this language of asserting a claim or a quest of reclamation over one’s body that I
wish to draw initial attention. The feminist language of reclaiming one’s body sounds universalist in its scope (all women everywhere are entitled to their bodies), as well as transnational in its usage. The Indian titles would seem familiar to any member of an international feminist audience. To an Indian immigrant woman like myself, who has followed the Indian women’s movement with a sense of personal affiliation, it resonates easily with slogans shouted in the 1970s, during the early marches of the Sydney women’s movement (“Not the Church, not the State, women must decide their fate”). The transnationality of the demand for female bodily autonomy seems, at first glance, then, to deny both the displacements of migration, and the cleavages of cultural difference, in favour of confirming a certain embodied continuity within the transnational culture of the women’s movement itself.

In part, this transnationality is the effect of a common heritage of practices and texts which circulate among feminist audiences and practitioners. Sabala and Kranti, authors of My Body Is Mine, themselves hark back to a time in the 1980s when reading the Boston Women’s Health Collective’s (1973) manual, Our Bodies Ourselves (now available in at least three Indian languages), was an important phase in their questioning of their hitherto exclusively Left perspective (Sabala & Kranti, 1995, p. 1).

However, inside the cover page the reader finds a note from the authors:

Nā Shariram Nādiḥ!—My Body is Mine are words of the participant women in this self-help training. They express their right over their bodies and the need for control over their lives. We cautioned them that, saying it like this, it can be misunderstood as being individualistic. But the women were very clear. They said “To bring about a broader change, we have to begin with ourselves.” The title speaks of our identity and our politicism. (Sabala & Kranti, 1995, inside cover page)

The reviewer (whose comments are reprinted on the back cover of the book), is a member of the nongovernment health network known as Medico Friend Circle. She also feels the need to remark on the the title:

“My body is mine” is a dignified yet humble proclamation, not meant to demonstrate individualism, or imperialist control of brain over body. The body once considered a seat of helplessness and shame becomes a source of pride and pleasure. (Gupte, in Sabala & Kranti, 1995, back cover)

The editors and the reviewers are evidently acutely aware of the possible divergent interpretations that readers may place around the central concept of “rights.” They are concerned with pre-empting some of these interpretations. In particular, they wish to pre-empt individualistic interpretations of rights over one’s body. Equally, they warn us against conflating their notion of the relation between self and body with any formulation that is predicated on the psychic economy of an active subject–mind reclaiming an inert object–body. It is further emphasised for the benefit of the readers that it was the poor women who participated in the programme who insisted on the language of the title, overriding the hesitations of the middle-class organisers.

In the one self-help programme, we are dealing with the interactions between urban, middle-class feminists, staff members of nongovernment organisations engaged in interventions in health, literacy, and development programmes in rural areas and the dalit1 and tribal women who are the focus of these diverse programmes and interventions. The ranks of the nongovernment organisations include a diverse range of rural-based lower middle-class intellectuals2 who recruit a social strata of “animators” from among village women. In this particular sociological combination of women from different social strata, and in the “mix” of meanings they collectively bring to bear on discourses that are largely pregiven, we can glimpse already the complexity of the “local” and the “modern.” A global discourse of socialist political economy is employed in critique of the inequalities in the distribution of resources. However, when it comes to discussing the categories of women most disadvantaged by this maldistribution, the language of class is modified and replaced by local categories: women are described, not as “working class,” but as “dalit” and “tribal.” The categories are created by the admixture of class with caste and by the marginalisation of those nonagrarian, “tribal” modes of production, which give India some of its specificity for political activists such as Sabala and Kranti.
Furthermore, each of the social classes and groups involved in an experiment like the self-help health programme are articulating different negotiations with modernity. I have written elsewhere on the embodied experience of modernity among women of the labouring poor, with particular reference to the medicalisation of childbirth. The focus of this article will be on the urban, middle-class feminists in the health movement. I turn to the complexities of their discourse after a preliminary consideration of the framework within which I wish to situate my account of the women’s health movement.

THE HISTORICAL POLITICS OF RECLAIMING THE FEMALE BODY

The transnational resonances of the claims to rights over one’s body obscure the fact that this project has also proved to be the site of some of the most powerful controversies that have challenged the internationalist thrust of the women’s movement. Western feminist formulations on abortion, contraception, and reproductive rights have been sharply repudiated by women from the labouring poor all over the world, as they highlight divergences in the politics of reproductive embodiment. Here I consider the divergent politics around the issue of amniocentesis—controversial in the United States with respect to its routine application in the detection of genetic foetal abnormalities, it is the target of the Indian women’s movement for quite different reasons. Here it is used to detect the sex of the unborn child, so that couples may abort the female foetus.

Such contemporary divergences in body politics between “West” and “India” are only the latest manifestation of a complex colonial history that links “the West” to “the colonies,” as well as allocating vastly different and unequal places to each. In this paper I wish to adapt to the study of feminism in postcolonial India, the striking thesis put forward by Chatterjee (1986) in his characterisation of Indian nationalism. Chatterjee denies that Indian nationalism is a completely independent and autonomous discourse. To suggest this is to disregard the realities of colonial domination itself. Indian nationalists adopted many features of colonial discourse, including characterisations of the Indian tradition as one in need of reform and re-constitution. However, Chatterjee is able to demonstrate, equally forcefully, the resistant qualities of Indian nationalism. Colonialist discourses, he argues, are modified and refashioned to provide the moral basis for nationalist struggle which is, by definition, anti-colonial.

In this article I apply his thesis to the historical emergence of an Indian feminist body politics. The politics of the Indian women’s health movement today is marked by the dominance of categories such as “tradition” and “modernity.” While it contests practices inscribed by both these registers, Indian feminism is unequivocally (as is Western feminism) a child of modernity. It therefore “talks back” much more vigorously to “tradition” than it does to the modern, and in ways that necessarily bear the mark of the colonial genealogies that lie behind the Indian modern.

Consider the following excerpts. The first comes from a feminist collection entitled In Search of Our Bodies: A Feminist Look at Women, Health, and Reproduction in India (Bhate et al., 1987), in a chapter entitled “Prisoners of the Courtyard” by Behal. The second comes from Dr. Katherine Vaughan, superintendent of the Jubilee Zenana Hospital in Srinagar in 1918:

(A) Childbirth in Karimpur village is subject to ritualistic and traditional priorities that are observed and followed with great care among women and the new mother herself. The latter, after giving birth to the child, is doomed to confinement in the same unventilated and dark quarter for the following ten days. . . . The placenta is dug in the doorstep of the new mother’s quarter and left to burn for a certain number of days. This is a ritualistic process to keep the evil spirits away, though the permeating smoke and fumes adds a greater hazard to the unventilated quarter, affecting the most decrepit and unhygienic condition that both mother and child have to live in. There have been instances of young mothers attempting to wash themselves or keep the baby away from too much handling by people. But she is invariably chided for going against conventional norms. (Behal, 1987, p. 28)

(B) A summons comes and we are told a woman is in labor. On arrival . . . we are taken into a small, dark and dirty room. On
the floor is the woman. With her are one or two dirty old women. Their clothes filthy . . . their heads alive with vermin. They explain that they are midwives . . . and they cannot get the child out. On inspection we find the vulva swollen and torn. (Victoria Memorial Scholarship Fund Report: Improvement of the Conditions of Childbirth in India, 1918, Calcutta, cited in Shetty, 1994, p. 199)

However, to represent the relationship between these excerpts as one of straightforward continuity is to omit nothing less than the complex and distinctive version of Indian modernity, born in this very interaction between colonialism and nationalism. This history, and the institutionalisation of aspects of this history in the form of the Indian nation-state, form the preconditions for the emergence of Indian feminism.

The first half of this article traces one way in which we can historically situate Indian feminist demands for reclaiming one’s body within the broader framework of the emergence of modernity and a modern body politic in India from the late 19th century onward. The second half of this article explores the postcolonial complexities of modernity, as key terms such as choice, autonomy, and freedom are taken up and given different meanings by the postcolonial state, and by different social groups. Indian feminism situates itself through such contestations, pitting its interpretations against those of the Indian state, as well as against the powerful “double articulation” that defines ideologies such as “son preference”: the articulation of the politics of kinship with the politics of state population control programmes and the modern medical profession.

THE LINKING OF FEMALE HEALTH WITH FEMALE UNFREEDOM: COLONIAL LEGACIES

We may trace the articulation of a critical discourse on Indian women’s health conditions to white women professionals in particular. As compared with the colonial state’s general neglect of the health needs of the population (Arnold, 1988, 1993), white women physicians exhibited considerable zeal in voicing, in the words of Dr. Mary Scharlieb, a lecturer on midwifery and diseases of women at University of Madras at the turn of the century, the needs of “anaemic mothers and starved infants” (Shetty, 1994, p. 193). Their main targets were the incompetence of local midwives, and the lack of hygiene in childbirth, linked to the general characterisations of female seclusion in colonial India (Engels, 1996; Shetty, 1994). Shetty argues that white women took gynaecological health as their own peculiar domain of responsibility, as the “white woman’s burden” within the imperial economy (Shetty, 1994, pp. 193–194). In doing so they at once articulated an identification with the plight of Indian women, carved out a professional niche unavailable in the metropolis of Europe and England (where male physicians had displaced midwives and were opposing women’s entry into medicine), and simultaneously utilised the structure of colonial authority to carry their interventions into areas of social life hitherto little touched by colonialism. The emancipatory impulse cannot be separated from the establishment of relations of colonial and racial superiority.

Colonialist critiques particularly focused on the gender relations of the elites: such practices as female seclusion, child marriage, early sexual intercourse for girls, and practices to do with childbirth, such as the use of midwives. All these practices were indicted not only as so many forms of female unfreedom, but as fatal from a medical point of view. The cultural practices were linked directly with high rates of maternal mortality (Engels, 1996; Shetty, 1994).

As Chatterjee’s argument would suggest, elements of this critique were inherited by the nationalist movement. Social reform movements among male elites from the late 19th century onward, as well as among women’s organisations from the 1920s onward, also deployed medical arguments in order to reform child marriage and early sexual intercourse for girls:

the increased medical regulation of women’s bodies linked the habitus of the reforming middle classes, with their imagery of physical, social, and moral improvement, to wider ideologies that reflected the passive political revolution of the Indian National Congress (Whitehead, 1996, p. 190).

Although nationalists turned biomedical arguments against colonialism by characterising
foreign rule itself as unhealthy for Indians (Whitehead, 1996, p. 193). Gandhi was one of the few in the nationalist movement to reject biomedical regimes of truth as part of imperialism. Rejecting all lifestyles—traditional or modern—that did not permit subjects to cultivate moral agency through bodily self-regulation, Gandhi developed an indictment which was simultaneously directed at both biomedicine and such indigenous practices as child marriage (Alter, 1996). Nevertheless, Gandhi, too, subscribed to the centrality of scientific experiment and empirical experience as the road to truth (Alter, 1996).

The prestige of family planning technology as medical science fed into this particular brew of emancipatory rationalism. The Bhore Committee Report published in 1946, on the eve of independence, is considered a pioneering document. The report vividly brings together an indictment of female unfreedom with a rationalist scientific view of the reproductive body as a machine which can be more efficiently maintained with the application of contraceptive technology:

[Currently] children are born not as a creative evolutionary response to the vital urge, but as brittle, standardised products of a tired reproductive machinery automatically set in motion by the sexual act. The reproductive system has to be kept fresh and vitalised to respond creatively and must not therefore be subjected to that strain. (cited in Prakash, 1987, p. 32)

The very entry of Indian women into the discourse on Indian women’s health is shaped by colonialism and by class. The colonial regime sought out Indian women of a “better class” to be trained in medical science (Engels, 1996; Minocha, 1996). Such biases were justified as a form of deference to the seclusion norms of the elites. Elite women were supposed to be unreachable by medical science unless attended by other women, medically trained (Burton, 1995; Engels, 1996). Elite women who responded to this call for training were at once enabled by male social reformers, while having at the same time to face critical opposition from the spokesmen for caste orthodoxy and from male nationalists.

Shetty rightly finds the origins of Indian women’s “subject constitution” as professionals within the colonial network of secular and missionary women’s teaching hospitals, women’s wards of general hospitals, midwife training classes, maternity and welfare centers, health training schools, home-visiting activities by Health Visitors, exhibitions and conferences, and scholarship and aid funds (Shetty, 1994, p. 194).

The importance of medicine in shaping the emancipatory quests of Indian women such as Ananadibai, Rakmabai, and Pandita Ramabai who all went overseas in the late 19th century in search of medical training—not merely for their own advancement, but on behalf of Indian women—is now receiving the feminist attention it deserves (Burton, 1995; Chakravarty, 1996; Kosambi, 1996; Shetty, 1994). By the early 20th century, Indian women’s organisations subscribed to the prestigious biomedical health model along with associated international discourses such as racial eugenics. At the same time, women’s organisations did not merely reflect these wider ideologies, but also contributed a new set of agendas. The Women’s Indian Association (WIA) argued that women had to be educated in hygiene in order to train “the strong, great race of the future children of India” (Stri Dharma, WIA’s journal, cited in Whitehead, 1996, p. 196).

Women doctors, such as Dr. Muthulakshmi Reddy, were also prominent in the WIA. Dr. Reddy was the first female graduate of Madras Presidency and a President of the WIA in the 1930s, and along with Annie Besant and Saroj Nalini Dutt, deployed medical arguments to raise the age of consent and of marriage.

Middle-class women were again prominent in the establishment of nongovernment voluntary associations dedicated to family planning (Soonawalla, 1992). An examination of women’s political stances on birth control in early 20th-century Tamil Nadu, undertaken by Anandhi (in press), brings to light a spectrum of positions as wide ranging as was permitted within the class and caste coding of Indian nationalism. Thus women, like the men of their class, took on the neo-Malthusian attitudes characteristic of elites, viewing birth control as particularly necessary for the poor and ignorant. Women like Muthulakshmi Reddy and Annie Besant contributed to nationalist constructions of women as spiritual mothers of the nation and preferred Gandhian methods of self-control to the use of technology (Anandhi, in
press). However, organisations like the All-India Women’s Congress (AIWC) also opened up a space in which women were able to articulate female experience, and to introduce it as a legitimate and important point of reference in debates on birth control and population control.

It is in this general political context of strong contestation around issues of gender, female status, health, and population, that we begin to hear the language of “Nā Shariram Nādhi.” My body is mine, articulated in India for the first time. Kamaledevi Chattopadhyay, the first organising secretary of the AIWC and member of the Indian National Congress, argued for birth control and against male nationalist advocates of large families by urging “the sacred and inalienable right of every woman to possess the means to control her body and no God or man can attempt to deprive her of that right without perpetrating an outrage on womanhood” (cited in Anandhi, in press).

A historical perspective on the the language of female bodily autonomy is instructive not only for revealing the temporal depth and social complexity of the discourse in countries like India, but also for tempering modernity’s view of itself as an emancipation from the evils of tradition. Relations of racial and class superiority mingled with the emancipatory. The language of inalienable female rights was a qualified one even when wrested from colonial and male definitions by Indian women’s organisations. Only married women were to have access to birth-control information, women’s rights were predominantly discussed as the rights of mothers, and most analysts of this period note the middle-class women’s distrust of women’s sexuality when exercised outside the confines of marriage and motherhood. Prostitutes and even the devadasis, women who had traditionally practiced dance and arts in the temples and courts of precolonial India, fell outside the scope of the nationalist women’s construction of female rights over one’s body (Anandhi, 1991; Kannabiran, 1995; Whitehead, 1996).

**THE POSTCOLONIAL STATE AND FAMILY PLANNING**

The Indian state was among the earliest, in its first Five Year Plan of 1951, to adopt family planning as state policy. The ground for this measure was evidently prepared before independence, in the course of the nationalist movement. It was a consequence in part of the paramount status of economic planning, nationalism’s response to the economic anarchy and exploitation which was regarded by nationalists as a hallmark of colonialism (Chatterjee, 1994). Population control was regarded as a crucial component of any attempt to rationally reallocate economic resources within the country. Equally significant in respect of the early adoption of family planning as state policy was the development we have just traced—the emergence of scientific medical discourse as one of the forms of scientific truth in terms of which Indian society’s shortcomings could be evaluated. These evaluations coalesced particularly around depictions of women’s dependency as “unfreedom.”

The postcolonial state’s discourses on demography and population yoked together the discourse on unfreedom and that of rational planning, reform, and progress. Contemporary demography seeks, all unconsciously it seems, to locate the determinants of “fertility profiles” and “reproductive careers” precisely in those aspects of social relations that were constituted as sites of unfreedom in the 19th and early 20th century: the low age of marriage, the lack of literacy and education, and purdah or norms of female seclusion. The 1981 census demonstrated to policy makers that 7% of women in the age group 10 to 14 years and 44% of women in the age group 15 to 19 years were married. The report of the Eighth Five Year Plan’s working group on family planning responded to these facts with a renewed call for changes in the social practices of early marriage, increased surveillance, and the selective use of “motivation” and “preferential treatment” for those who comply with the population goals of the state.7

In the original vision of the Nehruvian state, redistributive justice and planned development were meant to provide a broader material foundation on which to realise purely liberal individualistic notions of “choice.” The historical experience of the last 50 years, however, has shown that such expectations were not fulfilled. Developmental goals have been used, not to encourage a wide range of choices consistent with a liberal ideology, but rather to justify restrictions of choice.8 Over the years, the state, typically, has pushed only one technology at a time, moving from one to the next,
not on the basis of side effects experienced by the user, but rather on the basis of the reliability of the technology in carrying out population goals. There has been an overwhelming preference on the part of the state for methods which are not within the control of the individual user. Either the approved methods are irreversible—as with sterilisation—or they require dependence on medical personnel for insertion and removal, as with intrauterine device (IUDs) and hormonal implants. Incentives and annual targets, features of state policy since 1966, reached their apotheosis in the “Emergency” of 1975–1977, when the consequences of suspending civil liberties were notably realised in the forced sterilisation programmes directed at men of the poorer classes of northern India. The subsequent electoral rejection of both sterilisations and the Emergency persuaded the state to shift the burden imposed by population control policies to the more vulnerable category of women, particularly among the poor. Although the policies of the Emergency have been officially repudiated, it remains the case that the range of availability of methods other than sterilisation becomes severely restricted for the poorer classes (Narayana & Kantner, 1992; Ravindran, 1993).

Recently, in 1996, the Ministry of Health and Family Welfare has released a document entitled Manual on Target Free Approach in Family Welfare Programme (Ministry of Health and Family Welfare, 1996). It recommends a shift of approach. Rather than aiming at target fulfilment, the new approach emphasises the need to respond to the demand for quality services. However, the rationale for this change in policy—even if it were actually implemented—continues to be expressed in terms of the failure of the previous approach to meet the needs of population control. The kinds of criteria advanced by the nongovernment health movement, or by the women’s movement to which we now turn, continue to be ignored.

**THE WOMEN’S MOVEMENT AND THE POSTCOLONIAL STATE: THE “SECOND WAVE”**

As with many of the feminisms examined in this volume (see Kauanui, Marsh, and Ryang, in particular), the social imaginary of the Indian women’s movement has been intimately bound up with that of the nation (John, 1996a, p. 122ff): first with the nation in its incipient, anticolonial form, and then with the independent nation-state in all its historical vicissitudes. There are, undoubtedly, many significant differences between the first phase of the women’s movement and the second. The sexual and maternal morphology of the prototypic “Indian womanhood” of Indian nationalism is under increasing scrutiny from feminists. The exclusion of women who fall outside the bounds of elite models of marriage and maternity from the nationalist imaginary is the subject of considerable debate and re-evaluation (Anandhi, 1991, in press; Kannabiran, 1995; Srinivasan, 1984; Whitehead, 1996).

However, there are striking continuities between the politics of the first and the second wave, and they refer to the relationship between the women’s movement and the nation-state. Like the first wave, second-wave feminism continues to display an intimate association with the attempt to establish a viable and equitable nation-state. The critique of state development policies that was first enunciated in the 1970s by urban, middle-class feminists was based on the unrealised emancipatory promises of the state as the central agent of modernity in postcolonial India. The pioneering feminist report, *Towards Equality* raised the alarm about the worsening status of women in independent India (Committee on the Status of Women in India, 1974). Girls could anticipate a life expectancy that was lower than that enjoyed by boys, rates of female infant mortality were rising, while the work participation of women was declining. However, the critique of the state was based on requiring the state to act in consonance with its potential for delivering greater justice and equality for all (John, 1996a, 1996b). The feminist strategy has been a productive one. Not only was *Towards Equality* published by the Ministry of Education and Social Welfare in 1974, but by 1988, the government was openly acknowledging the importance of the feminist initiative in shifting state attitudes toward women and development. In her Preface to the report, the *National Perspective Plan for Women*, Margaret Alva, then Minister of State for Youth Affairs, Women and Child Development, singles out the Report of the Committee on the Status of Women in India as one of the “three important events [that] have influenced the status of
women in India.” The other two events she mentions are the United Nations Women’s Decade, and the “freedom movement,” that is the anticolonial struggle (Department of Women and Child Development, Ministry for Youth Affairs, Sports and Women and Child Development, 1988, p. i).

Such divergences between the state and the women’s movement as may be noted occur within this shared framework of modernity, testifying to the shifting nature of modernity itself. The feminist critique takes up key terms made available through a history of modernity which feminists have shared with the rest of the Indian middle class, but combines the elements differently, phrases questions differently, and has different strategic priorities.

In what follows, I wish to follow through more closely one strand of the women’s movement’s critique of state policy, in the area of family planning. My account will end with a brief case study of the public controversy over amniocentesis, taken as a telling contemporary instance of the contestation over the meanings of terms and concepts central to modernity.

Placing women at the centre of the agenda

The refusal of the women’s movement to place anything but women at the foreground of its concerns means that, unlike the state, it does not dilute its goals with other priorities, such as population control. This single-mindedness also allows the women’s movement to challenge patriarchal discourses on women in a way that the state has shown itself incapable and unwilling to carry through. This is particularly evident in the patriarchally central trope of women as mothers. Even the newer discourses of the state never quite expunge older nationalist figurations of women as mothers of the nation (Bagchi, 1990; Lakshmi, 1990). These older discourses constantly impinge on and subvert the intentions of newer state documents. Policy documents such as the National Perspective Plan for Women (Department of Women and Child Development, Ministry for Youth Affairs, Sports and Women and Child Development, 1988) can best be viewed as “compromise formations,” which attempt to encompass newer feminist discourses, but never succeed in repudiating a patriarchal imagination in which women are valuable primarily as mothers. In the following excerpt from this document, the language of women’s rights and women’s “control over their own bodies” is adopted (this itself is a tribute to the continuing pressure from women’s groups), but continues to mingle with the language expressive of women as heroic reproducers of the nation:

Recognising that the renewal of the human race is the unique contribution that women make at considerable personal cost, to the nation’s existence and productivity, it must be taken as a national obligation to ensure that the fulfilment of this role occurs with minimum personal risk to women’s lives and health. Control over reproduction is a basic right for all women, as this right forms an important basis for the enjoyment of other rights. (Department of Women and Child Development, Ministry for Youth Affairs, Sports and Women and Child Development, 1988, p. 105)

Feminist critiques, by contrast, are resolute in trying to widen the scope of the discourses on women and women’s bodies beyond an exclusive concern with mothering and reproduction. Indeed, just as nationalists pinpointed the presence of the British as itself a cause for ill health, feminist health activists point to the persistent reproduction of ideologies of maternalism in state policy as detrimental to women’s very survival. For example, Prakash (Bhate et al., 1987) objects strongly to the 1977 plan for Health Care Services in rural areas, which stresses the centrality of the selfless sacrifice of Indian mothers for their families and the importance of family and community welfare to development processes. To this Prakash responds:

And what is the nature of her sacrifices? It hardly needs to be enumerated—that she go hungry so as to be able to feed her children and menfolk of the family; that she work long, hard hours to make ends meet; that she bear child after child or accept the high levels of morbidity associated with every available method of family planning in the context of the current health care system; that she forego much-needed medical care because her sons or her husband need it more; that she be abused, beaten, bruised and burnt alive . . . all for the sake of the family. How can we ever hope that health policy will
pay attention to women’s health issues when it accepts implicitly, without question, and as unchanging, the very conditions which make for women’s low social and health status? (Prakash, 1987, p. 33)

The rejection of an exclusivist construction of women as mothers has been a preoccupation of the urban women’s movement in India. A special issue of the influential *Economic and Political Weekly* (1990) is devoted to deconstructing the motherhood myth, with special attention devoted to nationalist constructions of the nation as mother.

In the context of the health movement, the deconstruction of patriarchal maternalism has involved a deliberate effort to recontextualise reproductive health issues. Instead of assigning the responsibility for women’s health problems to their reproductive phase alone, these problems are attributed to the systematic neglect women experience at every phase of their life cycle. Girls are given fewer resources than boys: less food and meagre access to health care, both in terms of indigenous medicine and biomedicine (Gandhi & Shah, 1991, p. 102). The work done by girls within the home is further related to poor health. An enormous amount of documentation has gone into detailing the health hazards of domestic work—particularly the carcinogenic fuel that is burned while cooking over congested hearths, and the increased workload of gathering basic fuel and water as the environment deteriorates (Agarwal, 1986). Bhatt goes so far as to argue that accidents and infections, and “not the oft-touted problems of childbirth,” are far more dangerous killers of women, even during the reproductive years (Bhatt, 1987, p. 15). The infections she lists, such as tuberculosis, malaria, and respiratory diseases are not exclusive to women but have particularly disastrous consequences for them because of their already low-nutritional status (p. 15). Feminist campaigns on the problems of violence encountered by women within the family (Chatterjee, 1987; Gupte, 1987) have enabled a further erosion of patriarchal constructions of the family as the safest place for women.

Feminist health campaigns have moved easily between home and the wider world. The issue of broader environmental deterioration became a women’s issue with the Chipko movement against deforestation (Agarwal, 1992; Shiva, 1988). Equally, the continuities between the types of work performed within the home and the kind of work women perform in the vast “informal” sector has been illuminated by health campaigns which precipitated the Task Force on Health, set up in 1988 by the National Commission of Self Employed Women. As workers in the informal sector, women perform tasks which involve arduous repetitive movements in conditions that, by definition, are nonunionised and poorly paid (cf. also Chatterjee, 1987).

**A different handling of liberal choice and developmental imperatives**

Within the state-driven discourse on modernity, the twin discourses of developmentalism and liberalism are deployed in such a way that weaknesses in state policy can be papered over. Thus, developmentalist agendas, such as population control, are explained by demographers and population experts as “not working,” because the state’s commitment to liberal democratic values allows irresponsible “minorities” to subvert the rational plans of the state. On the other hand, suspensions and abrogations of liberal democratic values are typically explained in terms of the underdevelopment of the people (cf. Gandotra & Das, 1984; Narayana & Kantner, 1992; Soonawalla, 1992), whether this underdevelopment is conceived in economic terms or culturalist terms.

It is not necessary for feminist critique to devise wholly original discursive frameworks or to dispense altogether with the terminology of liberalism and developmentalism which characterises state discourses. It has been possible instead for feminist discourses to strategically exploit the internal tensions between liberalism and developmentalism. Such strategising is made possible by the existence of a larger moral vision, that of securing justice and emancipation for women. Most obviously, the state’s commitment to liberal notions of choice and rights affords ample opportunity for scrutinising the narrowing of meanings that has occurred with the implementation of developmentalist agendas. This commitment of the state to liberal values permits women’s groups to ask a range of pertinent questions which have the potential to be embarrassing. Does the state in fact offer poor women a choice that provides options other than sterilisation?
Does the state offer a choice as to whether it is women or men who undertake sterilisation? The state has been using poor women as a target for achieving its quotas ever since the popular rejection of the coercive methods used on poor men at the time of “Emergency” (Shatrughna, 1990). What choices do women have in the way that they are recruited for family planning? Both legal abortion and biomedically supervised childbirth taking place in primary health centres have become new sites for pressurising women to use sterilisation and birth control (Rao, 1994; Swaminathan, 1996) What choices do women exercise when even the much maligned midwife is recruited by the state as a conduit for the population-control programme (Gandhi & Shah, 1991)? What choices are available when women are recruited without their informed consent for the testing of contraceptives, such as long-lasting hormonal injectibles? What choices are made available in the provision of follow-up care, after invasive contraception or sterilisation has been implemented? Since informed consent is basic to the question of choice, how much and what kind of information is made available to women at each phase? A significant experiment was carried out in the 1980s by a women’s group while campaigning against the secrecy surrounding the trial usage of the injectible contraceptive Net-en. They found it enough to confine themselves to informing women volunteers about the experimental nature of the trials, after which most of the “volunteers” dropped out of the programme (Gandhi & Shah, 1991, p. 121).

In the hands of the state, the developmental agenda has come to be used in order to narrow the sphere of choice and freedom available for its citizen-subjects: targets and incentives, for example, radically redefine the meaning of terms like motivation to mean something located outside the choosing subject (Ram, forthcoming). However, in the hands of feminist groups, the developmentalist discourse retains its capacity to widen the liberal discourse on freedom and to provide a stronger material basis on which to realise these freedoms. Gupte finds state policy to be limited by a capitalist conceptualisation of freedom:

... in a “cafeteria approach” one can “choose” from amongst the available limited options. These options are seen as commodities and not as active decisions to be taken. (Gupte, 1987, p. 11)

Guided by a broader Left agenda, the women’s movement insists that unless the wider inequalities of gender and class are tackled, the concept of “choice” becomes watered down to the point of virtually eroding the distinction between choice and coercion. Instead of relinquishing liberal notions of participatory democracy and freedom, or seeing them as incompatible with developmental agendas of social reform and intervention, the women’s movement has consistently argued that these terms can only find their fuller meaning through this broader process of social transformation.

The example of amniocentesis

I will give one striking example to illustrate the range of manoeuvrings which are evident in contemporary India around the meaning of terms such as choice and freedom. This example comes from the controversy over the use of amniocentesis and abortion as a means of sex-selection directed against the birth of girls. The experiments in amniocentesis undertaken in 1975 by the All India Institute of Medical Sciences were intended for the detection of foetal abnormalities, but “most of the couples who learnt that the foetus was female went in for abortion” (Menon, 1996, p. 376). Efforts to ban the use of this technology in government institutions (by making the use of prenatal sex determination for the purposes of abortion a penal offence) resulted in the privatisation and commercialisation of sex determination clinics all over the country (Menon, 1996, p. 376). In the early 1980s, investigative journalism reported that between 1978 and 1982, around 78,000 female foetuses were aborted after amniocentesis and sex determination.11 Between 1986 and 1987, the numbers reported were between 30,000 and 50,000 (Arora, 1996). Despite legislation against the practice in the state of Maharashtra since 1987, and more recently, in Punjab, Haryana, and Rajasthan, the legislation seems full of loopholes and as a result, the practice continues (Arora, 1996, p. 420). Many doctors, influential members of the family-planning establishment, and many government officials have fostered an amazing and ingenious combination of the discourses of
developmentalism and liberalism in order to justify the abortion of female foetuses. Sex-selection, it has been argued, is an effective means of meeting the developmental goals of population control, of keeping down the absolute numbers. According to the Head of Obstetrics and Gynaecology at the Government General Hospital in Bokaro:

Our priority is population control by any means. Amniocentesis should be used as a method of family planning and should be made available to everyone at a minimum cost or even free. (cited in Menon, 1996, p. 377)

Previously, the value of son-preference set a problem for population control: People would keep having children until they came up with the desired son. Now, the technology of sex-selection has become a potential ally of “son preference” (Balasubrahmanyam, 1986, p. 67). Many doctors and intellectuals have found in the technology a means of marrying the concept of “choice” with the goals of rationally and economically planning the nation/family. At the level of the individual woman herself, it is argued, the technology allows greater choice and freedom. The woman, in this view, can now choose the sex of her next offspring, and free herself from unwanted pregnancies and superfluous children.

The hegemony of economics in the discourse of rational planning at the national level, is exploited to the full here to invoke the desirability of amniocentesis in the rational planning of one’s family. Now couples can choose not only the spacing and absolute numbers of their children, but also their sex. The provision of this opportunity was even described as a form of “quality control” (Arora, 1996, p. 422). Others have argued that it would be better to abort a girl foetus rather than to make a girl child endure a lifetime of abuse. Legislatively curbing the use of such technologies has become represented, therefore, as a curbing of women’s rights to reproductive control.

Feminist groups campaigning against pre-natal sex determination were joined in 1984 by civil liberties and health groups, to form a broad coalition known as the Forum Against Sex Determination and Sex Pre-Selection. Their responses entail mobilising the two kinds of feminist strategies outlined in more general terms earlier: first, restructuring the questions by placing women’s collective interests in the foreground; and second, expanding the scope of the term freedom. Feminists have responded to populationist arguments by interrogating them from the viewpoint of women’s interests. A policy that controlled total population at the expense of the population of girl children offered no sort of service to women.

In response to their opponents’ idiosyncratic appeals to “freedom” and “choice,” women’s groups responded by drawing on less eccentric notions of freedom, arguing that the imperative in this case was to work for a broader restructuring of social relations in which the lives of girl children would not be so devalued that it became preferable to abort them (Arora, 1996; Balasubrahmanyam, 1986). The status of women is not, in this view, to be determined by sheer numbers, but rather by the wider relations of social power and patriarchy which also shape the meaning of modern technology itself:

The lack of social and economic security available to women in the present framework of rights and opportunities, whether due to the discriminatory property laws or due to policies which systematically deprive women of means of livelihood, for instance, have played a significant role in creating or reinforcing son-preference. (Arora, 1996, pp. 421, 422)

In both the United States and in India, the language of choice has been pivotal in the debates around amniocentesis. In India, this language may not have the same ready application across all classes that it does in the United States, but it has been just as important in shaping the public discourses of the Indian nation-state, and, subsequently, in the controversies over inequality. However, the contexts of application of the technology of amniocentesis in the American context and in the Indian context could not be more different. In the United States, the language of choice with respect to amniocentesis focuses on varying responses to the detection and abortion of genetic abnormality (Rapp, 1990). In India, this application is not widely known; for example, the state did not, despite demands from women’s groups, make such information available to women in the aftermath of the chemical explosion in Bho-
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It is precisely the interests at stake that give urgency to feminist attempts to maintain a steady focus on the meaning of choice and freedom. These are practical, not merely philosophical undertakings. No doubt, the concepts bequeathed by modernity are acquiring new “meanings and materialities” (Comaroff & Comaroff, 1993, p. xiii). However, not all aspects of modernity have proved equally susceptible to appropriation and redefinition by subordinate groups, such as women. That place is reserved in particular for concepts, such as autonomy, and choice. Resisting the constant pressure to define these terms in the narrowest possible way, the women’s movement has, through its campaigns and texts, directed public attention to the alliances and complicities between the “traditional” and the “modern” sources of gender inequality. Amniocentesis is fed not only by traditional preferences for sons, but by the pressure from the modern state to limit the growth in population, by pressure from the professional and commercial classes seemingly intent on introducing the most modern technology, and by the market-driven rationale for social behaviour.

CONCLUSION

Modernity is under challenge both from the Hindu religious nationalists and from many Indian left-liberal intellectuals. “The return to the colonial scene” (Prakash, 1995, p. 11) in contemporary theory is one contributing factor. Prakash, in concluding his critique of colonial constructions of “bonded labour,” sees the concept of freedom as exhausting itself in a colonial-bourgeois juridical framework which persists as an “enduring presence” in the post-colonial state (Prakash, 1990, p. 225). The only alternative to this capitalist notion of progress, in his view, lies in the nonmodern subaltern subjectivities of the labourers themselves. The oral traditions and spirit cult practices of the labourers, however, are unable to radically change the relations of power, but are merely contestatory (p. 225). We are left, on the one hand, with a sphere of the modern which is so hopelessly contaminated by its colonial origins that it seems exhausted as a source of critique and action, and on the other, with a nonelite discourse which is completely unconnected with the modern and is unable to represent anything other than utter Otherness.

In rejecting this unmodified contrast between a bankrupt modernity and the radical alterity of the subaltern, I suggest that the critiques of state and society produced by the women’s health movement testify to a lasting vitality in certain concepts engendered by modernity. These concepts are applicable in quite different ways and for different purposes. I have tried to indicate, in this fragmentary treatment of a very diverse movement, that (having Chatterjee’s framework in mind) we need not dislodge the urban women’s movement from its place in the history of colonial modernity in order to appreciate its capacity for critique and sustaining emancipatory struggle. Colonial modernity itself gives rise to the critique of “indigenous” patriarchal tradition. However, the dislocations and readjustments set in motion by this critique lead not only to a nationalist movement that expels the British, but to a women’s movement that finally turns its critical gaze on all the constitutive elements of patriarchal oppression. Even when there is evidence of a more recent impulse to submit “the modern” to a more searching scrutiny than in the past (e.g., Tharu, 1995, p. 55ff; Meenon, 1996), the conclusions of these feminists do not represent modernity as exhausted, but, characteristically, as in need of reformulation. The achievements of the Indian women’s movement are not to be taken for granted. As a counter-discourse, feminism is forged in the arena of contestation with other groups equally intent on appropriating the meanings of modernity for their own purposes.13

ENDNOTES

1. A miniature history of colonial modernity lies buried in the terminology of caste itself. The term dalit (literally, “the oppressed”), is being used by activists, in preference to the previous discourses based on purity/pollution (which gave us the term untouchable), colonial administrative classification which continue into present government programmes (giving us the terms scheduled castes and backward castes), but also in preference to the Gandhian terminology of moral uplift (which gave us the term Harijans or “people of God”).

2. I have written about the importance of this strata of

4. For a consideration of these divergences in the embodied field of maternity, see the essays gathered in Kalpana Ram and Margaret Jolly’s edited volume Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific (Ram & Jolly, 1997). See also, in the same volume, Ram “Epilogue. Maternal Experience and Feminist Body Politics: Asian and Pacific Perspectives” (Ram, 1997b, pp. 275–299).

5. I have examined another aspect of Indian feminist body politics in an examination of campaigns around rape, domestic violence, and religious communalism. See Ram (in press) “The Women’s Movement and the State: Instabilities in the Discourse of ‘Rights’ in India” in Maira Stevins and Vera Mackie (Eds.) Human Rights and Gender Politics. For more ranging historical explorations of contemporary Indian feminism, see Gandhi and Shah (1991); John (1996a); Kumar (1993).

6. This body of scholarship examines the subject constitution of upper-caste women as professionals. For an account of the way in which missionary emancipatory discourses based on literacy and the Bible also constituted women from the labouring classes as professional “Bible Women” who could transgress gender and caste norms, see Haggis (1997)” “‘Good Wives and Mothers’ or ‘Dedicated Workers’? Contradictions of Domesticity in the ‘Mission of Sisterhood,’ Travancore, South India” in Ram and Jolly (1997).

7. The report of the Eighth Five Year Plan recommends: (a) publicity campaigns to highlight the adverse effects of early marriage on maternal and child health; (b) a social reform movement to be generated through a network of social and voluntary organisations “to combat outmoded customs and traditions”; (c) motivation of grassroots level workers; (d) stricter enforcement of relevant legislation such as Child Marriage Act of 1978; (e) compulsory marriage registration; (f) preferential treatment in development programmes to those who comply with the later age of marriage; (g) stipends for girls in rural areas to encourage them to continue education or skill acquisition (Eighth Five Year Plan, Report of the Working Group, 1988, pp. 26–27).

8. The argument in this section has been elaborated in a separate paper devoted to examining state family planning policy and discourses of citizenship. Ram (forthcoming) “Rationalizing Fecund Bodies: Family Planning Policy and the Modern Indian Nation-state” in Margaret Jolly and Kalpana Ram (Eds.), Borders of Being. State, Fertility and Sexuality.

9. Recent volumes such as Das Gupta, Chen, and Krishnan (1995) Women’s Health in India. Risk and Vulnerability, which attempt to look at different phases of the female life cycle, are another indication of the absorption of these earlier feminist arguments into a more mainstream discourse of demographers, development economists and anthropologists.

10. Again, please refer to Ram (forthcoming) for more details.

11. Reports were published in English language magazines such as India Today, Eve’s Weekly, and Sunday, as well as regional language journals. The figure quoted here is from an editorial in the Times of India (1983), June.

12. I am referring here not only to debates over gender inequality, but the inequalities of caste which culminated in the mobilization of the upper classes against the continuation by the state of affirmative action programmes (the “reservations policy”).

13. In addition to the examples given in this paper, I have in mind here the more consequential appropriation of the language of citizenship, democracy and even gender equality by the Hindu nationalist or “Hindutva” movement in India. For feminist evaluations of this challenge, see Hasan (1994) and Sarkar and Bhutalia (1995).

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