# Participatory action research (PAR) in women's health: SARTHI, India

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# PART III PR PROCESSES AND EMPOWERMENT

## 6 Participatory action research (PAR) in women's health: SARTHI, India

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I would like to place these reflections in the context of my own experiences, both personal and work-related. I do this because I believe that I am typical of my kind, an activist and a practitioner working on women's issues.

My educational background and training have contributed to the way I see myself. I have been a practitioner concerned with pragmatic action to bring about social change. I understood research as something lofty and abstract, concerned with a world of ideas. I have had, in fact, a mortal fear of research, resulting in a tendency to distance myself mentally from anything which was even remotely research-like. Second, somewhere quite early in my working life, I began seeing myself as an enabler, a facilitator for empowerment. This commitment to empowerment grew and gradually I began recognizing this, and around nine years ago I made some very conscious choices about my future work which I decided was to be in the area of women's empowerment. It is against this background that I shall examine the topic of PAR in women's health. What implications and meaning does PAR have for practitioners and for women's empowerment?

In order to arrive at a conceptual understanding of PR for women's-health action, I shall draw upon the last nine years' experiences that I have had working with Social Action for Rural and Tribal Inhabitants of India (SARTHI).

### Background to the Social Action for Rural and Tribal Inhabitants of India (SARTHI) case study

SARTHI is a voluntary organization which started its operations in 1980 in the Panchmahals District of Gujarat in western India. This district is classified as backward and as a drought-prone area. It is resource-poor and, has a higher population density and a far lower literacy rate than the rest of India. Originally SARTHI started as a branch of the Social Work and Research Centre (SWRC, Tilonia). In 1985, it was registered as an independent entity. Its initial work consisted of conventional development projects like installing hand pumps, deepening wells and setting up income-generating projects.



The status of the women in Panchmahals, as elsewhere in the country, is quite discouraging. Their workload is heavy. In addition to all the housework, many women work on daily wages either in the fields of big landowners or in public works. Women of landowning families also perform substantial agricultural tasks. While men do the ploughing and marketing of the produce, women shoulder the major responsibilities of hoeing, weeding, irrigating, harvesting and processing the produce. Women's work also consists of collecting fuel, fetching water and cattle care.

Desertion, domestic violence, alcoholism among men (despite prohibition in Gujarat) and husbands bringing in second wives to beget sons are common problems facing women in the area. On top of that, during drought years they have also to shoulder the responsibility of men's work if men migrate in search of wages. Many women also migrate with men to labour in more prosperous areas.

The F:M sex ratio in the Panchmahals has changed from 959:1,000 in 1981 to 953:1,000 in 1991; female literacy in the district is 22.66 percent as compared to 41.18 percent for Gujarat state (figures from 1991 Census).

Also, as elsewhere, women own little land or property. Whether at her parental home or that of her in-laws, although she labours hard in a subsistence economy, the woman's economic status is like that of an unpaid domestic labourer. Decision making concerning land is almost exclusively a preserve of men.

My involvement in SARTHI began in 1984. Our team was invited to help the voluntary organization start its first programme with women. This was the improved cookstoves (*chulhas*) programme. My colleague, Madhu Sarin, had devised a system and a methodology to improve cookstoves. The philosophy underlying our approach was empowerment of women by helping them gain control over a technology which was, until then, controlled by men. And the main goals of this programme were to help reduce the drudgery of women related to fuel collection, cleaning of cooking pots and the house, as well as to reduce the health hazards for women by reducing the smoke within the house. By 1987, we had succeeded in creating a cadre of about thirty local women, the *chulha mistries* (technicians), who were in constant touch with SARTHI. The year 1987 was a period of dialogue and reflection. Through leadership-and-awareness *shibirs* (camps) and village meetings with the local women and the *chulha mistries*, SARTHI tried to find out what direction its women's programme could take. This was also the time of an acute drought in this area, The women reported high morbidity due to weakened physical states resulting from malnutrition, anxiety and work overload. They suggested that SARTHI start a health programme for them. Thus, in 1988 a women's health programme was launched.

## The women's health programme

The years 1988 to 1992 can be considered the pilot phase of the women's health programme. The perspective with which this programme was launched is summarized below.

Women exist within a social framework where they are defined primarily through their bodies. Their physique is assessed for the ability to work or to bear children, their appearances are judged within the framework of traditional beauty and their bodies are restricted to satisfy the claims of ownership by men. Surrounded by and immersed in the stereotypical images of women, as mother, woman as sacrificing wife, woman as burden, there is little space for women to value their experiences and ways of being in the world, and through this, to take control over their bodies and lives.

Woman's subjectivity, her experiences of existence, are negated and rendered invisible, her body is used as a battleground by the forces both of tradition and of progress. Women continually face both external and internal, physical and emotional violence. This violence against women, their lack of control over and identification with their bodies, become visible through the statistics reflecting women's poor health status, through deaths in infancy and at childbirth and through invisible but high levels of morbidity such as anaemia and gynaecological problems. Alongside the health problems women themselves face is the role of women as carers of the sick. Within the family context, a large amount of a woman's time, energy and resources is spent on tending those who have fallen ill, particularly children and old people. Yet again she receives little recognition for her input of physical, emotional and economic energy. In approaching women's health, it becomes vital, therefore, to move away from the paradigm of issue-based health care inputs that focus primarily on maternal and child health (MCH) and family planning (FP), developing instead a fresh conceptual framework. Working with women's health involves exploring and understanding woman's experience of herself within society, her relationship to and control over her body. The layers of negation and devaluation need to be peeled off, so that women are empowered, their experiences are validated and they are enabled to develop their self-image within a context where they can exert control over their bodies and recognize their intrinsic strengths, both individually and collectively.

From this will emerge a space in which women are then freer to define and work with what they perceive as health problems, definitions that may well include the components of MCH and FP but have the potential to expand to issues of water and sanitation, physical work burdens, liquor and much else. The possibilities become enormous as the stereotypical, pre-defined barriers are broken down and women come to value themselves and to recognize and value their contribution to society.



In this context, development is seen as a process which begins with the validation of the individual and encompasses the changing relationships of that individual and other individuals within that community, rather than being simply a set of targets to be achieved.[1]

The women's health programme in the pilot phase had three distinct, chronological parts:

- the maternal and child health component;
- action research on traditional medicines; and
- training for gynaecology through the self-help approach.

Today the women's health programme is being implemented through a group of fifteen trained and experienced *arogya sakhis* (barefoot gynaecologists). They treat the common gynaecological problems of women in their villages with validated herbal medicines. They also work as counsellors and as organizers, mobilizing women for collective action on common problems. In May 1993, in response to increasing demands from other women in the community, SARTHI initiated training for a second group of thirty women health workers. Four of the original *arogya sakhis* were helped to develop their skills as trainers and undertook the training of the new group.

SARTHI has decided to focus on sexually transmitted diseases (STDs) in the next phase of their women's health programme. STDs seem to be a significant problem in the area. The causes may perhaps be the seasonal migration patterns of the local people, and cultural mores influencing sexual behaviour in the community. In the second phase of the programme, the voluntary agency has decided that it is necessary to include men, too, in its work on women's health issues.

## Participatory action research in SARTHI's women's health programme

On reflection it appears as though PAR was built into the women's health programme in three ways. Although not originally planned to be a PAR, the entire programme actually emerged as this: the problem was identified by the local women, SARTHI decided to respond to it and with the participation of the women as well as a lot of external support succeeded in creating an alternative model of woman-centred, holistic health care at the primary level.

An essential part of the introductory work had to do with creating space for the local women to start sharing their stories. In workshop sessions, as well as out of them, women were encouraged to talk about their experiences of their bodies, for instance their experiences of menstruation and childbirth. This sharing helped the women to recognize how their bodies had been used to keep them in a subordinate position. The aim of this

kind of sharing was also to shed their sense of *sharam* (embarrassment) and help them revalue and claim an essential part of themselves.

Second, the action research on traditional remedies for women's health was PAR. Through workshops with traditional healers, village meetings with elders, participatory field exercises with school-children and field visits with local women into the forests, identification of flora traditionally used for common health problems, especially women's gynaecological problems, was carried out. This process was strongly empowering; once we started putting it together, the local women began to realize the wealth of knowledge that they have. Validation by the SHODHINI (a feminist network in India, doing action research on alternative healing practices based on traditional remedies) botanist revealed that almost 80 percent of their remedies had a sound phytochemical/botanical basis. This was further reinforcing. The result of this PAR is that the village people are now making conscious efforts to propagate medicinal plants and revitalize the systems of traditional medicines for their primary health care needs.

Third, the self-help workshops for training in social and gender-sensitive gynaecology were also a PAR. Eleven of us (eight *arogya sakhis*, two programme planners and the facilitator) met regularly each month for three days from December 1990 to February 1992. The purpose of these meetings was to learn the basics of gynaecology by examining our own selves. We also started dealing with our own common health problems with the use of validated traditional remedies and other non-drug therapies. As we started equipping ourselves with these skills and knowledge, many of us could begin working in the community as barefoot gynaecologists. The self-help effort was, to my mind, a classic example of PAR.

- There was no distinction between the researcher and the researched. The group of eleven women, eight of whom were local, came together as equal members of the self-help groups. The research question, how to treat common problems of women, was defined jointly. The data were generated by using each of our own bodies and relating these to our life experiences. The analysis and the planning for follow-up action was done collectively.
- This process had the effect of transforming each and all of us. Our ways of perceiving reality were changed radically, as were our responses to situations which faced us.
- We started becoming actively conscious of imbalances due to gender relations in our own lives and the society at large. We also became aware of our own rights in relation to the state, particularly the government health structure. In short, this PAR resulted in the politicization of us all.
- The politicization and transformation processes resulted in many of us initiating concrete action to change the situation that we saw around us.[2]



## PAR and the difficulties faced

The major initial difficulty that we faced was related to breaking mental barriers. As mentioned earlier, I myself resisted anything to do with research. The aura surrounding research activities as they are typically carried out was not appealing to me. Treating people like objects, limiting interaction with them to the extraction of information, not leaving behind anything that they could use in a reciprocal process, were elements of research with which I disagreed.

With the women, the major barrier that had to be broken was one of participation. For generations, women were used to contributing only their labour to society and not their conscious thoughts. The women that we were working with had tremendous difficulty in seeing themselves as anything other than passive recipients of handed-down knowledge. Through a gradual process, which was painful and slow, the women first began formulating their own opinions and then moved on to analysis and formulating conclusions.

It was because of these mental barriers that we saw the initial stages of our women's health work as pure action for empowerment rather than as participatory research. Once we overcame our resistances, we realized that with our commitment to empowerment and participation, any grassroots action addressing people's own issues could be termed PAR.

The second difficulty (if it can be called such) that we faced in the PAR in women's health was devising suitable methods. The methods of data collection and, of analysis had to be based on women's own reality, reality in terms of their abilities, their belief systems, their metaphors. For instance, we learned that to ask the traditional healers to name the plants that they used in their practice would not get any results. There was a belief that uttering the name of the plant, which was considered sacred in its healing power, was paramount to disrespect and would result in the plant losing that power. A more correct way of approaching the data-gathering for this purpose was to go on a field visit with a group of women, including the traditional healer, who would then point out the plant whose local name the other women would then speak. In this way the PAR became a true partnership, facilitating mutual exchange rather than just a one-way process of either extracting information for research purposes or imposing our own knowledge and beliefs in the interests of an efficient service-delivery programme and, with some of us who had received training of a different kind having to de-learn and re-learn.

The third difficulty, which remains unaddressed and unresolved even at this point in time is related to the issues of the recording, documenting,

writing and dissemination of the PAR experiences. How can the women truly own the body of knowledge resulting from the PAR experience? How can they participate as equals in the production of the documented material and not just as notional members? How can they disseminate their experiences directly? These questions haunt us still.

## PAR and the lessons learned

Some of our learning from SARTHI's PAR in women's health may be reflective of the collective wisdom of experienced participatory researchers. However, we do feel the need to list the lessons here, because they are a part of our own personal discovery. We learned that :

- PAR requires an attitude of mutuality, an openness and a commitment to learning on the part of all those involved. These words have acquired a different meaning for us, as programme planners: we have really learned how difficult it is to open up ourselves as recipients of traditional knowledge, and how difficult it is to leave the position of those who have all the answers.
- Truly participatory action research results in all the actors going through a process which transforms them at a very personal level and politicizes them with respect to relationships at another level. The transformation of Rasiben was amazing. In the first few self-help workshops, she could not even come near a woman doing a self-examination because, as she stated, 'It is dirty, the odours make me vomit.' By the sixth workshop, she was the keenest learner, the first one to see the cervical erosion or the infections! The transformation really had to do with different ways of perceiving things.
- PAR calls for a form of organization which not only allows space for this kind of transformation but which can also respond to it by changing itself. SARTHI, for instance, has had to respond to the growth in the women by allowing them more space. The organizational structure, the programmes, the processes have all undergone some degree of change. The women's health programme is used as an illustration of sustainable development, an example that has to be emulated in the other programmes that the organization takes up. Had the organization remained rigid and not kept pace with the women, an unmanageable tension would have been created, perhaps resulting in many of the women health workers leaving.
- Further, PAR can succeed in or through organizations whose ultimate objective is empowerment. The chances for success are less in organizations whose ultimate goal is efficient service delivery. This is because the values which govern the two kinds of organization are different.
- PAR, to be truly successful in relation to women's issues and women's empowerment, has to challenge patriarchal structures and modes of thinking. For instance, conventional methods have created a divide between the researcher and the researched. In this division, the researcher is ascribed a greater value on the basis of a more cerebral function. A corollary of this is the notion that only professional researchers can generate knowledge for meaningful social reform.
- PAR has greater chances of success where some feminist values and modes of functioning already exist, for example, a more equitable division of labour based on gender analysis and revalued gender roles, an holistic perception of reality, principles of mutual support, 'personal is political', non-hierarchical or fluid and adaptive structures.
- There is a difference between PAR and PR methods. The assumption that the use of participatory research methods is actually participatory research leads to serious problems. Participatory research is much more than the application of PR methods. It is an entire process which includes education, pain and struggle and results in empowerment.



## Conclusion

I would like to examine some of the concepts contained in the title of this chapter. I will begin with the concept of participation. In recent years, participation, and especially 'community participation', has become a slogan to be adopted by community health programmes before they can be evaluated as successful. The questions 'participation by whom?' and 'participation in what?' are seldom asked. It is accepted that community participation at its simplest level occurs when local people contribute in cash or kind to the implementing agency's programmes. A high level of community participation is thought to occur when the community is involved in identifying a problem and managing a programme. But the programme is still that of the implementing agency. In my mind, it is becoming clearer that we need to put the horse before the cart. We need to understand that it is the people's (or community's) needs and programmes that we, the action groups or implementing agencies, need to participate in. This calls for a fundamental shift in our perception of our work. Our agenda in the community thus becomes one of helping the community to recognize and focus on its needs and helping it increase its capacities to meet these needs, rather than to implement health care delivery programmes for it and solicit its participation in these.

As mentioned earlier, the participatory research process would have greater chances of success if the action component of the PAR has as its

goal empowerment of women and not just efficient service delivery for women. Empowerment of women with respect to women's health programmes would need to be defined clearly so that all those who are involved in action know in unambiguous terms what they are striving for. One possible way of conceptualizing manifestations of empowerment related to women's-health action could be as follows:

**Figure 6.1: Manifestations of women's empowerment**

| | | | |
|---|---|---|---|
| Building confidence in self, shedding off sharam (shame), owning one's body, beginning to talk about what affects the body and health. | Awareness and increasing control over relationships through which the body is affected. | Appropriating health services that rightfully belong to the group. | Organizing for collective action<br>- demanding and getting quality health care; health rights<br>- dealing with issues which are health issues of women, eg. violence. |
| Intra-personal | Inter-personal | Group | Community |

The above diagram indicates that empowerment of women could be manifested along a continuum. At an intra-personal level, empowerment begins with individual women having a changed perception of themselves. What they thought earlier was dirty and a cause of *sharam* (shame, embarrassment) they now begin to claim and own. The physical problems which earlier went undiscussed now begin to come out of the shrouds. At the inter-personal level, women begin to realize how certain relationships and their subordinate role in these directly affect their bodies. An example of this is the relationship with their husbands. In small ways they also begin to negotiate relationships in the environment. For instance, a small group of women may decide to accompany their neighbour to the health centre to make sure that she gets the service that she requires. At the community level, women organize themselves for collective action around their own issues, for example, to pressurize the state to have their health rights met, or to draw attention to issues which affect their bodies and health directly, issues like rape and violence, which were till recently left unaddressed.

My present understanding of research leads me to believe that any grassroots action which is interspersed with serious reflection to bring out learning is research. This research may or may not contribute anything new to a larger body of existing knowledge. However, at a micro level, it becomes research because it contributes to an increase in local people's understanding about existing problems. This kind of



participatory, grassroots-level action research does not in any way lessen the value of research done by academicians and researchers. The two, to my mind, can feed into and strengthen each other, but this strengthening can occur only if there is an appreciation of the strengths and limitations of each mode of research by both the action researchers and the academic researchers. Patronizing attitudes of academic researchers or the short-sighted self-righteousness of activists can both be damaging to the agenda of large-scale social change.

How then can PAR contribute to the traditional paradigm of 'good' research? First, PAR, by not separating the subject from the object, can identify research agendas which matter to people, especially poor people. This is important in a country like India where research priorities (and paradigms) are still copied from the West, making our research institutions lifeless and, by and large, irrelevant. Second, PAR would (re)introduce feelings and human considerations into research by teaching us to respect people's concerns and feelings as opposed to the objective and often amoral stance traditional science and research tends to take. Third, PAR reaffirms by its inherent relevance that knowledge building and the frameworks of knowledge are not neutral. They have to be circumscribed by the morality of the people they purport to serve. Thus planning and policy frameworks and social programmes emerging from such research will learn not to marginalize poor people but truly serve them.

Women's health as a concept also needs to be examined. The definition of women's health needs to be made broader than maternal health which views women in only their reproductive roles. Women as persons, having health needs other than just antenatal and postnatal care, must become the focus of women's health programmes. Further, women-centred health programmes need to acknowledge that women's health status is a product not just of their condition but also of their position in society. Health programmes for women need to be based on an analysis of the gender issues. Women's health is not just a physical issue, it is also a psychological, social and political issue.[3]

## Notes

1. Excerpted from 'Working note on SARTHI's women's health programme', April 16 1988 by Janet Price and Renu Khanna.
2. For other details of the self-help approach, see Chapter 4 ('Becoming *aroygya sakhis*'), *Taking Charge: Women's Health as Empowerment; the SARTHI Experience*, SAHAJ/SARTHI, Baroda, India, 1992.
3. This chapter is dedicated to the women of Santrampur Taluka who have been partners in this PAR. I also acknowledge the contributions of the following: Nirmalben, my colleague at SARTHI, Janet Price, who gave us the courage to take the first step, and the SHODHINI network which continues to sustain our efforts, especially Vd. Bajpai and Rina Nissim.