Gender, Technology and Development
http://gtd.sagepub.com/

Tradition, Colonialism and Modernity: Women's Health in Goa, India

Shaila Desouza

Gender Technology and Development 2003 7: 189
DOI: 10.1177/097185240300700203

The online version of this article can be found at:
http://gtd.sagepub.com/content/7/2/189

Published by:
SAGE
http://www.sagepublications.com

On behalf of:
Asian Institute of Technology
AIT Asian Institute of Technology
Gender and Development Studies

Additional services and information for *Gender, Technology and Development* can be found at:

Email Alerts: http://gtd.sagepub.com/cgi/alerts

Subscriptions: http://gtd.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.com/journalsPermissions.nav

Citations: http://gtd.sagepub.com/content/7/2/189.refs.html

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

>> Version of Record - Jul 1, 2003

What is This?

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

Tradition, Colonialism and Modernity: Women's Health in Goa, India

SHAILA DESOUZA

This article documents practices related to pregnancy and childbirth among the Gauda tribal community in Goa, a south-western state of India. The Portuguese colonizer introduced a 'scientific credo' in every sphere of life, including health, for reasons of ideological supremacy, moral justification, and social legitimacy. There was a well-orchestrated effort on the part of the Portuguese to phase out the traditional system of healing in order to replace it with a western system. However, traditional beliefs and health-related practices persist, albeit often in 'modified' forms. Two possible reasons are forwarded for this persistence: first, traditional beliefs and practices are indicative of their role in identity formation for this community; and second, traditional health and healing are practised by women.[1]

In India, the status of western medicine during the struggle for independence was ambiguous. On the one hand, some nationalists saw the revival of indigenous medicine as part of a rediscovery of cultural roots and, therefore, rejected western medicine. On the other hand, the benefits of western medicine were supported by domestic practitioners of western medicine, who were influential members of the nationalist middle class. There is also a strand of literature which argues that colonialism is the cause for change in traditional practices resulting from imperial domination, which creates a monopoly over scientific knowledge in order to morally justify its colonization. It is also argued that this domination creates resistance and an awakened consciousness of identity among indigenous populations due to the perception of threat from this external 'force', which accounts for the persistence of traditions. Despite the varied

Shaila Desouza, Center for Women's Studies, Goa University, Taleigao Plateau, Goa, India 403 206.

Gender, Technology and Development 7 (2), 2003
Sage Publications New Delhi/Thousand Oaks/London

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

positions that surround western medical practice, the reality is that post-independence health policy in India accepted the modern western system of healthcare and largely ignored traditional healing systems. Traditional practitioners are not supported by the state and state-funded research in this area is absent. This policy thus excludes vast sections of the population of India which continue to seek the services of traditional health practitioners. For example, according to the National Family Health Survey in India, traditional birth attendants assisted 35.2 percent of all deliveries in 1992–93.

This article originates from the position that although traditional health practices have sustained communities for generations (Mitcham, 1996), the benefits of these systems are overlooked by proponents of western medicine.[2] In India, knowledge of traditional remedies has been the domain of women. This article argues that, with regards to women's health in particular, modern medicine alienates women from their own bodies by 'medicalizing' certain natural processes of womanhood, such as menstruation, aspects of pregnancy and child birth, etc. In doing so, modern medicine disregards women's knowledge and traditions by monopolizing technical medical knowledge, and further controlling women's bodies. Despite critiques of modern medicine (Hufford and Chilton, 1996; Illich, 1976), that form of health practice has widespread acceptance in industrialized societies today. Some argue that its base of scientific research explains its superiority. Mutalik (1983) has pointed out, however, that certain remedies that are invaluable to biomedical treatment are in fact not the discovery of scientific research, but are unique to traditional healthcare. Nevertheless, there has been no assessment of the quality of care provided by traditional medicine so that its value can be demonstrated only by its persistence.

This article challenges the invisibility of traditional healthcare practices by documenting their continued importance to many women in Goa. It begins by locating the case study within the context of western-style health promotion. By focusing on women's reproductive health, this article makes visible the ways in which traditional practices, however 'quaint', are relatively more friendly to women. While traditional practices, like modern medicine, recognize the potential 'dangers' of pregnancy and childbirth, they provide women-centered rituals and observances to help eliminate or minimize these risks. This quality of traditional healthcare, as well as the lack of available and appropriate alternatives, helps account for its persistence in the face of 'modern' medicine, especially as the latter has been imposed upon colonized populations during

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

the past several centuries. Contemporary health promotion professionals, therefore, have much to learn from 'tradition'.

Understanding Health

Development literature and public policy base their assessment of health status in terms of quantifiable numbers such as measurements of life expectancy and mortality. World aid for health and nutrition by international donor agencies are also primarily based on such indices. Recent studies acknowledge that the quality of life is affected by the incidence of disease, injuries, repeated illnesses, and disabilities, making morbidity data important for understanding health status. While loss of life is easily assessed, morbidity is difficult to quantify and is subjective as it is determined by the interpretation of ill health.

Health is an important component of well being that influences learning capabilities as well as economic productivity. However, the understanding of 'health' continues to be ambiguous, particularly with reference to women's health, especially in the developing world. The ambiguity arises from the divergent understanding of the needs for the well being of the human body within two dichotomous healing systems, namely the modern clinic-based western science and traditional health practices. This dichotomy has been completely ignored by state health policy, which makes no provision for the inclusion of traditional healing practices and practitioners into state health services. What we are arguing here is that different cultures have varied and unique perceptions of well being and, therefore, disease. The acceptance and perpetuation of one or the other system is dependent on state policy and a community's unique experience (tradition and affordability) of either system.

Women's health activists in India have repeatedly argued that India's policy regarding women's health is exclusively concerned with women in the reproductive age group of 15–45, neglecting both younger and older women. With the exclusion of the recent focus on HIV and AIDS, expenditure on curative and preventive healthcare has been almost stagnant over the last few decades: Family Planning alone has seen an increased allocation. This lopsided focus on population control has led to a total neglect of general health and other critical health issues such as malnutrition, anemia, the high incidence of depression, reproductive tract infections, chronic back pain, sexually transmitted diseases, and blindness in women. Murthy (2001: 20), argues that 'although history has proven Malthus wrong, and the earth continues to produce sufficient

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

food for all its inhabitants, over the last two centuries, his theories have been modified, twisted and propagated to ease the conscience of the rich and consequently, augment the power of the nations of the first world'.

The exclusive focus on population control has extensive international donor backing. For example, the most ambitious family health survey ever conducted in India is the National Family Health Survey (NFHS) 1992–93. It was a project of the Ministry of Health and Family Welfare and was conducted with technical assistance from the East-West Center, Hawaii and Macro International, Maryland, USA. The United States Agency for International Development (USAID) funded the project. This survey is a data resource for policy planners but, unfortunately and not surprisingly, it has focused on fertility patterns and family planning. Since 1972, the World Health Organization (WHO) has run a special program of research, development, and research training in human reproduction in developing countries. In 1988, the United Nations Development Program (UNDP), United Nations Population Fund (UNFPA), and World Bank (WB) joined as co-sponsors in a program of development and improvement of methods of 'fertility regulation'.

The list of long lasting, provider-controlled, contraceptive technologies that have been tried on the third world populations are extensive. The women's movement in India is concerned about the manner in which these trials are being conducted. For example, the consent obtained from a woman registered for a trial is invariably not informed consent. The woman registered in the trial is more often than not from the lower sections of society and illiterate; her signature has been obtained on forms in a language she does not understand. The focus of the so-called family planning program is on long lasting contraception to lower the birth rates rather than to help people plan their families. Opposition to these trials by the women's movement in India is not only because of their use of provider-controlled technologies, but also because of the lack of commitment to follow up in case of contraceptive failure.

Until two years ago, aggressive strategies such as media promotion, targets, financial incentives, and disincentives were used to promote 'family planning'. Sterlization or tubal-ligation camps were common all over India. The focus of these camps was on 'quantity' rather than 'quality', with no after care or follow up commitment. Interestingly, three quarters of the contraceptive users in India are sterilized. Women who chose sterilization were those who already have, on an average, four children (NFHS, 1992–93). According to the NFHS 1992–93, in the state of Goa, which has the second highest literacy rate in the country,

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

the knowledge of contraceptives is very high—95 percent. However, sterilization is better known than spacing methods. This finding might reflect the double monetary incentive for sterilization that was being offered by the health and welfare departments till a few years ago, amounting to more than a month's wages for a daily wage earner. The NFHS also revealed that the current use of 'modern' methods is lower among women with high school education and above than among illiterate women, although the average family-size among those with education is less than that of those who are illiterate.

Health in Goa

Goa, a small state on the western coast of India, became a Portuguese colony in 1510 and was liberated only in 1961. Covering 3,702 sq. kms this was the only region of the Indian subcontinent under Portuguese rule. One reason why a case study of Goa is pertinent is that Goa is often used as the 'model' state in terms of health, education, and standard of living. The Government of Goa boasts that traditional-birth-attendants and *dais*/mid-wives have been completely replaced by hospital staff, trained-birth-attendants, and doctors. This move was a conscious plan of the Government of Goa after liberation, when the primary health services were established in 1975. However, as we will see in this article, traditional health practices continue to serve certain ailments and health needs of the population despite the denial of their existence by the state.

Most of this article is based on a field study among the Gauda Community in Goa. The Gaudas were converted to Christianity in the 1620s during Portuguese colonization and later converted to Hinduism in the 1920s (Kakodkar, 1988) as part of the Shuddhi Movement, which encouraged conversion to Hinduism.

Methodology

During fieldwork, information was collected through interviews and informal conversations with women across generations about their experiences through life's various stages. Information sought concerned illnesses they suffered, cures and treatment they received, taboos and food practices, as well as other rituals. For this article respondents were divided into two categories: first, older women whose narratives have been used to refer to the recent past of approximately 35 to 40 years which roughly coincides with the period prior to Goa's liberation. The

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

second group comprises the younger generation of married and unmarried women whose narratives are used to discuss the present situation or post-liberation period.[3] Stories were narrated from selective memories of the past and present, sometimes accompanied by an interpretation to enable understanding of their lifestyle. On several occasions, however, explanations were not possible. Stories narrated about an individual's life were also stories about the community. The responses and sketches from 'verbal testimony' were then transcribed into field notes, and worked on together with our own reflections and observations into a textual 'reality' as the basis of this article. Thus, 'even though the informants speak, their authenticity is warranted by the ethnographer's incorporation of them into the definitive record' (Atkinson, 1990: p. 61); like the historian the ethnographer cannot reproduce all the 'evidence' and detail available, resulting in 'an element of bricolage' (ibid.: p. 49). The bricolage presented here is pieced together from ethnographic field notes, the existing literature, and archival records, painting a picture of the health practices of a vulnerable community in India.

Traditional Health and the Gauda Community

The Gauda community were a nomadic tribe in earlier times, involved primarily in cultivating areas surrounding their settlements or engaged as landless laborers in interior parts of Goa. Gaudas held a low status in society and during the colonial period felt that conversion to Christianity would fulfill their aspirations for a better economic status, as well as help them escape persecution and exile (in case of non-conversion) (Xavier, 1993). The 1620s saw most of this community convert to Christianity. However, even after conversion, like most tribal communities the Gauda community continued to hold a low status, as employment at senior government levels, as well as other monetary benefits of conversion, were enjoyed chiefly by Goan converts of the 'higher' castes (Ifeka, 1985). After conversion, several families of this community moved to the coastal areas and were involved in construction activity, road laying and in more recent times, fishing. Today's generation is seeking education and involvement in service (semi-skilled and skilled) with the government, private organizations, and as domestic labor in households. Despite these efforts, most families of the Gauda community continue to remain in the lower economic and social strata of society.

Prior to their conversion to Christianity, the Gaudas had not worshipped images apart from nature. Today the Gauda community continues health

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

practices that are traditional to their tribal culture, and believe in spirits (*devchar*) that inhabit certain trees, water sources, etc. This belief is held despite three centuries of Christianity, centuries that included the Portuguese Inquisition. The Inquisition banned 'pagan' practices and inflicted severe punishments on traditional healers. The worship of nature also persisted despite the recent conversion to Hinduism. For the Gauda community, health practices, and therefore illness, are interwoven with religious, social, and cultural life. The human body is referred to as *kudd*, literally meaning 'home'. The body was the dwelling place of both good and bad, and one is expected to treat it with reverence. Contrary to western medicine, illness is seen as the pollution and invasion of the body by both internal and external elements, such as unpleasant events in the community, water, food, evil eye (*desht*), and spirits in the air (*vare*) which do not just affect body parts but the whole *kudd*. Interestingly, in the language of the Gauda community, there are no indigenous words for 'illness' and 'health'; the words used today are Portuguese words—'*doent*' and '*saud*'.

In the Gauda community 'health' is not considered to be merely the absence of mental and physical illness, but rather harmony in the relationship between humans, the environment, nature, and god. There is also inter-dependence between an individual and the community. For example, a woman who has just given birth to a child, and for the six-month period following childbirth (known as *baanpan*), is both vulnerable and powerful because, should any harm come to her, the whole community faces the ill consequences. In the case of her death, it is believed that she (called an *alvantine* or bad omen) would haunt the village and, therefore, be feared by other expectant mothers. As a consequence, during pregnancy and *baanpan*, a woman is compelled to conform to the rules and taboos regarding food and movement, not only for the sake of her baby but also the whole community. For 11 days after the birth of an infant, no religious function or ceremony will be held in the neighborhood as it is considered inauspicious, although the arrival of a baby itself is considered a joyous occasion. This Gauda perception and interpretation of 'health' and 'illness' stands in stark contrast to the symptomatic approach by modern medicine.

The sections of the Gauda community who have recently converted to Hinduism are now referred to as *nav*-Hindu Gaudas (new Hindus). It may be pertinent to note that their conversion to Hinduism, which began in 1920, can be understood in the context of the cultural permeation of the Indian mainland neighboring Goa. Interestingly, several families even

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

today continue to go by their previous Christian names. This retention of Christian names suggests the possibility that conversion represents a strategy of survival rather than self-assertion. Today the community is demanding 'tribal' status in order to claim discriminatory privileges from the State.[4]

Portuguese Policy and the Advent of Western Medicine in Goa

The Portuguese colony in Goa was established in 1510 with a primarily economic agenda. This agenda included not only political but also social, cultural, and religious domination and control of the subjugated population. Religious control seemed to hold the key to the control of the domestic population, which probably explains the importance given by the indigenous people to conversion.

At the time of colonization a flourishing system of indigenous medicine existed in and around Goa. There are records indicating that the Portuguese aristocracy availed themselves of this treatment (Ball, 1676; Burnell, 1885).[5] However, the continuation of 'pagan' practices was viewed by colonial authorities as an obstruction to their mission. It was felt that permission to continue 'pagan' practices would wean away local 'converts' and thereby put their mission in jeopardy. Additionally, as Arnold (1989) points out, the moral justification for colonization asserted the superiority of the colonizer's knowledge systems as modern and scientific. These modern practices are contrasted to those of the 'colonized' by labeling the latter 'traditional' and 'unscientific'. Medical knowledge is one such domain, not unlike religion. European medical practitioners believed that their superior knowledge and skill could effectively bring under control the 'fatal and incapacitating diseases' that gripped Asia, Africa and the Americas. This view held European medical intervention as a representation of progress towards a more 'civilized' social and environmental order (ibid.).

Restrictions on the mobility of traditional health practitioners, enforced through severe punishments, were imposed by both the civil authorities and the church at the time of the inquisition which began in 1560 and ended in 1812. Royal Orders (e.g., of 1563) (da Cunha Rivara, 1865) prohibited traditional health practitioners from providing indigenous medicines. Both the healer and the healed were likely to be held guilty. Records indicate that traditional healers were persecuted and fined, even

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

for successfully curing Christians, while Christians were punished for consulting such healers (Gracias, 1994). Christian women were prohibited by the Church Provincial Council of 1567 (da Cunha Rivara, 1862) from seeking the help of traditional birth attendants who were suspected of using rituals involving offerings to the pagan deities. It was feared that this practice might lead to re-conversion. A subsequent notification in 1574 curbed the mobility of these practitioners even further (Goa Archives 1 and 2). By the mid-1700s all traditional childbirth ceremonies were prohibited, including the celebration on the sixth night after the birth of a child (Sotti), as well as the use of symbols and ritual items such as betel leaves (*paan*), areca nut (*veedo*), turmeric (*haldi*), and certain flowers. All were believed to be pagan (Boxer, 1969; Estevao, 1857; Saldanha, 1948).

One problem is that the state failed to make western healthcare available to the local people despite their conversion, making orders banning traditional medicine difficult to implement. In 1618, the Municipal Council attempted to regulate the practice of indigenous medicine by stipulating the requirement of a license for practice (Goa Archives 3). It later granted licenses to 30 non-Christian practitioners, under the condition that they would not force Christian patients to make offerings to pagan deities (Goa Archives 3 and 4).

The Portuguese set up a western medical school in Goa in 1842, the Escola Medico-Cirurgica de Goa (now known as the Goa Medical College). Subsequently, several other hospitals of western medicine and institutes of infectious diseases and mental illness were established in and around urban areas, some of which aimed to cater to the local population. While the earlier doctors were of European origin, in later years Christian Goans trained in western medicine practised in the college hospital (Gracias, 1994). However, right up to the 1930s, there were no maternity clinics in Goa so that most deliveries, especially among the lower socio-economic strata, took place at home. Specialized departments such as the Obstetrics and Gynecology Department at the Goa Medical College were established only as late as 1946. By 1961, when Goa was liberated, there were only 18 hospitals in Goa while today, there are over 100. In the post-liberation era, the Directorate of Health Services established several primary health centers and other rural health dispensaries for maternal, child health, and family welfare services based on the western pattern of medicine. The rural health centers employed field and other staff from around the rural areas, which might have made the health

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

services less intimidating and alien to the people from the less privileged sections of society. As we will see, around this time the tribal communities began availing of these services during pregnancy and childbirth.

Understanding 'Kaido' or Custom

The understanding of disease no doubt varies with different cultures (Good, 1994; Lynch, 1969). These unique perceptions, that are handed down through generations, form part of what becomes termed as 'tradition'. The word 'tradition' is a fuzzy concept that evokes both 'what was' and 'what is'. Seneviratne (1997) discusses the intermingling of 'facts' about the past with myths and fantasy to create new customs, traditions, and rituals. In this process, the past is continually re-fashioned by events, perceptions, and interests of the present. Among the Gauda community we noticed ambiguity in regard to what the community meant by the term (*amchi kaido*) 'our custom or tradition'. When discussing restrictions on food and movement during pregnancy and childbirth, in the community the term 'kaido' was often mentioned. It was not clear whether the term was being used to refer to what existed in the past or what ought to be but did not necessarily exist, or to the actual practice in the community today. However, what was clear is the value with which 'kaido' is regarded across generations. It is considered almost sacred, as that which ideally should be followed. When asked about reasons for change in 'kaido', responses were always framed in terms of a lack of alternative, of a free and informed choice to change. It was noticed during the study that changes in the health practices have been more dramatic in the post-liberation than in the pre-liberation era, when severe restrictions were placed on the practice of traditional medicine.

The Persisting Belief in Goddess Sati and Changes in Practices

The goddess Sati is integral to the community's understanding of disease and problems related to menstruation, pregnancy, and childbirth. Sati is both a benevolent and a malevolent force. The goddess Sati, regarded as the overseer or protector of women and children, can also inflict fatal harm to a woman and her baby if she was displeased. In particular, Sati can be angered if norms and taboos are not adhered to. A pregnant woman is forbidden from being present and from eating at a wedding reception, for example, in order to escape the wrath of Sati.

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

Belief in Sati today provides an alternative, religious explanation for the incidence of maternal and infant mortality, and prescribes ritual observances that often run counter to western medicine. Matters regarding the belief in Sati were not readily discussed, as they may have been considered inauspicious. There were no physical images to depict her. Rather she haunted specific places in the village that were to be avoided, revered, or visited only during certain occasions, such as to throw away the clothes of the dead or the afterbirth and clothes of the new born. There are clear gendered practices surrounding the preservation of the sanctity of, and the veneration of, the sites inhabited by Sati. For example, men today may park their boats near one of these sites and, in order to guard their expensive fishing equipment, the men will sleep with their boats all night. The women, on the other hand, avoid these areas altogether. A story narrated by women in the village illustrates how Sati is feared:

> A woman in her seventh month of pregnancy strayed into the restricted burial area to pick firewood. She noticed a red cashew fruit on a tree. Despite knowing that it was out of season, she could not resist the temptation and ate it. When her baby girl was born, she cried incessantly and no village doctor (*gaddi*) could cure her. A month later the infant died.

On the sixth day after the birth of a child, Sati is believed to visit the home of the newborn to write the child's fate. There is a grand celebration (*Sotti*) held on this night, especially for the first child in the family. A lamp is lit and a tray (*tali*) of rice, coconut, turmeric (*haldi*), vermilion (*pinzar*), and other items from the *baanti*'s mother's house are offered to the lamp. The night meal is also cooked with ingredients from the mother's home. That night the child is never put down, but is held throughout the night in someone's arms. There is a lot of singing. The women perform lively group dances (*phugdi*) and play loud instruments to keep 'Evil Women' in the community apart from pregnant women. Those with very small babies attend, bringing with them some home made sweets (or today, store-bought biscuits). At dawn boiled gram (*channa*) is distributed, after which everyone must leave. The day after this ceremony all leftover food is thrown out and the house is swept clean. Historically, the traditional birth attendant (*vaigen*), who was always a Catholic woman from the neighboring village, was very important at this occasion. Since there are no *vaigens* today, the celebration is attended by a Catholic woman who is specially invited for the occasion.

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

This practice is getting increasingly difficult to organize, however, as getting someone who will play the role is not easy. As a result, this ceremony has several variations. Due to the fact that deliveries now take place in hospitals that often require the mother and baby to remain in the hospital beyond the sixth day, this ceremony is held on another date in the month.

The Traditional Birth Attendant (*Vaigen*)

Until four decades ago, all births were assisted by a woman attendant (*vaigen*), the only person permitted to cut the umbilical cord. The *vaigen*'s role cannot be likened to that of a doctor or the present day midwife, as her role does not end with the delivery. The *vaigen* is responsible for burying the umbilical cord outside the house and covering the burial place with three palm leaves. The cleanliness of this burial place is important for the health of the new born. It is the *vaigen*'s job to assist the *baanti* and baby for 11 days. Her tasks include ceremonial baths on the seventh and eleventh day after birth, as well as throwing coconut palm leaves and the dried cord navel at the place allocated for Sati on the seventh day.

On the eleventh day the ceremonial bath is followed by a ritual held around the well. The purpose of this ceremony is to purify the *baanti* and permit her to draw water, which she had been forbidden to since childbirth. The *baanti* carries a tray (*tali*) of rice, a cereal (*nachne*), turmeric (*haldi*), vermilion (*pinzar*), betel leaves, and areca nut (*paan* and *veedo*). She throws *paan* and *veedo* into the well, along with a few drops of oil. She also applies *haldi*, *pinzar*, cow dung, soot, and a paste of lentil (*urid dhal*) on the wall of the well in five different colored stripes. She then draws water from the well and pours water five times on a coconut tree, each time looking up at the tree. She draws another pot and walks straight to her home, signifying that she is pure once again. In later years the *vaigen* was given rice and coconuts, as well as a token for her services, but it was believed to be inauspicious to deprive the *vaigen* of anything she asked for.

According to older women in the study, today deliveries in hospitals cause more complications than in the past despite the involvement of medically-trained doctors. Traditional deliveries were assisted by three or four women from the village who would hold and support the mother through her delivery. In contrast, at the hospital women are alone and

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

insecure. There was a time during the lifetime of the older women during which the village priest (*gaddi*) had to be consulted for permission to go to the hospital; today the *vaigen*'s services have been completely replaced by the hospital. Interestingly, however, the ceremony at the well on the eleventh day is still held in the absence of a *vaigen*.

Evil Eye (*Desht*): A pregnant woman and her unborn, or newborn infant for that matter, are the most vulnerable to the evil eye. The evil eye is believed to be an inherent trait in some persons, sometimes as the cause of jealousy, but often not intentionally. The effects of the evil eye vary, and can result in illness and suffering of different kinds, behavior changes, and financial losses. It is also believed that certain persons (*destikars*)—ranging from lay persons to Catholic priests—have the power to get rid of this evil eye through prayer, dried red chillies, salt, burnt hair, onion skins, broomsticks, etc. Often, *desht* is removed from a pregnant woman, child, or *baanti* when they have been outdoors and when they receive compliments. Strangely belief in the evil eye is not only prevalent in the Gauda community, but also amongst Catholics. For a newborn baby, black markings on their faces, glass or plastic colored beads, and other amulets are used to ward off *desht*.

Lut: *Lut* is an illness with no parallel in modern medicine. It affects women chiefly during menstruation, pregnancy, and menopause. It is related to blood volume, the imbalance of which can be fatal. It is believed that during menopause or troublesome menstruation the blood becomes trapped within the body and needs to be 'let out'. Apart from blood letting, a treatment of herbs (*lutiche*) is applied to the affected person's head. A concoction of the same root is to be drunk and the body rubbed with burnt herbs tied in a cloth. Even younger women insisted that modern medicine has no remedy for *lut*.

Karmin: *Karmin* is less serious, affecting both women and men. It can reoccur several times a year. At first, we drew parallels to jaundice but later realized the fallacy in our attempt to force such similarities. There are seven kinds of *karmin* with varying symptoms such as diarrhea, nausea and vomiting, loss of appetite, giddiness, yellow tone of skin, discoloration of nails, temporary loss of consciousness, etc. The exact causes are unknown, but the treatment entails branding of the patient with a scalding metal rod on the forearm or with a heated coin under the

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

foot. No medicine is to be applied to hasten healing of the wound, as its slow healing aids the cure of *karmin*. Although the causes of *karmin* are unknown, the varying symptoms and their treatment were well defined by our informants. According to the older women, in the past *karmin* did not affect children, but now the incidence is not uncommon because babies are taken out of the house before one month and are polluted by the air (*vare*).

Compromise as Adjustment to Contemporary Realities

Today, menstruation remains an occasion for celebration, as fertility is highly valued. To celebrate a bride's coming of age (*zante zaub*) after marriage, a ceremony (*sangop, foresaban* or *garbadan*) is held at the husband's house which includes a *puja* (*hoam*), and the abstinence from fish, demonstrating the sanctity of the occasion. Menstruation is also accompanied by several restrictions, especially regarding movement. These customs are seemingly oppressive, as they regard this period of a woman's life as a time of impurity. Against this view, older women in the community argued that this custom is, in fact, beneficial to women as it gives them respite from certain chores and physical labor in the kitchen and at the well.

In the past girls were married at the ages of 12 and 13. Widespread disapproval was expressed if a young girl attained puberty before she was married. Currently, most girls go to primary and middle schools and are also employed. As a consequence, women now get married in their twenties, well past their puberty. A symbolic *garbadan* is celebrated the day after the wedding. Older women believe that girls now come of age earlier than they did in the past. They explain this as a result of changed diet resulting from less strict adherence to food restrictions, comparative freedom of movement, and changed dress habits. According to these older women, dietary changes are a consequence of the development of land around the village in ways that make traditional foods less accessible. It may be pertinent to note that several of the forbidden areas have been constructed upon by people from outside the community.

A woman's marital status continues to determine her importance in the village. Her role as mother is given greater distinction. If a woman is childless (*vazre*, meaning void, hollow, or empty), she is considered inauspicious, especially at occasions such as weddings and after-birth

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

ceremonies. She is excluded from village discussions. Surprisingly, these beliefs and resulting exclusion continue today.

Unlike menstruation and *baanpan*, pregnancy is not seen as impure. However, it is believed that the woman and child are vulnerable to evil eye and spirits. A pregnant woman is, therefore, forbidden from attending weddings, going to places inhabited by the goddess Sati, and being present at the celebration of *Sotti* on the sixth day after a child is born. To ward off evil and to protect a pregnant woman, four peppercorns are tied into her saree the day a child is born in the village and after six days these peppercorns are thrown away and replaced by six fresh ones. Food restrictions during pregnancy are abundant. They forbid the consumption of certain vegetables and other foods that are believed to cause harm to the mother and child. Restrictions apply to pineapple, beans (*arsane* and *chowle*), drumsticks (*muskachio sango*), papaya, red pumpkin, melon, a preparation (*pinagre*) of coconut and molasses sugar (*jagri*), aerated drinks—particular colas—to name just a few. If the pregnant woman has any food cravings, they are believed to represent a requirement of the unborn baby and the pregnant woman may be permitted a small portion of that food. Even today the restrictions and customs surrounding pregnancy are more strictly adhered to than those at any other stage in a woman's life.

As mentioned earlier, a woman who has just given birth (a *baanti*) is seen as being impure and vulnerable at the same time. She is not allowed out of the house for seven days after the delivery, as it is also believed that the now empty (*khali*) uterus needs to dry up (*pot sukhopak zai*) and is vulnerable to spirits in the air. The *baanti*'s stomach is therefore tightly bound, and she is given very little food for seven days—a diet of boiled rice along with the water (*kanji/paes*) is given for the first three or four days after delivery. This diet is replaced with bread and tea. From the fourth to seventh day she is given a curry (*aksal*) of roasted coconut, onion, and a few mild spices twice a day. On the seventh day she is given *aksal* with a small amount of fish but no prawns or chicken since it is believed that a newborn infant being breast fed can get a rash in its mouth. After seven days the *baanti* does not have to eat special food (*rashi-chi jewon*). Today all deliveries take place in hospitals, either government run or private. Hospital deliveries make it difficult for all traditional food and movement restrictions to persist as hospital staff, who forbid such abstinence, often supervise the *baanti*'s diet.

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

Recent development and large-scale construction activity have lead to the extinction of several plants and herbs used in traditional healthcare. Though the hospital system has instituted changes in the community's healthcare practices, whether it has begun a process of significant social transformation remains unclear. Interestingly, those practices that can be followed in the privacy of the home are still adhered to. For example, even today the *baanti* is not allowed to wear flowers in her hair for three months after delivery as this adornment might anger Sati.

Despite the ambiguity about *kaido*, no one in the community completely disregards traditional practices and taboos regarding food and movement. However, the younger generations seem to have accepted a changed lifestyle, their present occupations, and easy access to hospital services. It was noted that often the practice of the present day is at variance with what was narrated as *kaido* or past tradition. The changing significance of traditional beliefs, though a cause for some tension among the older generation, was at a certain level accepted, illustrating that a 'plurality of ideologies can always be accommodated within a single lifestyle' (Nandy, 1983: p. 82).

Today, several older women go to the hospital for some of their health concerns, but most often they visit private doctors despite the fact that they have to pay for services. In the final analysis, there is a mix of recourse to indigenous and modern medical cures. For certain complaints the faster cure of modern medicine is preferred. For other problems that cannot be cured by modern medicine, indigenous (*ganvti*) medicines continue to be used. However, even with regard to doctors, it is believed that a doctor must have the healing touch (*hathagun*) for her/his remedy to be effective. The faith put in the doctor is similar to faith in the village priest (*gaddi*). Often, medicines prescribed by modern doctors are treated like offerings (*prasad*).

The present changes in diet are apparently due to economic compulsions. The change in occupation from agriculture to fishing and construction has adversely affected their nutritional status.[6] Due to subsequent alterations in lifestyle, changes in the health practices are inevitable. The involvement of members of the Gauda community, though only at the maintenance levels, in the government hospitals and clinics has played a significant role in the increased use of these services by the community. Part of the explanation for the change from home delivery to hospital delivery lies in the affordability, availability, and accessibility of hospital services. Another part lies in the non-availability of traditional birth

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

attendants. The administrative problems of obtaining a birth certificate for a child born at home also adds to the preference for hospital deliveries.

The childbirth practices in the hospital-based system continue to be culturally remote from the lives of the Gauda community. Within this context the government has made no effort to make the modern healthcare less intrusive and more acceptable. Although care in public hospitals is free, there are always other associated expenses, including the purchase of medicines. The question of affordability is an added tension for women from such communities because modern medicine is far more expensive than traditional healing systems. In Goa, the increased use of hospital services post-liberation may reflect the increased educational status of the younger generation, recent economic independence, and decreased reliance on the family and community for economic support, a changed lifestyle and, most importantly, relaxation of identity guards.

The Portuguese colonization experience in India lasted 450 years, a period that would seem long enough for the establishment and acceptance of new medical practices. The clinical approach to illness as propounded by the western medical practices represents an effort to dominate traditional healing practices. However, this domination does not seem to have happened. Traditional medical practices continue to exist, although they have not prospered because of both the lack of state support and the dichotomous understanding of well being promoted by the two competing systems of healthcare. Modern medicine, like modern education, came to Asia and Africa along with European colonization. While colonization imposed changes in traditional practices through domination and persecution, it also awakened urges to retain identity. Women of the Gauda community have been able to retain their traditional, tribal health practices despite colonial restriction, three centuries of Christianity, and the recent conversion to Hinduism. Reasons for the continuance of these practices that have sustained communities for generations lie not only in the value system of these societies which have culturally resisted oppression, but also in the privacy and sanctity of the woman's body that these practices offer. The fact that fertility and reproduction are an arena of women's control plays no small part in the fact that women continue to regard traditional practices with respect. National health policy, therefore, should take into consideration not only the health practices of such communities, acknowledging women's knowledge, it must also incorporate indigenous understandings of health and illness to be more effective, less intrusive, and true to its stated agenda of the 'Empowerment of Women'.

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

NOTES

The author would like to thank the participants of the 'Women's Studies: Asian Connections' Conference organized by the University of British Columbia and participants of the Third International Conference of the Lusotopie, Goa, for their comments on earlier versions of this article. Comments from anonymous referees of this journal are also gratefully acknowledged. I wish to thank the Shastri Indo-Canadian Institute for making it possible for me to attend the conference in Vancouver, Canada.

1. This article does not support the irrationality of some of the traditional practices or those that discriminate against women. However, the article suggests that the reasons for the continuance of these practices lie not only in the value system of these societies which have culturally resisted transformation despite religious conversion to Christianity, but also in the perceived advantages to women. Some advantages of seemingly irrational practices include the privacy and sanctity of the woman's body that they sometimes offer. Affordability and accessibility too seem to play a vital role in the continuing prevalence of indigenous medical practice among such communities. The article seeks to understand healthcare and sexuality within the arena of the 'cultural' bound by political hierarchies.
2. Mitcham (1996) discusses the divergent concerns of biomedical and environmental ethics. For Mitcham, biomedical ethics is 'essentially an ethics of the rejection of nature in order to promote individual human physical welfare' (p. 11). He opines that while modern science and technology are based on the acceptance and understanding of nature, its orientation towards nature is 'so methodologically attenuated and remote, disembodied from the lifeworld and its immediate experience, that it can provide no substantive guidance for human action' (p. 11) resulting in the control and manipulation of nature for strictly human interests. On the other hand, one view of environmental ethics acknowledges that nature has value independent of any human utility function and thus requires moral consideration. This view holds a moral obligation for humans to recognize that they are part of a larger reality and must sacrifice their individual interests to those of the whole.
3. Ages of respondents were not known to the respondents themselves, thus the broad categories. Older women are those who have delivered their children at home, while younger women are those who have availed of hospital services for their deliveries.
4. According to the Goa State Commission for Backward Classes, the tribal population forms 13 percent of the total population of Goa. The Gauda community has been demanding tribal status, but they have yet to receive the Central Government's sanction. This assertion of the community's 'backwardness' is to claim discriminatory privileges from the state.
5. 'There are in Goa many Heathen phisitions which observe their gratuities with hats carried over them for the sunne, like the Portingales, which no other heathens doe, but (onely) Ambassadors, or some rich Marchants. These Heathen phisitions, doe not onely cure there owne nations (and countriemen), but the Portingales also, for the Viceroy himselfe, the Archibishop, and all the Monkes and Friers doe put more trust in them, then in their own countriemen, whereby they get great (store of) money, and are much honoured and esteemed. The countriemen (in the villages round) about Goa, and such as (labor and) till the land, are most Christians: but there is not much difference (among

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

them) from the other heathens, for that they can hardly leave their heathenish superstitions, which in part are permitted them, and is done to drawe the other heathens (to be christened), as also that otherwise they would hardly be persuaded to continue in the Christian faith' (Burnell, 1885: p. 230).

6. As mentioned already, the community was involved earlier in agriculture and rice, vegetables, fruit, and a cereal (*nachne*), grown near their settlements.

REFERENCES

Arnold, David. (1989) 'Chapter 1: Introduction: Disease, Medicine and Empire,' in David Arnold (ed.), *Imperial Medicine and Indigenous Societies*, Oxford University Press, Delhi, pp. 1–26.

Atkinson, Paul. (1990) *The Ethnographic Imagination: Textual Constructions of Reality*, Routledge, London and New York.

Ball, V. (1676) 'Travels in India by Jean-Baptiste Tavernier, Baron of Aubonne,' Translated from the original French Edition, Volume 1, Second edition edited by William Crooke, Reprinted in 1977, Oriental Books Reprint Corporation, New Delhi.

Boxer, C.R. (1969) *The Portuguese Sea-borne Empire 1415–1825*, Hutchinson, London.

Burnell, Arthur C. (1885) *The Voyage of John Huyghen Van Linschoten to the East Indies: From the old English Translation of 1598*, Volume 1, First printed for Hakluyt Society, London. Reprinted in 1988, Asian Educational Services, New Delhi.

da Cunha Rivara, J.H. (ed.). (1862), *Archivo Portuguez-Oriental*, Nova Goa, Imprensa National 1862, Fasciculo 4, Que Contem Os Concilios De Goa E O Synodo De Diamper, p. 25, Reprinted in 1992 by Asian Educational Services, Madras.

———. (1865) *Archivo Portuguez-Oriental*, Nova Goa, Imprensa National 1865, Fasciculo 5 Parte 2, pp. 543–45, Reprinted in 1992 by Asian Educational Services, Madras.

Estevao, Thomaz. (1857) *Grammatica da Lingua Concani*, Imprensa Nacional, Nova Goa.

Goa Archives 1. Book No. MS 9529 'Provisoes A Favor De Christandada': 1, Directorate of Archives, Archaeology and Museum Government of Goa, India.

Goa Archives 2. Book No. MR 93: 363, Directorate of Archives, Archaeology and Museum, Government of Goa, India.

Goa Archives 3. Book No. MS 7795 'Livro De Posturas' (1808–1832): 25–27, Directorate of Archives, Archaeology and Museum, Government of Goa, India.

Goa Archives 4. Book No. MS. 7696 'Registos Gerais' (1609–1623) C.M.I.: 118, Directorate of Archives, Archaeology and Museum, Government of Goa, India.

Good, Byron J. (1994) *Medicine, Rationality and Experience: An Anthropological Perspective*, Cambridge University Press, Cambridge.

Gracias, F. da Silva. (1994) *Health and Hygiene in Colonial Goa (1510–1961)*, Concept Publishing, Xavier Centre of Historical Research (Studies Series 4), New Delhi.

Hufford, David J. and **Chilton, Mariana.** (1996) 'Politics, Spirituality and Environmental Healing,' in Chesworth, Jennifer (ed.), *The Ecology of Health: Identifying Issues and Alternatives*, Sage Publications Inc., Thousand Oaks, pp. 59–71.

Ifeka, Caroline. (1985) 'Chapter 14: The Image of Goa,' in de Souza, Teotonio R. (ed.), *Indo-Portuguese History: Old Issues, New Questions*, Concept Publishing Co., New Delhi, pp. 181–95.

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012

Illich, Ivan. (1976) *Limits to Medicine–Medical Nemesis: The Expropriation of Health*, Penguin, UK.

Kakodkar, Archana. (1988) 'Shuddhi: Reconversion to Hinduism Movement in Goa,' in Shirodkar, P.P. (ed.), *Goa Cultural Trends (Seminar Papers)*, Directorate of Archives, Archaeology and Museum, Government of Goa, pp. 242–63.

Lynch, Riddick L. (ed.). (1969) *The Cross-Cultural Approach to Health Behaviour*, Fairleigh Dickinson University Press, New Jersey.

Mitcham, Carl. (1996) 'Biomedical Technologies and the Environment: Rejecting the Ethics of Nature,' in Chesworth, Jennifer (ed.), *The Ecology of Health: Identifying Issues and Alternatives*, Sage Publication Inc., Thousand Oaks, pp. 3–16.

Murthy, Laxmi. (2001) 'Gender Perspectives in Population Policies,' *Vikalp IX/2001: p. 20.*

Mutalik, G.S. (1983) 'Organizational Aspects,' in Bannerman, R.H., Burton, J., and Wen-Chieh, C. (eds), *Traditional Medicine and Health Care Coverage*, World Health Organization, Geneva, pp. 281–89.

Nandy, Ashis. (1983) 'The Uncolonized Mind: A Post Colonial View of India and the West,' in Nandy, A. (ed.), *The Intimate Enemy: Loss and Recovery of Self Under Colonialism*, Oxford University Press, UK, pp. 64–113.

National Family Health Survey. (1992–93) *Goa 1992–93*, Population Research Centre, J.S.S. Institute of Economic Research, Dharwad, Karnataka and International Institute for Population Sciences, Bombay (Technical Assistance from East-West Center/ Macro International, USA).

Saldanha, Mariano. (1948) 'O Ritual Do Parto Entre Os Hindus: O Seu Folclore Medico, Religioso e Social' (The Childbirth Practices of the Hindus: Their Medical, Religious and Social Customs), Separata das: Actas Do II Congresso Luso-Espanhol de Obstetricia e Ginecologia, Tipografia Portuguesa, Lisboa.

Seneviratne, H.L. (1997) 'Identity and the Conflation of Past and Present,' in Seneviratne, H.L. (ed.), *Identity, Consciousness and the Past: Forging of Caste and Community in India and Sri Lanka*, Oxford University Press, Delhi, pp. 3–22.

Xavier, P.D. (1993) *Goa: A Social History 1510–1640*, Rajhauns Vitaran, Goa.

Downloaded from gtd.sagepub.com at BROWN UNIVERSITY on December 2, 2012