RECONFIGURING HOME, WORLD AND COSMOS: HEALTH INITIATIVES IN WOMEN’S SELF-HELP GROUPS IN KANYAKUMARI, INDIA

DISSERTATION

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ABSTRACT

Based on ethnographic research, this study focuses on health education programs organized by a women’s self-help network in Kanyakumari, India, the Mahalir Association of Literary, Awareness and Rights (MALAR), and the familial practices of individuals who make up the network.

The MALAR health initiatives are part of a larger vision for women’s empowerment, consisting of economic programs that include a loans and savings scheme and development of small businesses by women (or microcredit enterprise), the building of national and international alliances to expand their efforts, based on the principles of “health-as-a-right,” which call for revising national priorities in development, as well as local campaigns that incorporate a wide variety of educational resources, including community knowledge on herbal medicine. This study argues the health practices reorient community health care and social identity, in the context of the home and in larger social domains (the world). Through the practices of belief, individual practices also revisit healing and its relationship to empowerment in the context of spiritual domains (the cosmos). The study argues the reorientation occurs simultaneously in global-level relationships and values and local relationships and values, under the overarching concept of “self-help.” Local global dynamics help to produce the claims about what
accounts for health and determine how health is negotiated in cultural practices, and involve strategic and value-laden enactments, and sites of tension such as in belief practices.

The study posits “self-help” denotes the strategies of “lay” people, a line of enquiry which stresses alternative domains of expertise and systemization in health that question official narratives, but also lays bare the ideological underpinnings of all health systems, their interconnectedness and differences. The health practices are analyzed using an agent-centered model of performance, which involves the study of cultural practices as they emerge in context, with the stress on the frameworks articulated by the people themselves. The performances establish the agency of women as patients, practitioners and activists negotiating multiple and multi-layered health care systems, but also underscores the limitations of the resources available to women.
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CHAPTER 1

APPROACHES: LARGER-THAN-LOCAL HEALTH SYSTEMS

Our purpose is to demonstrate the social and cultural character of all medical knowledge, but by doing so we are not denying the existence of real, painful stress and suffering. There is, of course, a biological reality, but the moment that efforts are made to explain, order, and manipulate that reality, then a process of contextualization takes place in which the dynamic relationship of biology within cultural values and social order has to be considered.

-Mark Nichter, Anthropological Approaches to the Study of Ethnomedicine.

Reconfiguring Home, World, and Cosmos.

Based on ethnographic research conducted in a women’s self-help network in the predominantly rural district of Kanyakumari, Tamilnadu, the Mahalir Association of Literary, Awareness and Rights (MALAR), this study focuses on the health education programs and healing practices organized by the MALAR network and the familial practices of individuals who make up the network. The material presented here comes out of my extensive travels in 2000-2001, and my observations of the activities of the MALAR network in Kanyakumari district. The focus is on group and individual practices in the village of Mangaalimoodu and its vicinity.

The MALAR health initiatives are part of a larger vision for women’s empowerment, consisting of economic programs that include a loans and savings scheme
and development of small businesses by women, the building of national and international alliances to expand their efforts, based on the principles of “health-as-a-right,” which call for revising national priorities in development, as well as local campaigns that incorporate a wide variety of educational resources, including community knowledge on herbal medicine. The MALAR “self-help” initiatives involve the development of particular kinds of networks and programs that address women’s complex social roles in local and global politics. I argue this involves strategic community building exercises within the MALAR network, but also the knowledge base on social and economic issues within the local communities is expanded and systematized through the creation of publications, discussion forums, and training and leadership modules. Born out of a successful and popular government-initiated district wide literacy campaign, the MALAR network aims to continue informal adult education and mobilization of community women around social justice issues. These goals are achieved by developing a community-run economic base to ensure a democratic mode of functioning and also sustainability of community programs while providing greater economic opportunities for women. The health practices are key strategies in enabling social change. I argue, articulated as “self-help,” the health practices reorient community health care and social identity, in the context of the home and in larger social domains (the world). Through the practices of belief, individual practices also revisit healing and its relationship to empowerment in the context of spiritual domains (the cosmos). I argue the reorientation occurs simultaneously in global-level relationships and values and local relationships and values, under the overarching concept of “self-help,” that is, local
global dynamics help to produce the claims about what accounts for health and determine how health is negotiated in cultural practices. I argue this reorientation must be understood as involving strategic and value-laden enactments. I also emphasize the agency of the women of MALAR in negotiating health care and envisioning futures for their local communities, but also larger “imagined” national and international communities.

What counts as development is the pervasive backdrop of this project- the MALAR initiatives stand for one of many kinds of “lay” articulations or in MALAR network’s terms a “people’s” point of view, in the context of India, which specifically address the challenges and affects of globalization, or more specifically neo-liberal principles implemented in India since the early 1990s through the Structural Development Policies of the World Bank and other institutions.

Margaret Lock and Mark Nichter have noted, in the recent era of development interventions, non-governmental actors have played a crucial story in telling the story about “development” in the developing world especially. The stories of the non-governmental actors complement the governmental or nation-state’s official narratives of development but have also radically changed the nature of the dialogues and range of activity, reflecting and reworking notions of development itself (see Kamat for an excellent overview of these trends in the Indian context). Arguing for understanding the political nature of these claims, Lock and Nichter observe that non-governmental actors are “ushering and resisting new moral orders” through their development interventions which involve particular kinds of claims about “empowerment, emancipation,
nationalism, internationalism, individualism and so on” (9) (my emphasis). MALAR’s is one such project, involving community members in participatory and leadership roles.

MALAR’s initiatives involve visions for social change in the local communities of Kanyakumari district but also seek systemic, national level change. MALAR argues for a rights-based vision of development – that is, “the moral orders” (borrowing from Lock and Nichter) envisioned here are those of “health-as-right” and “health-for-all.” MALAR takes on the challenges of the shifts in role of both the nation-state and those of civil society and non-governmental actors and proposes partnerships among them, while at the same time seeks autonomy as an organization, which is crucial to its organizational identity especially at the local level. The health initiatives of MALAR in the process of reorienting global local relationships, seek the opportunities within the modern nation-state that will empower MALAR women in meeting the challenges of their patriarchal but also poverty-ridden communities (that is, MALAR envisions changes in local norms and resources), at the same time critique some of the affects of “modernity,” in health policy and biomedicine in particular [what Mark Nichter has called “defective modernization” (“Political Ecology” 102)] through the practices of indigenous folk healing as well as through a general reification of the “home” (where the bulk of the initiatives take place) as an asset for women (that is, some forms local knowledge and sense of community is valorized). It is the integration of these claims enshrined in MALAR’s vision that my analysis seeks to track and unpack, articulating that underlying this seemingly seamless integration is a kind of history-telling, what I call in Chapter Two chronologies of health, which involves the selections of various perspectives on
health, a complex undertaking in ritualized activity (what I call the “rites” that embody “rights” in Chapter Three), ongoing internal critiques in the organization revisiting these claims and so on. I demonstrate that the cues to how these claims are made, a process which I refer to as reorientation, are embedded in the practice of health initiatives themselves. Lest my arguments are called upon to claim that organizations like MALAR represent a “partial” view of things and are therefore dismissible, I argue these chronologies and rituals are part all health systems. The integration of multiple healing modalities also speaks to the “co-existing ideologies” within all health systems, a process, which Mark Nichter notes, has sometimes involved resistance to established ideas of health, but also appropriations of those agendas (Anthropological Approaches to Ethnobotany xiii). The MALAR initiatives and the nature of the network itself exemplify the appropriation of established notions of health and empowerment but are also sites of resistance. The practices of the MALAR network are also sites of tension such as those involving spirituality, which offer in some instances critique of all existent avenues for empowerment, but exist in an uneasy relationship with other practices in MALAR. The project of the empowerment of women is thus characterized by these sites of appropriations, resistance and contestation.

My line of enquiry uses the post-modern critique of interrogating the ideological underpinnings of local and universal truth-claims, including those underlying “the invention of authentic traditional cultures as place-holders of their opposite (modern, mass-produced, global economies)” (Shuman and Briggs 115). As critics of development discourse like Arturo Escobar have noted, development, by contrast, has been conceived
as a globalizing force which is seen as a corrective to local norms, and furthermore has been constructed as a value-neutral project. Arturo Escobar has noted, speaking to the nature of history-telling (or value-laden culturally informed narratives) involved in development discourse itself, that it involves telling the story about the “objects of development,” that is, the recipient communities like those that MALAR members are part of, by first stripping them of history so that they can then be “reinstated into implicit (and explicit) typologies” with “development as guide” (9). In this history-telling, people are “development categories” who are “at risk” for various kinds of real and perceived threats but also are threats themselves to the project of a particular kind of ordered world (see especially Lock and Nichter, Pigg, and Escobar). Development discourse constructs local knowledge and norms in a similar fashion that it does the recipient communities, so that it would appear development “animates the static and manages the chaotic” (Escobar 9).

The interrogation of claims made about local knowledge and the local communities involved, both in the universal claims about development, as well in those that see the local as a corrective to universal claims, that is, where local knowledge is a claimed to be a natural “placeholder” for certain kinds of values (to evoke Shuman and Briggs) lies at the heart of MALAR’s own critique in terms of self-help that focuses on the position of disadvantage and advantage of women in these narratives about local knowledge, and my own project of understanding the political, dynamic nature of MALAR’s critique. The practices of the MALAR network reveal that local knowledge about health is dynamic not static, but they also demonstrate local knowledge can be
highly systemized not chaotic, and is already “larger-than-local” to begin with (Shuman 345). If anything, the state of “chaos,” from the perspective of the MALAR women, ensues from within their communities, particular policies and delivery methods of the nation-state and the larger forces of globalization all at once, against which they self-consciously position their vision, that is, they too construct they own chronology of chaos and cure, but their vision highlights the asymmetrical relationships of power involved in the large range of community resources and programmatic interventions in their communities, and the conditions that both support and constraint the agency of women. MALAR’s women-run, “people-centered,” rights-based initiatives are thus characterized by both resilience and fragility.

**Ethnographic Trajectories and Fieldwork**

I conducted fieldwork research in India from October 2000 to June 2001, which included long periods of observation in the MALAR network in Kanyakumari, Tamilnadu, India between December 2000 to May 2001. I had spent two summers (1998 and 1999) prior to this visit looking at health literacy programs conducted by governmental and non-governmental groups in villages and semi-rural cities in other districts in the state, to address general health issues but also specific practices in the communities such as female infanticide. While conducting this research, I got interested in the notion of “culturally” and “locally” appropriate presentations that were defining features of many of these campaigns, using performative forms such as street theatre. It was my observations that these were increasing becoming buzzwords in development initiatives.
In the cases I was observing, the principles of “culturally and locally appropriate” programs generally alluded to the forms of presentation, such as street theatre that borrowed from other traditional and contemporary forms of entertainment, but also the involvement and the training of local youth from the villages. The purpose here was to involve the local populations and build a core of social workers over the long run but also was intended to get the viewers to identify with the actors and to recognize that the issues being raised were happening in “their backyards.” The processes of producing material that was distinct in its style as plays (though it borrowed from forms of traditional theatre) but portraying characters and situations that were “real” (and therefore likely to be persuasive or “locally and culturally appropriate”) was interesting to me, but equally fascinating was the idea that the recipient community was both part of the problem tackled and its solution. It raised questions for me about the reliance of these interventions on framing (and reframing) social identities in particular ways. Shiv Visvanathan had noted in his analysis on the discourse of development, the “poor, the squatter, the migrant” who the primary targets of development are seen to be “paradoxically both the unit of progress and the index of retardation” (7-8). The question of social change and intervention (including through that seek cultural appropriateness) as connected to social identity is clearly thick with contradiction and irony.

My own questions were: so who are the recipient populations (or “target” populations in the parlance of development work) and how did they negotiate these characterizations? And what of the local practices that were to be changed (while of course there were others than were encouraged)? How is “change” itself articulated and
by whom? My first sets of questions were very much focused on the agents involved in these initiatives. As I spent more time observing other campaigns in the country, I also became interested in the idea of networks that agents are part of and the impact of the nature of the network on community knowledge. What counts as community knowledge itself began to emerge as one in a state of flux.

On my return to the U.S. in 1999, the desire to be a more direct participant in these campaigns lead to me to activist work, mostly in Columbus, Ohio, through the Association for India’s Development, whose focus is in fund raising and funding non-governmental work in development projects in India, but also involving direct delivery by activists in various local organizations in India itself. It is connected to a wide network of non-governmental organizations in India. My own interests with these networks especially those focusing on health lead me to MALAR, a women’s self-help group run by community members themselves. The street theatre groups in the state of Tamilnadu trace their systematic use in development campaigns to mass literacy movements, initiated by the government through the National Literacy Mission in the early 1990s through involving various community groups. Several self-help network in districts like Kanyakumari including MALAR followed from the mass literacy campaigns as a way to sustain efforts of the literacy programs. The occurrence of both “instant” mobilization programs such as through street theatre and long terms efforts were very much a part of the development terrain, with non-governmental intervention especially, in my observation. This is significant because, as I will argue, ongoing and incoming programs are understood at the community level with relation to prior experience. In this complex
terrain, community knowledge is cumulative, highly diverse and already “larger-than-local” (Shuman 345).

Another trajectory of interest and critical positioning comes from my interest in (Indian) indigenous healing, based on my family practices in dietetics especially, which involved various “home remedies” for small ailments and food as preventive medicine. I became interested in MALAR’s health initiatives primarily because of their education programs on indigenous healing practices, alongside with lessons on communicable disease prevention, family planning, hygiene etc. These practices were seen to be part of a movement involving the notion of health as embracing physiological, social and economic issues and the role of “citizens” (a social category based on particular assumptions itself) in addressing gaps in health delivery and seeking change in health policy and implementation. These ideas echoed my own growing orientation in viewing the healing practices from my own family with relation to larger “alternative” health movements in the U.S, often involving non-western therapeutics, addressing a wide range of health issues ranging from palliative care to diseases like cancer and AIDS to countering everyday stress. In my research interests and participation in the ever growing network of health stores and food cooperatives in the U.S., I observed an articulate “lay” population and “lay” evaluations integrating numerous and often complex health therapeutics which I felt inspired by. Having said that, my interest in my fieldwork were in the particularities of MALAR’s experience, conscious that my own participation in these “lay” or ”citizen’s” health movements evolved from access to very different set of resources. I will demonstrate what I shared in common emerged in my interactions,
though my starting places in enquiring about indigenous healing within the MALAR network came from my personal practices.

MALAR’s primary task was that of collective savings but also, like other similar programs in many parts of India and other developing countries, were forums for informal adult literacy, in which health was an important topic. This literacy program was part of a larger effort organized nationally by groups such as the All India People Science’s Network (more specifically its state level entity, the Tamilnadu Science Forum). There were avenues and an organized mechanism for sharing resources and programming in this national network but local organizations like MALAR work autonomously to conceptualize and implement their local programs. For instance, within MALAR, workshops for teaching and training women in the use of traditional women are conducted by national and local non-governmental organizations, in which women voluntarily take part, but women develop and implement their own programs as well, including dialogues in the 1000-odd self-help groups (each comprising about 20 women) that make up MALAR based on a common newsletter and organizing herbal medicine preparation in groups.

In these literacy programs, herbal medicine is promoted as a ‘first-aid’ and linked to ‘self-help’ in economic and social spheres. As mentioned earlier empowerment and well-being in the physiological, social and economic sense together constitute health. These issues I deal with in Chapters Two and Three specifically. Chapter Four takes up these issues within the context on one healer’s practices.
The programs use recipes and home remedies that are part of the local folk indigenous healing knowledge but there were some crucial differences between the home-based knowledge patterns and those in the self-help groups, including the practice of folk healing as a collective activity (outside the family) by MALAR group members, issues dealt with in detail in Chapters Three especially, and the lack of emphasis and sometimes skepticism about the spiritual/religious aspect of folk healing in the self-help groups, the subject of Chapter Six. The relationship of each practitioner to MALAR is varied suggesting a diversity of ways in which women’s own home-based health practices were affected by these programs and how their practices differed from those promoted in the programs, which I deal with in all chapters but especially Chapter Three.

As noted before, these programs are also, in local memory, linked to various failed governmental projects but also other NGO programs in the district that several of the coordinators of MALAR in particular have had contact with. They are equally concerned with the commercialization and corruption of professional indigenous healing. In Mangaalimoodu, this took the form of criticisms of a local healer who was selling herbal medicine as alcohol. Local memory of the value of the “genres” of literacy and other development programs that had existed prior to MALAR (included those conducted by a local church in Mangaalimoodu) as well as traditional healing thus also contributes to local evaluations about home remedies and health literacy in interviews with me.

My documentation in the MALAR network covers the proceedings of numerous meetings of the self-help groups in the Mangalimoodu and some neighboring villages, observation, participation in activities in the homes and extensive interviews with
practitioners. In the two key forms of ethnographic research, participant-observation and interviews that I employed, I was guided by the following questions that I developed within the first month of my time with MALAR. The questions, directed towards the MALAR groups and individual practitioners, addresses how their practices figure into larger questions of health, the resources available to the local community and how they are used and interpreted.

1. Do you use herbs and medicinal plants, in your cooking, worship and to treat illnesses? Are there other uses?
2. What are some of the main illnesses in your community/family? Could you prioritize them for me?
3. What are the different ways in which you manage these illnesses, both short term and long term (if you need to make that distinction)?
4. What are the different traditions/places you can turn to? Why do you select the ones you do? Is it based on traditions of belief in the family, or issues of access, or particular illnesses?
5. Why do you use herbal recipes in the household level? How do you prepare them? Is this work collaborative?
6. Where did you learn this? Have you taught other people? If you have taught other people, in what ways did you do so—individually, through organizations like MALAR? How did you develop the material—whether from memory, printed material and/or demonstration? Do you do this for a livelihood? Do you know if
people adopted your recipes? Do you monitor what they have done? What are some of the successes of your project and its limitations?

7. If you learnt from other people, what did you learn-something new, a validation of practices you already knew perhaps? What did you adapt/renew/start and what are some of your evaluations based on this?

8. Were your family or you doing things differently a decade ago/a year ago/when you were younger? If you are a newcomer to the village, are things done differently here than where you come from, and in what ways have you adopted local practices?

9. What are the things you see as fundamental to both understanding and practicing these traditions?

In looking at MALAR initiatives, I looked at several reports and newsletters from their office and also observed many MALAR activities and spoke to their coordinators at length. My interests were:

1. What is the impetus of MALAR’s health programs? Since you have conducted assessments of health conditions in villages, what are some of your observations there, and what issues does MALAR’s programs address? To what degree and in what ways has the question of folk medicine been addressed?

2. What is your sense of MALAR structure? Which ones did you begin with and which ones were evolved later? What models do you look at when starting yours, including the ways in which the different voluntary work is categorized, and in what ways did you adapt them to your local needs?
3. What is your sense of how MALAR fits in ideologically in terms of social work/movements—in terms or women’s rights, or development models, or particular local, state or national problems etc.? What is your sense of how volunteers understand this larger picture and its connection to local needs and identity? MALAR is an offshoot of a literacy movement in the early nineties and you have suggested that it informed a great deal by the ethos of that movement—in what ways? In what ways have you grown differently from that structure and ethos?

4. Are you aware on other projects/networks similar to yours? Have you visited them and if so, what were your evaluations?

In trying to understand the role of the members in MALAR involved in health programs in particular, I asked:

1. What is the length and degree of involvement with MALAR (including the literacy movement if you were involved in that as well), and could you construct a biography within the organization, detailing the highlights? What were you doing before that, and where do you think you want to go, outside or within the organization, especially with particular ideas that you would like to see implemented?

2. What health programs have you been involved in, and in what capacities have you been involved—could you give me details of some of your assumptions, the training, implementation, dilemmas, re-appraisals working on the program in as much detail as possible?.

3. What is your understanding of MALAR, and what are some of its effects on your attitudes and your work? What have been your personal initiatives in the programs,
especially on the programs on folk medicine, in terms of evolving the
program/material, implementing it, monitoring it?

4. Were you preparing and using herbal medicine and recipes before you worked on
this project? Did this program affect the practices you were already practicing- in
terms of belief, or practical knowledge? In what ways in this network helpful to your
attempt to bolster the traditions, and what are the limitations?

Though I do not explore all of my interactions in this project, my research also
included interviews with professional health care practitioners in the village, including
staff of government hospitals and professional traditional medical healers, as well as
observation of activities of groups similar to MALAR and conversations with activists in
the state and other parts of the country involved in health literacy projects, especially
those involving women’s groups.

My own interest is not to provide a prescriptive analysis or assess the efficacy of
the programs or the remedies but to explore the rhetorical strategies that seek to reorient
notions of health and individual and organizational/network agency. This includes
records of what practitioners offer as criteria and methods of evaluation, echoing Bonnie
O’Connor articulation of interests in health systems (O Connor xvii). I am also interested
how community is “made” through these performance- to give life to the narratives, one
needs a network. To create and maintain a network, one needs to present ideas about
identity that denotes commonality. What is of interest to me also is how these politics are
played out in practice in this particular context and the interrelation between the
“imagined” and experienced spheres of health-as-politics.
MALAR’s “Self-Help” Initiatives

From the start, MALAR sees health as interrelated to social and economic empowerment. Related to this idea is the argument of “health-as-a-right” (following from the “health-for-all” declaration of the Alma Ata UN Conference in 1978), which embraces the idea of health not just as illness management but also as a state of well-being which includes social equality. The focus of the “health-as-a-right” perspective is health delivery to everyone irrespective of economic status. Ongoing local health programs (which are discussed and evaluated in the MALAR groups) and MALAR’s own initiatives are framed around the idea of “health-as-a-right.” Furthermore, the programs emphasize “self-help” which qualifies the notion of “health-as-a-right” in particular ways. First, “self-help” involves the familial home-based practices as well as those organized by MALAR which also involves group efforts. The programs include discussions, training members in workshops held by various non-governmental groups and by MALAR member themselves, and the making of herbal medicines in groups. As defined by MALAR, self help includes embodied, everyday practices that rely extensively on local natural resources and social networks.

“Self-help” is also a conceptual framework which assigns value to all these practices in terms of creating and maintaining autonomy for community-based organizations such as MALAR from governmental and international non-governmental organizations. On the one hand, the stress is on educating community members to be pro-active about their health, in terms of increased education about health issues,
administering their own therapies, and in building networks with like-minded organizations to build a collective voice to represent their cause for “health-as-a-right.” But “self-help” also encompasses MALAR’s desire to maintain an identity as an organization in which the terms of participation in social and economic programs in the community will not be one dictated to them but one which involves MALAR women as equal partners and collaborators. The desire to maintain an independent identity encourages MALAR to avoid funding from international or “foreign” aid agencies as well as to seek autonomy in decision making in accepting governmental financial support.

As I have noted earlier, MALAR operates a loans and savings scheme for its members, commonly referred to as a microfinance or microcredit enterprise, which is a scheme widely practice to tackle poor people's access to capital in developing countries since the Grameen Bank pioneered the practice in the 1970s in Bangladesh, which involves credit allocation for the poor. One aspect of the microcredit enterprise that the MALAR network uses is organizing women into groups of at least twenty women each. MALAR is a network that is composed of about thousand such self-help groups. A standard practice in microcredit schemes across the developing world is to call these groups of twenty or more women “self-help groups.” This title is based on the group’s own credit generating and credit monitoring abilities. As is typical in microcredit schemes, in the self-help groups I observed, each group generates its own funding from

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1 For history of Grameen Bank, see Banker to the Poor, a book by its founder. See Mayoux, discussed in Chapter Three of this dissertation for critical reviews of the microcredit scheme. My project does not take up a comprehensive study of the micro-credit scheme but rather focuses on the health initiatives that complement the scheme in MALAR.
weekly savings by the members of the group and also receives loans at low-interest rates from banks and governmental credit agencies. These funds become part of a common corpus of the self-help group. The funds are then redirected as individual loans to the members of the group. The members of the self-help group decide which member can receive the loans, depending on levels of emergency. They also keep track of repayment and maintaining accounts with the bank. Each group has its own separate account with a government bank nearest to their village. In the MALAR network, a small portion of the funds of each self-help group go directly into a corpus fund for use in activities common to the whole network.

Government credit institutions also lend money to the MALAR network as a whole. These funds are then redirected back to individual self-help groups based on decision made by the district level office bearers of MALAR, based on similar criteria that each self-help group uses. Typically, each network, such as MALAR, which use the microcredit scheme, determine the scope of “self-help.” In India, the government institutions which provide financial and logistical support to self-help groups and monitors the use of micro-credit schemes, including the National Bank for Agriculture and Rural Development (NABARD) expect some level of informal adult literacy programs take place to in these groups, but each group or network of groups determines the scope of those programs. Therefore, MALAR interprets “self-help” based on its own vision, though following general guidelines and credit regulations set out by government institutions such as NABARD. Through the microcredit scheme, MALAR is able build a funding structure for the network’s activity and to provide credit for its members based

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2 Based on personal communication with NABARD official in Kanyakumari.
on decisions by the members themselves, and therefore maintain a high degree of autonomy, while also utilizing funds from governmental entities like banks and credit institutions.

In addition to the use of microcredit schemes, another way to view MALAR’s use of the idea of “self-help” to create identity for itself as a distinct network, is to understand how it involves the articulation of MALAR’s role in the larger health delivery scenario, which includes the work of institutions of biomedicine (governmental and private) and indigenous medical systems like Siddha and Ayurveda (which are mostly private). MALAR sees its work as complementing these other resources. In its own programs, women’s role in providing health education and care (among a host of social issues) is acknowledged and strengthened compared to these other networks. Member of MALAR also position themselves as watchdogs to monitor the services of the government health care system in particular. Members of MALAR acknowledge that they are connected to these other systems as patients but also as practitioners. The MALAR members stress their work as practitioners overlaps with those of biomedical and indigenous medical services, in material and conceptual ways. At the same time, the MALAR network wishes to assert its role as an independent network, especially in terms of finances. In other words, the particular configuration of the network is seen by MALAR members as an intrinsic part of the change envisioned, so understanding the strategies of networking is very important in my analysis of MALAR’s health initiatives.

The role that MALAR envisions for itself addresses particular contemporary problems. “Self-help” is seen as necessary to address the gaps in current health delivery
which do not adequately address health problems in the community and which are now only widening. With the implementation of the Structural Development Programs in Indian national policies since the early nineties (or more popularly known as India joining the global economy or the advent of globalization in India), based on neo-liberal principles, including an increase in privatization in all sectors including in social services like health, MALAR and its partners, a large network of civil society and non-governmental organizations, argue governmental health care system in the service of the poor especially has been scaled back and also the quality of health delivery has depreciated. MALAR and its partners see government health care as a key site where “health-for-all” programs can and has to be implemented. With relation to its own programs, MALAR sees self-help practices in workshops and home based medicine as complementing these services but do not see the practices as viable replacements for governmental support in health. Indeed, MALAR initiatives stress civil society groups such as itself are potential collaborators with the government since civil society groups are increasingly doing the important work of health education and delivery of particular services anyway.

More importantly, MALAR and its networks seek to change the new directions in national policies of the nineties and rearticulate those priorities so that there will be a focus on the basic rights of citizens irrespective of social and economic class. The relationship with the government is not discounted but rather reframed and reiterated. Primarily, MALAR members seek change by educating their local communities and by building coalitions, and participating in local, national and international campaigns that
will help to put pressure on the government. “Self-help” is then part of a political movement which seeks to place at the forefront of national development the needs of the poor (which still make the majority of the country’s population) - framed as “people-based” health where basic human rights have a priority over profits. The MALAR campaigns emphasize that in determining national development, the experience of people should be taken into account—their experience of their needs and inadequacies of the government health system as well their potential to be collaborators in health delivery. Indicated here are then changes in ways of governance—since a more decentralized health system is being called for. MALAR’s members seek better coordination with the local personnel in the governmental health care system, such as the Village Health Nurse (VHN) but also seek more systemic, national-level change through participation in international campaigns like the People’s Health Assembly in 2000. I will look that these initiatives in depth.

MALAR’s own dialogues in weekly meetings at both the village level and district level are especially useful sites to understand how health care is being reoriented. It is at the level of the everyday meetings and interactions that MALAR members take up these challenges regularly, expressing these frameworks of “self-help” and articulating what MALAR can do. The contours of these dialogues among MALAR members are complex. On one hand, MALAR sees itself as conversant in community’s attitudes and challenges, as it is made up of community members, but its organizational identity comes from seeking social change in the communities; awareness and leadership building and increasing economic opportunities for women constitute the larger vision for women’s
empowerment. I will argue that these ideas and programs are highly dynamic. The informational resources come from both inside and outside the network and these ideas are evaluated in terms of MALAR’s own priorities and experiences. MALAR supports ongoing dialogues about what is valuable with an element of trial and error rather than a fixed set of practices or values in terms of what constitutes health care. Further, the responses within each of the groups in the network and those of individual members are themselves diverse and dynamic as well. It is in this sense, in stressing the dynamic, diverse and strategic nature of MALAR’s initiatives, that I will argue that reorientation in community health takes place. This reorientation emerges in the everyday performances but it is also something that MALAR self consciously undertakes, identifiable in meta-narrative cues in the dialogues about the value and the meaning of these initiatives. MALAR members understand clearly they are involved in social change and dialogue about their own particular ways of seeking and embodying those new directions. Some of the outcomes of these dialogues concern empowerment, autonomy, development, ideas which are part of the everyday language of the movement. These ideas are not fixed but interpreted and assigned value on an ongoing basis, based on whatever set of challenges face an individual group in the network or the whole organization itself. The boundaries of the network itself are constantly being redrawn as it keeps growing and its informational resources are always changing too. Explaining its vision and discovering its priorities in the light of these changes are important for convincing both new and older members. Further, MALAR begins with the understanding that while many ideas about health may seem self-evident, they will be more effective if they are reiterated. For
example, the inclusions of healthy recipes borrowed from members’ own families will be seen as valuable if taught anew in groups as preventive medicine.

My work also addresses how “self-help” is part of a politics of solidarity which emphasizes commonality of women’s experiences and their collective challenges. One of the areas within home based healing traditions that receive less attention in the MALAR groups is practices that have a spiritual or religious basis, as religion is seen as divisive. This is an example of how the boundaries-drawing aspects of the MALAR network can also involve some tensions. In other words, what emerges as community knowledge about health care interpreted by MALAR is not just dynamic and diverse but also selective.

Performances of “Lay” Practices

My study views MALAR’s initiatives as communication strategies or performances, which involve the contextualizing of health within specific cultural practices and social relationships. Contextualization takes place through frameworks of “health-as-a-right” and by creating a system of workshops, discussions and campaigns that provides the embodied basis for such agendas at the everyday level. Performances that have emerged through my ethnographic research include the telling of narratives, teaching, engaging in embodied healing rituals, and participating in training programs. These performances draw from cultural resources from within and outside the Kanyakumari communities. I refer to these as “performances” because I understand them to be interactive and to involve the participants in complex social roles vis-à-vis each
other and vis-à-vis healing. One kind of performance is the performing of healing. Talking about healing, whether in narrative or in training programs, is also a kind of performance integrated into the healing rituals.

When analyzed as performances, these initiatives can be understood as reassembling notions of social identity and power, circulation of knowledge, and cultural values and norms, including the role of women and notions of poverty, which emerge in interaction between people. This research project is based on an *agent-centered* understanding of cultural performance, that is, taking into account patients’ and practitioners’ understanding of what they do. An agent-centered view of cultural performances reveals how people are actively engaged in negotiating their health care through interaction and dialogue. I will demonstrate how the practices are diverse and dynamic, drawing together cultural resources and interpreting multiple healing modalities. I will also argue the performances offer complex, sometimes contradictory notions about health care. I am also interested in how these initiatives involve larger social discourses. These practices are not random or new responses to health but rather organized movements that draw from a variety of cultural resources and seek to actively connect their work to larger social movements and long standing debates about health, through discursive and embodied means.

I understand these initiatives of “self-help” as the practices of “lay” people or “lay” practices. I do so first to emphasize the various levels of systemization involved in these initiatives. In this conceptualization of “lay practices,” I follow MALAR’s position as exemplifying “people’s experiences” which in my reading is about creating for itself,
as an organization and for its women members, an arena of expertise that contrasts to official narratives about health. MALAR initiatives include “lay” theories about what health policies should include and why and emphasizes the role of MALAR members as “lay” practitioners themselves. As practitioners, MALAR members see themselves as outside of institutional networks (the professional networks of biomedicine and indigenous healing) and revisit their own practices and recognize them as valuable though indeed they assign special roles for themselves in community health care in the process of arguing for greater collaboration with the governmental network. I want to note that there are strategic moves involved here by MALAR members, in carving out conceptually a place for their work, based on which certain kinds of social change are called for.

MALAR initiatives involve a process of systemizing in taking what are home based practices and making them part of district wide, group-based efforts. The initiatives also involve developing training and teaching modules that incorporate both new resources and build on well known home based practices. Further, these initiatives integrate both biomedicine and folk/indigenous healing practices, from education in AIDS prevention to herbal medicine. So a range of issues are involved in these performances—from articulating ill-health to particular programmatic interventions. Further, MALAR is involved in complementing its local programs with national and international campaigns. I will argue there are multiple layers to these “lay” initiatives, where traditional practices, with a strong basis in past customs and new contemporary health issues are taken up, and also new kinds of local and global relationships are being
envisioned. In addition to investigating MALAR’s own initiatives in groups, my research also looks at individual members’ responses to the MALAR initiatives and their own family-based practices in understanding how the MALAR network reorients health care. I want to also observe that the members of MALAR, as patients of the existent health care systems, offer their evaluations in their group initiatives and on an everyday basis within families. This represents another level of systemization. This is included in my study of “lay” initiatives in health care as well.

It might appear that I am seeking to emphasize a kind a separate arena or sphere of health activity in describing MALAR’s work through the framework of “lay” practice. I will argue that this is indeed so but uncovering what that entails is part of the project. I see notions such as “lay” and “self-help” not as natural categories but rather as strategic ones, involving frameworks that present selective views of reality (Burke, Language as Symbolic Action 45). Resources of traditional knowledge or global alliances, for example, are selected and integrated into the local level practices and the local level health issues are collated and framed through principles of the human rights at the global campaign level and so on. In the MALAR initiatives, the “traditional,” “global,” and “local,” “indigenous,” “lay” etc. are conceptualizations whose boundaries are being reworked. How the levels of integration take place is evident in individual performances and group dialogues. The performances suggest a diverse, complex terrain about what constitutes “lay” practice.

Further, my interest is in the conditions under which performance and the cultural knowledge that the performances embody is produced and what kinds of interests and
norms are supported by these selective frameworks. My analytical framework involves understanding the politics of culture embedded in these performances, so that for example, we can see how the particularities of local politics influence the selections of the lessons from global campaigns in the local level initiatives. Thus, I will explore how healing practices are embedded in the dynamic interplay of values and organization of social relationships and networks, local and global politics, and in varying discourses of self embedded in these relationships and networks. I am particularly interested in how gender identity emerges in these performances and the questions the performances they raise about agency of women as patients, practitioners and activists negotiating multiple and mutli-layered health care systems.

I base my arguments on the view that all health care systems, including those of biomedicine, are themselves culturally embedded and dynamic- indeed the basis of what comes to be an “institution” or a “system” itself is included in this line of enquiry. Viewed this way, “lay” practices cannot be dismissed as “subjective” (and therefore “random” and “unsystematic”) since I begin with the understanding that all medical systems are cultural systems and value-laden. In other words, I argue “self-help” denotes the strategies of “lay” people, a line of enquiry which stresses alternative (or “lay”) domains of expertise and systemization in health that question official narratives, but also lays bare the ideological underpinnings of all health systems, their interconnectedness and differences.

As I will note, in the history of scholarship on folk and indigenous medicine, these kinds of “lay” practices have been seen as outmoded and associated with
“backward” groups. Studies that emphasize the cultural dimensions of all health systems have questioned the basis of value-neutral categories and have uncovered the underlying ideologies in play, including those of scholars’ ideologies who have seen themselves as occupying a value-neutral place in making their own evaluations. These same studies have further questioned the purported superiority of “modern” medicine (referred to as biomedicine here, based on its theories of the biological cause of illness) over other systems of medicine. The studies have been interested in how folk, indigenous and other non-biomedical in general are coherent, sophisticated systems of knowledge themselves (where the emphasis is on “systems” of knowledge). Similarly, these studies have questioned the idea that these practices will eventually disappear with the increased use of biomedicine, and are therefore “backward” practices. This recent scholarship stresses that it is more the case that both biomedicine and other “alternatives” are widely used and in fact emerge as complementary systems.

Patients and lay practitioners have been especially useful in established the complementary nature of these health systems. The simultaneous use of the resource of multiple systems by patients and lay practitioners suggests that all these systems are co-present. Further, in “lay” practice, various health resources are being selected and integrated in complex ways. So the boundaries between the systems are especially blurred when viewed from lay practitioners and patients point of view. The distinctions are however important because of the issues of power between the social groups involved, such as between patients and doctors, one class of practitioners and another and so on. Therefore, I suggest the category of “lay” is additionally important in terms of how
it denotes a social group that is distinct. I am interested in the process of boundary-making and the strategic and political interests and values that these boundaries allow for, whether in “lay” or other health systems. I will also suggest that the strategies of boundary making emerge in performance (that is the boundaries cannot be assumed and defined in advance but emerge in interaction). Indeed, observing the “emergent quality of performance” (Bauman 48) is especially useful in understanding “lay” practice as it registers in social interaction and dialogue. I will also demonstrate how my own subjective position as “lay” practitioner of herbal medicine, health (primarily food) activist and researcher affected the constructions of these frameworks and the everyday level of interaction in my ethnographic research.

The analytical process in this project engages with the following theoretical trajectories within folklore, cultural studies and anthropology:

1. Discussions of health systems as intrinsically dynamic and culturally mediated. In other words, health systems cannot be described in value-neutral or culture-neutral terms. These discussions include the value of experience-centered and performance-centered perspectives.

2. Discussions of theories of performance nuanced by the politics of culture, connecting strategies of communication to issues of power and social justice. In other words, the context described here is “larger-than-local” situations and includes larger social discourses.

3. Discussions of self-reflexive ethnography, engaging with the role of the ethnographer in the production of knowledge. In other words, I am not attempting value-neutral
research but instead intend to address my role as part of the process of the production of knowledge.

My critical reading of the scholarship will focus on the ways in which patients and lay practitioners’ understanding have been constructed.

**Dynamic of Health Systems and “Lay” Perspectives**

Uncovering the value of “lay” perspectives involves an understanding of the value-laden scholarship that has assigned to them evaluations such as “backward” and “deviant.” Speaking about the history of scholarship on folk medicine, Patrick Mullen, Bonnie Blair O’ Connor and David Hufford in their reviews of the field have noted that folk belief (which includes folk medicine) has often been referred to as superstition or quackery. Cultural evolutionist theories have been largely responsible for much of the stereotypes about folk medicine, especially the notion of the “trickle-down theory” which places folk medicine on the lowest level in the hierarchy of knowledge. David Hufford argues that this “simple evolutionary model leads almost inevitably to the erroneous conclusion that folk medical resources are by definition outdated and uninformed, and to the equally erroneous presumption that they are likely to be replaced by conventional medicine through improved access” and education (*Healing Logics* 14). It is interesting to note that “education” of communities where these practices are widely prevalent has been used as corrective measures to these practices. I make this observation to contrast it to the kinds of community education I observed in which folk practices are validated. In
contrast, I will note that such cultural evolutionist perspectives with regard to religion or belief based practices were also evident in my fieldwork.

Emphasizing that these many aspects of folk belief are often integrated, Bonnie Blair O’Connor negates the view in folk medicine scholarship that separates the “ritual/magical” from the “naturalistic folk medical practices” (22). O’Connor argues that these practices are often all part of an integrated system whose conceptual frameworks are wide-ranging (22). Highlighting the sophisticated nature of the practices involved, O’Connor, building on David Hufford’s work, notes that these practices are “health belief systems,” which include a understanding of a wide range of issues related to illness management and health care at large and which involve: “illness-related technologies and narratives, such as about causes and cures and patient-practitioner relationship but also take into account a host of features addressing the cultural economy and its belief systems” (22). This disputes the theory that folk healing systems are “outmoded, simple-thought, or somehow developmentally antecedent to sophisticated thought” and also significantly seeks to question another underlying assumption in these same accounts (which in many cases is also explicitly stated) that “the people who use them” might show the same traits (O’ Connor 3). Indeed, folk medicines were seen as artifacts to be found in remote rural communities, among the poor or immigrant groups, that is socially marginal or supposedly “backward” groups. Therefore, constructions of social identity of the users and practitioners have been an integral part of the understanding of folk medicine, including in problematic ways. Studies that have critiqued these points of view have demonstrated that folk medicinal use is found in urban groups and also across class
lines, and is used for a broad set of criteria, of which financial resources are only one of many considerations (see especially Press, Santino and O’Connor).

Functionalist and psychoanalytical theoretical models, arguing that beliefs, have social functions in the communities “offer interpretations as if it were an sufficient explanation” or particular social functions as the only reason why folk health systems may be in use or have been interested in the individual often only in terms of disability or deviance (O’Connor 41). These models have reinforced notions of Otherness of the community of users. Another related set of studies based on the idea of so-called “culture-bound syndromes” characterize entire cultures in terms of pathologies. Romanticism has been another influential current in folklore scholarship, which has sought to present an “ostensibly more positive counter image of the folk” in terms of “natural,” “authentic,” “emotional” and so on, but has also contributed to the “pathologizing of belief” (Mullen 121).

The critical moves indicated by Mullen, O’Connor, Hufford and others is that all healing systems are cultural systems, and that folk medical systems each have their own underlying logic. Furthermore, all medical systems (each informed by social and political interests) exist complementarily with each other, a fact the perspective and patterns of use of patients especially reveals. O’Connor notes it is now “well-established people’s health care strategies frequently involve the use of both conventional medical non-conventional approaches, in varying combinations” and that “the possibilities encompass healing modalities ranging from religious and metaphysical practices, to mental and spiritual contemplation, to physical and manipulative therapies, to dietary
regimens and supplements, to botanical medicines” that is, a very diverse set of practices, several of which involve the combining of various healing modalities (xv).

Offering perspectives relevant to Asian healing systems, Charles Leslie’s work has been especially influential and very useful for this project. He has stressed the way non-western systems too have been seen as outmoded and “developmentally antecedent to sophisticated Western scientific thought” and/or have been evaluated only in relation to how they confer or differ with Western medicine (Leslie, Paths 3). Leslie argues that part of this problem lies with Western’s science link with modernity, in which the dominant philosophy of science is logical empiricism. Since thinkers like Thomas Kuhn, there has been a move towards historicizing and socializing of scientific knowledge by “calling attention to individual and social interests” informing epistemological principles (Leslie, Paths 3).

Charles Leslie argues that all systems, whether biomedicine or indigenous, are underpinned by a coherent network of assumptions about pathophysiology, therapeutics and so forth (Paths to Asian Medical Knowledge). Hufford has noted that systems are not discrete, self-contained units but should be seen in relation to the surrounding context. All health systems, while specifically addressing illness and/or well-being, are interconnected to other aspects of culture. O’Connor asks: “How are health belief systems interconnected with the larger cultural systems of which they are part? How do people learn about, enter into and evaluate vernacular health belief systems?” (xviii). Further, Leslie notes that healing practices are embedded in distinctive cultural premises and symbols and are dynamic practices to be seen “within the stream of history,” as
coming out of “both exogenous and endogenous forces” (5). Among these scholars, there is some agreement about the need to understand all health systems in context. In paying attention to context, they have emphasized patients and practitioners’ points of view. In other words, they stress it is important to understand the embeddedness of health systems within cultural performances.

I want to note that studies related to the social constructions of illness and health systems where patients’ point of view are taken into account have also been selective. In his review of the social theorizing of illness in the Handbook of Social Studies in Health and Medicine, David Amstrong notes that these notions has been systematically studied since Parsons’ concept of the sick role, which “recast the role of doctor/patient relationship from a therapeutic encounter to an engagement of wider ‘social control’ mechanisms” (30). O’Connor argues that Parsons’ concept is based on the assumption of middle-class choices and does not consider cultural differences in defining health, among other things.

The crucial move indicated in these studies is that “lay” perspectives have now begun to be acknowledged as offering alternative perspectives to official narratives of health sponsored by professional health care establishments. Amstrong notes, since the 1950s, ethnographic/anthropological approaches have argued for theorizing about health from patients’ understanding of symptom’s meanings and other health related behavior. He comments that “patients’ explanatory models posed an alternative understanding of the nature of illness…[so that even if they were not considered ‘scientific’] biomedicine no longer had the monopoly on theories of illness”(35). Another aspect to alternative
explanations to illness are the local interpretations of biomedicine itself. In the context of scholarship on developing countries, Arthur Kleinman is credited for first articulating the social construction of illness through a study of medical systems within various cultural settings. Criticisms against Kleinman’s work have included the fact his influential early work in particular failed to take into account larger political and social forces that inform people’s illnesses. His concern with illness and management within “clinical encounters” is seen as ultimately privileging a biomedical protocol for cure. In general terms, we could say in the process of articulating the experience of suffering, a complex relationship between the individual and larger healing/medical knowledges emerges. I would argue there has never been an absence of narratives of “lay” people, but rather the issue is the way that participation in health discourses had been read and valued by various vested viewpoints.

I focus on “local” meanings of the medical systems following an agent-centered model of knowledge, looking at participants’ articulations or performances about the relevance and meaning of these categories and the manner in which they are presented. This is a particularly useful site in which various health systems can be evaluated as co-present, rather than along as continuum of “progress” where one system is said to simply replace the other, as community members simultaneously use the resources of multiple systems. I articulate, through ethnographic accounts, where it might be relevant to think of folk medicine as “unofficial,” “lay,” “folk,” and “indigenous.” As I have noted earlier, the recurring theme of “lay” is used to qualify “self-help” to denote self-help involves notions of expertise and seeks to provide alternative formulations to health that highlight
differences with practices that have come to be seen as “credential-based” and “official.” The framework of “lay” negotiations focuses on the experience of people who are the recipients of such practices and who also seek to initiate their own practices by creating a more informal (though with a well-articulated mission and “system” of transmission) means for information building and training. I follow the many descriptive accounts from my fieldwork (explored later in this chapter and subsequent chapters) where it became clear that there were perceived to be differences between healers and between various kind of home-based practices. “Self-help” emerged as an important overarching category for a variety of other local descriptions for healing practices in the MALAR groups, including “home remedies.” In other words, while I use these terms, I also underscore that the boundaries between various sets of practices are blurred. I articulate the value of local descriptions and categories in terms of social power. In Chapter Six, I use the term “belief” in terms of locally understood meaning of “faith” in particular practices but also beliefs that have to do with the “supernatural” or the “spiritual” or the “religious” which community members themselves saw as a distinct aspect of folk healing.

O’Connor, Hufford and others have dealt extensively with the use of the word “belief,” especially in relation to “knowledge” and I acknowledge that “belief” can involve other practices that do not have supernatural components to them, though I have used the term in that more selective way here. O’Connor uses the term “vernacular health belief systems” to describe practices outside of biomedicine. Nichter and Lock, Leslie and others refer to “systems” as referring to codified traditions like Ayurveda but also a host of other non-western modalities whose boundaries are less defined, which
they also see as systems comparable to biomedicine. Part of the confusion (or amorphousness one could say, to be less judgmental) comes from the fact “laypeople are not merely consumers of health care also its primary providers” [viewpoints based on estimates that 70 to 90 percent of health care actions operate outside the sphere of conventional medicine! (O’ Connor 25)]. In other words, lay people are routinely both practitioners and patients. There is the prevalence of what Arthur Kleinman calls “the lay referral network” which tackles “when to go to a particular practitioner for care, which practitioner to visit, whether to change practitioners or seek therapeutics alternatives, how long to remain in treatment, whether or now to comply with therapeutic recommendations, and how to assess outcome” (“Indigenous Systems” 142). So “lay systems” incorporate certain distinct traditions but a host of other fluid and not so easily definable practices, but also suggests a ‘culture’ of pro-active health care which can generate new vocabularies, networks and even technologies. At any rate, in the studies I have outlined there is an agreement that these negotiations, conceptually speaking, involve many features of systemization and this to me is the crucial issue (I will return again to these issues around “systems” later in this chapter).

**Experience-centered and Performance-centered approaches to Belief:**

Speaking of vested viewpoints in folk medicine scholarship, David Hufford argues that the viewpoint that automatically assumes that beliefs (based on experience) of patients are false [a viewpoint he calls “traditions of disbelief” (“Traditions” 47-56)] is especially so with regard to the belief in the supernatural. Tackling the question of belief
by “reflexively identifying the underlying assumptions” of research (Mullen 131), Hufford argues for a experience-centered model for analyzing folk belief, which in my reading, echoing Patrick Mullen, essentially tries to move away from seeing belief in the supernatural as a pathology toward one based on experience. Equally importantly, the experience-centered model involves documenting the way “experiences provide a central empirical foundation” from which “some rational explanations” are derived (Hufford, “Beings Without” 18). His stress is on the logic or the rationality of narratives of belief which derives from experience that have hereto being considered illogical or irrational. Mullen notes: “By considering human ‘core experiences’ of the supernatural as possibly real instead of dismissing them as hallucinations, cultural constructions, or psychological mechanisms, Hufford has provided a valuable theoretical model for belief scholars” but Mullen adds that Hufford’s proposals “contains some subtle romanticizing of the folk” (133). Hufford, Mullen elaborates, does not question “the old dichotomous definition of folk belief as ‘unofficial’ in opposition to ‘official’ belief” reinforcing romantic concepts of the folk as associated with “intuition as opposed to rationality” (Mullen 133) for Hufford argues that direct experience with the supernatural involves connecting “intuitively to spirits without inference or retrospective interpretation” (Hufford, “Beings Without” 28).

Mullen argues, rightly in my view, that spiritual experiences can includes rationality but equally importantly, substitution between terms such as “folk” or “vernacular” or “unofficial” does not itself guarantee reversal in “condescending connotations” but rather it is more useful to articulate how belief works in “social
contexts of power relations” (134-136). It also appears contradictory to me, on one hand, to emphasize the value of beliefs because they are based on experience, from which some rational explanations can be derived, but on the other hand to set up a dichotomy between intuition and rationality. The foundational issue seems to me in Hufford’s anxiety is that mediation of experience through filters that are necessarily cultural will be seen as so “cultural” that the possibility of seeing a more universal value to experience of the supernatural might be ignored. The question I believe Patrick Mullen asks is why the study of the cultural performances have to be seen as contradictory to the task of acknowledging that an individual experience might be part of a wider phenomena.

In explaining their concerns, Bonnie Blair O’Connor and David Hufford have also taken special issue with genre-based readings of folk belief narratives that have focused on recurring patterns and commonalities in the narratives to the detriment of specific details of each narrative that denote the experience of the speaker. Though O’Connor acknowledges the various studies of belief in context since the 60s, which emphasize the dynamic nature of practices, like Hufford, she is critical of narrative/genre based approaches to folk belief narratives in general because of their focus on the artistic components. She argues, in such studies, narratives of experience appear to be “confabulations that emerge from artistic, fictive oral tradition” (46). In my reading, the approach in performance studies following from studies on the ethnography of speaking has usefully highlighted the need to study narratives in context and also their emergent quality, which is vital in understanding the particularities of individual narratives and
thus the performance-centered approach aids the understanding of experience-based approaches.

Interestingly, Mullen notes performance scholars have neglected belief narratives because they appear to lack an *artistic* dimension. So he highlights how performance strategies can be studied not just in terms of their artistic dimension but also it is useful to study them in “understanding the personal experience and cultural meanings” of both the “original experience” and subsequent retellings (136). He also tackles concerns about notions of “fictionalizing” in belief narratives and suggests “to analyze the telling of belief narratives does not invalidate the experience; rather, it recognizes that people enhance experiences in order to attract and maintain the attention of listeners” (137). It is important to also understand the underlying the politics of culture, he notes, to study “the social dynamic of belief,” in everyday contexts where multiple belief systems are being negotiated by people (137-138). In my reading, in doing so, the evaluations imposed by the “traditions of disbelief” are themselves better documented, for one, because these evaluations are themselves diverse (Hufford, “Traditions” 47-56).

In my work, the performance approach is particularly useful for understanding health systems as emerging in context, as I have noted. The idea that all health systems are found in localized forms has been noted by Charles Leslie: “The practices are varied, differing in form and content regionally and locally, and within local communities, where each practitioner and patient offers different interpretations” (*Paths 5*). Further, he notes, the differences that are noteworthy include those “between the classical, literate medical
system of a given Asian society and its local appearances…(and) the distinction between an urban pundit’s and village vaidyar’s\(^3\) versions of Ayurveda” (Paths 5).

Such local knowledge emerges in context in interaction and reveals among other things the relation of a larger body of healing practices to an individual practitioner’s work. Within an individual healing situation, the larger body of work is interpreted by each individual healer who brings it to bear on the particular patients’ situation. The values of various healing systems can be contradictory to one another, issues which the patient grapples with. As Margaret Trawick’s work on Indian traditional medical practices suggests while “different healing systems mesh together in a coherent overall pattern…for whom do they form a set, and how and why” (my emphasis) is a crucial question. Another kind of gap exists, she elaborates, “between the perspective of the healer and the broader perspective of the ancient texts and myths upon which the healing traditions are based,” and “part of the talent of the healer is in his or her ability to bring the ancient and general knowledge to bear upon the patient’s present condition, giving his problem a space in the overall scheme of things” (133) (my emphasis).

These perspectives stress open-endedness of health systems, but the debates about what precisely constitute a “system” continue. Lock and Nichter note:

Even though Charles’ vision of a medical system has always been an entity that is open and infinitely malleable, nevertheless a certain amount of conflict arose among the contributors to Asian Medical Systems as to how to best delineate the idea of a medical “system.” Some authors emphasized historical continuities whereas others stressed discontinuities (2).

\(^3\) Healer
David Parkin questions the notion of “system” as a category as it assumes certain levels of consistency. He points out:

People think ‘systematically’ in the sense of speaking and acting in ways regarded by others around them as consistent within a given situation. But that doesn’t mean that all their different situations themselves have to be consistent with each other as if governed by some overall system, to use the term in the substantive sense. The contestability here is whether and to what extent each of us as analyst imposes a view of system or non-system on indigenous users (150).

He elaborates:

Part of this fragmentary aspect of the whole medical culture, as Last calls the totality of medical services available, is the tendency on the part of patients rarely to complete their prescribed therapy: medicines remain uncollected or undigested and advice is only half-followed; patients filter through different, reported kinds of expertise...Basic to this fragmentary appropriation of medical resources is the simple fact that, on the whole, people are not concerned to know what boundaries of any putative systems are, nor to know what lies behind diagnosis, therapy or the canons of any supposed system. People are much too concerned with the voluminous and exacting practical demands of everyday life (150).

The studies I have outlined thus far do not suggest that people’s choices are governed by any single analytic system but rather that they are involved in pro-active and conscious choices and indeed in many cases there are consistencies in the pattern of choice. Bonnie Blair O’Connor’s Health Belief Model outlines the features that constitute systemic ways of thinking. The factors that she lists are not seen as criteria that must be satisfied in order for health negotiations to be qualified as “systemic” thinking. I will not analyze the model here but will summarize that her “Health Belief model” includes certain “provisions for constructing facts” (O’Connor 10). This includes: criteria for admissibility of evidence, definitions of kinds and weights of evidence required to establish proof, validation and verification processes, legitimation structures, definitions of acceptable ways of knowing and rules for reasoning and testing reasoning (O’
Connor10). She also emphasizes that the “order of resort,” the “order in which a person has recourse to various systems of care” (which is highly changeable) is important (27).

Parkin’s observation that people are not at all concerned with the boundaries of various systems does not play out however. Several ethnographic studies, including O’Connor’s outstanding account of the gay communities’ organizing around AIDS/HIV issues, reveal that lay people can become health activists who question the authority of available systems but also are able to push those systems in new directions. Therefore, they can become very interested in boundary mechanisms of health systems. The strategies of boundary maintenance are precisely the issues of interest to scholars analyzing health systems as dynamic processes. My own project demonstrates there is “lay” engagement with specific healing modalities of different health systems but also there are meta-narrative strategies that speak to the nature of networks in health activism and foundational ideas about what is health. The MALAR initiatives seek to rework what a national and local health system should include. The lesson from Parkin’s reading is that the agency of “lay” people and value of their experiences continues to be suspect, despite their gaining importance. My own orientation also follows Johannes Fabian who has noted, in asking “who speaks to whom, when, where, how, and why” using the performance approach have been crucial in understanding language as a “system in action” in terms of the politics of culture (8). It is not sufficient to observe the fact that “lay” practices are systems; we also need to understand issues of agency in dialogues between the lay and experts.
I want to suggest that these notions of contextualization in terms of the politics of culture may help us in only partially understanding questions of belief. The experience of the supernatural is important, and there is always the danger that the experience itself may seem less relevant than how a narrative works in interaction. On one hand, a performance-centered perspective helps us to situate belief in the context of life history, for example, where social identity of poverty may frame the meaning of belief practices as I demonstrate in Chapter Six. But it does not fully account for what A.K. Ramanujan has called a desire to be free of all context that some belief narratives are informed by. In posing the value of universal values that contrast with particular local ways of ordering the world (or “context-free” and the “context-specific”), he suggests that these are recurrent imperatives in all cultures (though most cultures are inclined towards one or the other) (Ramanujan, “Is There an Indian Way of Thinking”). Yet, for all its rootedness in context, the desire behind the certain practices (that is devotion or bhakti traditions) is impelled by something beyond all context. Noteworthy is the fact it is in performance that the bhakti traditions of belief find their voice—it is a culturally mediated experience which eloquently delivers what is seen to be an unmediated experience of the divine.

Patrick Mullen’s concern with the experience-centered model also addresses the theories of reflexivity proposed by Hufford that call for a non-judgmental stance to belief narratives, in staying open to beliefs that might not coincide with the researcher’s own. While commending the value of reflexivity in making a case for experiences of the supernatural, whatever the ethnographer’s own position, Mullen builds on Susan
Ritchie’s critique of Hufford in voicing concern about “use of reflexivity to create a privileged space to argue for one’s own religious beliefs” (131-132). Instead, he calls for an understanding, in my reading, of the use of belief and reflexivity in strategic, political terms, that is, one that is not value-neutral. In Patrick Mullen’s analysis, “in Fabian’s terms, Hufford has ‘ontologized’ the experience of spirituality, making it a way of being instead of treating it as a way of knowing” and Mullen instead proposes understanding reflexivity in the production of knowledge. He also notes the importance of understanding the “[ethnographer’s] own belief systems as culturally learnt” and the need to recognize the ethnographer’s “own individual influence on the representations of the people” who are the subjects of the research (139).

My own sense is that indeed through practices of reflexivity we can attempt to look out for problematic representations, but I am also interested, following Fabian, in the ways that researcher’s subjective positions are constitutive in knowledge production, so that reflexivity is not merely a moral issue but an epistemological issue first and foremost, a view that Mullen and Ritchie also argue for (7). As Fabian has noted about the role of the ethnographer: “The ethnographer’s role, then, is no longer that of a questioner; he or she is but a provider of occasions, a catalyst in the weakest sense, and a producer (in analogy to a theatrical producer) in the strongest” (7).

This is an orientation that is echoed within recent folklore studies at large, crystallized in Amy Shuman’s and Charles Briggs introduction to the special issue of the Journal of American Folklore (Theorizing Folklore: New Perspectives on the Politics of Culture), that underscores that it is essential to understand the terms of “the production
of knowledge” which “has, following Foucault (1980), come to be seen more than as a mode of creating and legitimizing social inequality than as an objective mode of illuminating the world” (115). These perspectives “motivated by the postmodern critique of an ongoing relationship between local and universal claims to truth, knowledge, or reality” involve critically examining “the invention of authentic traditional cultures as place-holders of their opposite (modern, mass-produced, global economies)” (Shuman and Briggs 115). In understanding issues related to the production of knowledge and politics of culture, I take my cue from folklorists who have focused primarily on cultural premises and values as they emerge in face-to-face interactions which is the bulk of my own project (see especially Gary Bulter). My own emphasis will also seek to understand larger historical and social discourses about health in these same performances and also in relation to them (such as Ritchie, Young in Bodylore). This is an aspect within folk medicine scholarship that has only just begun to be explored.

**Health-as-Development.**

My interest in ideological underpinnings of health systems include state health policy, that is, “story” of development. As I have noted, the scholarship in medical anthropology, specifically with relation to health issues in Asia, has long been interested in ideas of conflation of biomedicine with modernity. These connections between biomedicine and modernity have been revisited and are shown not to be “natural” connections but as strategies that have to be interrogated. Several recent studies highlight that through the process of development in post-colonial world there have emerged
multiple interpretations of modernity itself where biomedicine and indigenous or traditional medicine have both been incorporated into the agendas of the state. In the introduction to their important collection of essays, a tribute to Charles Leslie, *New Horizons in Medical Anthropology*, Margaret Lock and Mark Nichter note that Charles Leslie’s work shows how the historical and ideological processes have mediated the relationship between the medical systems, modern science and technology. They elaborate:

[In Leslie’s work] The integrity of each of the ‘great medical traditions’ is stressed, but at the same time it is argued that Galemic/Arabic, Indian, and Chinese medicine exhibit epistemologies and features of social organization permitting general comparisons with each other as well as with ‘cosmopolitan medicine.’ Charles favored this latter term (first coined by Fred Dunn in 1976) to ‘Western medicine’ because it drew attention to the manner in which biomedicine and other forms of medicine were adopted in and adapted to cosmopolitan lifeworlds, thereby contributing to lifestyles concordant with capitalist expansion. Charles Leslie challenges the dualism commonly made at that time between ‘traditional’ and ‘modern medicine’ and insists that all bodies of medical knowledge are dynamic and change as the result of political and social factors as well as the diffusion of knowledge and technological innovations (2).

Among these notes, several themes are key to my project: it highlights once again the systematic nature of nonwestern knowledge, as well as their dynamism. It seeks to understand the categories of “Western,” “Cosmopolitan” etc as social constructions, underpinned by ideological leanings. But these issues also apply to the non-western “great medical traditions,” as Leslie called them. Lock and Nichter note:

Charles Leslie’s own work on medical pluralism focused primarily on Ayurvedic practitioners and the conflict and accommodation that were apparent as they were increasingly confronted by cosmopolitan medicine. He was able to show conclusively how self-conscious attempts at revivalism of an ‘authentic’ Ayurvedic traditions were closely associated with nationalism and in large part responses to perceived threats by forces of modernization, and by implication, ‘westernization,’ emanating from both inside and outside India (7).
Ayurveda’s link with nationalism in post-independence India reveals the use of notions of the “traditional” can equally strategic as “scientific” or “Western.” Lock and Nichter have also noted the variant models of modernity implied in these negotiations, citing Steve Ferzacca’s work in Indonesia. In Indonesia, governments have used their commitment to development as “an ideological apparatus to govern the daily lives of its citizens” while as the same time “traditional values are lauded as essential to the state’s vision of reflexive and unique modernization” so that the “modernity envisioned for Indonesia (and some other countries) looks backward to find something recoverable—something felt to be lost in the present— but it does so for the sake of a better future” (7). Folklorists would recognize these moves as “invented tradition,” where past customs are selectively called forth in contemporary performances to address the social interests of the present.

Speaking specifically to trends in health care in developing countries, especially in the last decade in the era of what is called globalization, Lock and Nichter outline some key themes in recent studies, articulating how of global and local interrelationships need to be examined critically. They note that the particular configurations of social identity, national identity (or any other kind of institutional identity) are implicated and posited in explicit ways as being central to health issues:

International health priorities intersect with and contribute to local identity politics that in turn are informed by claims about local norms and values…Growing links between local and transnational NGOs having progressive liberal democratic agenda create new spaces where the moral tenants of ‘national identity’ may be revisited and challenged in the context of discourse on health and development. Diseases like AIDS force moral debates not only about sexual behavior, but what kind of development a nation is pursuing…In an era where international
‘development’ is the order of the day, and health care is promoted under the
banners of social welfare and human rights, it is no longer sufficient for medical
anthropologists to focus on medical traditions…and to document patterns of
resort—the way in which patients move from one type of practitioner to another.
…[but they must also] consider contemporary medical pluralism in the context of
cosmopolitanism…We now need to reconsider medical cosmopolitanism from the
vantage point of both local and global relationships (9).

Lock and Nichter articulate the need to understand the politics and means of production
of knowledge and circulation of knowledge between systems:

Ethnographic accounts of health care related behaviors (prevention, promotion,
harm reduction, cure) clearly need to take in account the political economies
fostering and inhibiting particular care modalities: the impact of globalization, the
impact of the media (local and international), and identity politics, among other
factors. Such an approach should be attentive to active rivalries as well as
cosmopolitanism and exchanges among different kinds of healers and
health care professionals as they respond to broader national and global interests
(12-13) (my emphasis).

They argue that globalization has generated new concepts and institutional practices that
have involved a “transformation [in health care reforms worldwide]” which “takes place
in several different ways”(10). They elaborate, focusing on the idea of the “invention” of
categories of people as a key component to the project of development: “Nationalistic
competitiveness is fostered by the widely disseminated World Health Organization
rankings of statistics on infant mortality risks, life expectancy rates, and so on. The
concept of risk, and the ‘making up of people’ (Hacking 1986) in terms of the categories
of risk, so central to the work of epidemiologists and public health practitioners is, of
course, one of the principle ways in which biopower is put into practice globally” (10).
They comment that it is important to critically evaluate these evaluations about social
identity: “It is one thing to know that you are poor, hungry, and often sick. It is another
thing altogether to think of oneself as underdeveloped or a member of a risk group. One [thus] comes to understand how to be a ‘development category’ (Pigg 1997:276)”

(10). Their concern is characterization of people in terms of defect or backwardness. The irony for me is how this echoes problematic cultural evolutionary models and the proposals of “education” or “development” as being correctives to “backward” attitudes.

Amstrong notes this notion of “risk” is pervasive in much of recent health discourse. Highlighting the ways in which ideological underpinnings pervade from outside and within medical systems, he notes that since the 1970s, there have been more studies “especially looking at the medical systems through the lens of social control” in which “medical resources are not only extended to the ill, but also to the healthy who were now ‘at risk’ where the net effect [is the] ‘medicalization’ of everyday life” (31). Crucially, in these moves, “‘experts’ took responsibility away from people” (Amstrong 31). I will note the importance of understanding how the language of illness and cure permeates social life at large. This is important to my discussions of health initiatives based on the notions of “health-as-a-right” in the ways in which health is conceived very broadly encompassing a general state of well-being that includes social and economic issues, but the “health-as-a-right” campaigns differs in the ways they categorize “lay” people as equal partners in heath delivery, rather than through “risk categories.” Indeed, the attempt in the initiatives I observed is to situate “people” (the People Health Assembly campaign’s way to describe “lay”) as having competence and expertise. “Lay” health narratives, in my reading, involve not merely articulating experiences. The
implications in terms of a politics of evidence-making, so to speak, in what counts as health and the means to make those claims, are also important.

In this emerging health scenario with respect to globalization, the role of all the social actors involved and their ideological underpinnings are important, whether state or non-governmental actors. Both their work should be seen as strategic. Lock and Nichter note what is at stake is the “the role of NGOs in ushering and resisting new moral orders propagated in the name of development (empowerment, emancipation, nationalism, internationalism, individualism, and so on)” so that what are needed are more studies of “how the agendas of NGOs are co-opted by development agencies while advancing their own agendas by means of funding workshops where local participants are resocialized and given new vocabularies with which to guide their thinking” (9) (my emphasis).

In development initiatives, Nichter and Lock are particularly interested in how people’s point of view gets incorporate into the programs, and seeing that inclusion as strategic, as studies such as Stacey Leigh Pigg’s work in Nepal points out (Nichter and Lock). Pigg is interested in understanding the promotion of so called “culturally appropriate” AIDS education as if what makes up culture are pre-determined set of norms. In fact, in her analysis what comes to mean culturally appropriate comes of out negotiation and contestation by a wide variety of players each with their own social and political agendas (Pigg, “Too Bold, Too Hot” 55-80).

In understanding the “new vocabularies” of being “resocialized” in the process of development, I rely on studies on development discourse, especially the work of Arturo Escobar and Jonathan Crush in the way “development is written, narrated and spoken”
and how “the vocabularies deployed in development texts to construct the world as an unruly terrain requiring management and interventions” (Crush 3). They deal specifically with issues of social identity or the idea of a “development category.” But most usefully they speak to the pervasiveness of arguments about development where modernity and traditionality that are set up as binary opposites, echoing view of folklore as modernity’s Other. Escobar notes:

Not only are the objects of development stripped of their history, but they are then reinstated into implicit (and explicit) typologies which define a priori what they are, where they’ve been and where, within development as guide, they can go…deeply embedded within development discourse, therefore, was a set of recurrent images of ‘the traditional’ which were fundamentally ahistorical and space insensitive. Collectivities (groups, societies, territories, tribes, classes, communities) were assigned a set of characteristics which suggested not only a low place in the hierarchy of achievement but a terminal condition of stasis, forever becalmed until the healing winds of modernity and development began to blow (9).

The issue of social identity of the “risk” categories is closely knit with evaluations of the culture at large, so that we are now calling about whole countries at risk. Escobar notes the call for intervention (or development initiatives) is based on static representations of tradition. Escobar notes: “The ‘traditional society,’ though motionless and misrepresented, it not often overly-romanticized in the development text. To do this would be to run the risk of implying that there is no necessity of outside interventions and management” (9). The redemptive power of development is the “the rebuilding of the landscape and the reclothing of its benighted inhabitants” and there are claims that development “animates the static and manages the chaotic,” claims I have noted earlier (10). I want to observe that here are uses of “the traditional” as a sign of backwardness and as obstacles to “modern” or “global” initiatives, but there is also a peculiar
contradiction: if the winds of modernity are supposedly inevitable, then why the need for strategic and seemingly all-encompassing intervention?

Escobar has noted this is because development is seen as a goal and a means at the same time, but also that these are “claims” about what modernity is and what it can do, and that it is these claims that legitimize interventions or development initiatives. I look at some depth at the history of health policy in Chapter Two but my purpose there is to suggest that notions such as “people-centered health” are not new dilemmas but that the particular configurations of the impact of the last decade of globalization are important to note. While I am familiar with debates on whether the particular modalities of the current form of globalization do indeed resemble older forms of a globalized world such as under colonialism, and whether the interventions in the arena of development since World War II have unique characteristics as Escobar has argued, I will not tackle these issues here but rather focus on some particular themes related to development discourse indicated in “health-for-all” campaigns in the current context. My analysis includes an articulation of the “actors” involved and networking strategies (global and local) involved in responses to globalization. Using frame analysis as expounded by Erving Goffman and others, I argue that notions of development (through “health-as-a-right”) used by MALAR and its networks call for particular changes in social roles of the actors involved and involve reframing priorities in terms the needs of the poor, while validating many other aspects of the current health system and development in general.

These complex responses to globalization have been variously described and I will speak again to the question of how or whether they can be accounted for as
“systems.” The fragmentary nature of emerging social practices has been noted (Arce and Long especially) but David Parkin’s concern about the presumption of “wholeness” in systems is worth raising here. Arce and Long argue the notion of “hybrid” that several studies employ often assumes whole systems coming together in new ways and fails to acknowledge the dynamic nature of healing modalities and the process of appropriations across systems. I want to acknowledge the range of descriptions of the emerging practices, citing Lock and Nichter’s observation that “it is by paying attention to the myriad ways in which encounters with development strategies have reconstituted and reworked modernity from within, producing multiple, alternative, fragmented, or hybrid modernities…while at the same time reassembling tradition, that we can better understand the effects and “side-effects of development” (Pigg 1997)” (9)(my emphasis). I would argue that the use of categories need to be accounted for, though there are common patterns that many of these studies are trying to describe, which are shifting boundaries and overlaps between systems. Further, notions of modernity and traditionality need to be accounted for in these shifts, as they carry certain kinds of social meanings which throw light on how the emerging practices are being viewed and constructed. As Lock and Nichter corroborate, all these characterizations relate to social power: “The activity is one of boundary making and disputes over power, which have direct implications for the health, well-being, and identity formation of peoples everywhere” (22). So when describing these practices, from the point of actors, these qualifications become more contentious as the actors’ social roles and their asymmetrical power relations comes to the fore. I have found it useful to think about the emerging
practices as part of a scenario where actors are co-present but have differential power. I follow Mary Lois Pratt’s idea of the “contact zone” and based on “a ‘contact’ perspective [which] emphasizes how subjects are constituted in and by their relations to each other” (7). Highlighting the presence of various actors with differential power, based on her work in travel writing, this perspective “treats the relations among colonizers and colonized, or travelers and ‘travelees,’ not in terms of separateness or apartheid, but in terms of copresence, interaction, interlocking understandings and practices, often within radically asymmetrical relations of power” (7) (my emphasis).

These views of “lay” systems parallels and resonate with critical essays in the 1990s in folklore studies on local knowledge. Since the 1970s, there has been an emphasis in the discipline on contextual approaches to folklore, which have elaborated upon cultural practices whose meaning is to be found in context in which they are performed. In her essay “Dismantling Local Culture,” Amy Shuman has suggested that concepts of local culture in folklore studies, however, have often been essentializing practices, which have worked with the “the agenda of protecting local groups against the incursions and interferences of global economies and claims for universal truth” (345). She suggests local traditions are in fact always “larger-than-local,” suggesting fluidity and interaction between various knowledge systems and entities, global and local. The critical task in understanding local knowledge is to “identify the positions, politics and interests that are involved in negotiating and maintaining its boundaries” (359). In summary, local knowledge emerges in a negotiated territory.
In the initiatives I observed, people demonstrate an awareness for “larger-than-local” knowledge. I argue that what is the “local” from the perspective of the agent actively operating within the world she or he find themselves, in empirical and imagined terms, is an ongoing negotiation and involves transformation of cultural practices that is rooted in politics and power-laden social relationships (Shuman; Goodwin and Duranti).

While I will not attempt an extensive review here I want to note the influential work of non-governmental health activist networks in India, as a reminder that the notion of self-help in terms of politics and larger social discourses, and also in integrating multiple resources is not new. Engaging with the overlaps between the various systems and the dilemmas involved, the bi-monthly magazine, *Amruth*, of the Foundation for the Revitalization of Local Health Traditions (FRLHT) in Bangalore, India is a sophisticated contemporary example. In addition to addressing the changes and trends within the codified traditions, *Amruth* also provides accounts based of the work of independent folk healers as well suggests a host of “home remedies” and exercises that can be used in children’s or adult education, which seeks to acknowledge the nuanced differences between various traditions but also the overlaps. At the same time, *Amruth* is a promotional tool for indigenous healing (what the editors call “traditional health care”) which offers models in “lay” training. I will add that based on my interviews with the coordinators of the organization, “revitalization” does not mean a kind of uncritical “revivalism” but is about providing support to healers based on their own articulation of needs and promotes that idea that these practices are ongoing, living traditions.
FRLHT is also interested in many aspects of intellectual property rights and developing a model for “benefit-sharing” between pharmaceutical companies and the communities of practice, which is a contentious issue in the country (see especially the work of Vandana Shiva in *Stolen Harvest*). Again, this is not meant to be a comprehensive review of the current activity in the emerging the network of health activism promoting indigenous knowledge in India (a topic that has not been documented systematically), but I will note that are many initiatives and a range of issues involved, that many organizations are always working to come together around issues (which I observed in the People’s Health Assembly movement, discussed in Chapter Two) but certainly there are contestations.

There are many other examples of such efforts as *Amruth* that are manuals, documentaries and critical reflections all at once, including *Touch me, Touch-me-not: Women, Plants and Healing*, a book compiled by a national network of women health activists, *Shodhini*, based on their work using medicinal plants in health programs for women, which proposes a “women-centered” and “self-help” approach to health. In terms of precedence to ideas of self-help as a form of politics, Mahatma Gandhi’s political ecology is perhaps the most influential (see especially Joseph Alter). Alter notes that Gandhi's interest was in a system of health care “that was eminently ‘public’ in the somewhat new way in which that term had come to signify the homespun nation as a rural whole”(14). Gandhi in his practice and advocacy of nature-care based self-help, Alter notes, “developed a rational justification for the earth’s applied use as a grass-roots therapy for self-healing” in which ‘earth therapy was a home remedy as intrinsically
natural- as an inherently important to him and his national ideals- as the principles for self-governance, self-reliance, and home rule” (14). Understood as a set of therapies coming from the grassroots and involving an eclectic set of practices, in Gandhian practice, “self-help” is given new meaning but also seen to be linked to a larger politics of culture which included independence from colonial rule.

**Between McWorld and Jihad**

While I deal with the particular strategies of MALAR and its networks in Chapter Two, I do want to discuss in this chapter my own orientation and ideological position issue related to globalization following from some important characterizations of the debates in Benjamin Barber’s article “Jihad Vs McWorld,” as it is relevant to this project as a whole. I will quote the article at some length as he articulates the layers and their implications of currents notions of globalization in a way that is particularly eloquent.

The two dominant forces in the current times, he notes are, on one hand: “a retribalization of large swaths of humankind by war and bloodshed…a Jihad in the name of hundred narrowly conceived faiths against every kind of interdependence, every kind of artificial social cooperation and civic mutuality” (53).

The second one “being borne in on us by the onrush of economic and ecological forces that demand integration and uniformity that mesmerize the world with fast music, fast computers, and fast food…one Mcworld tied together by technology, ecology, communications, and commerce” (53).
In a way that focuses on underlying principles but also referring to particular practices, he notes that are four imperatives that make up the dynamic of McWorld: a market imperative, a resource imperative, an information-technology, and ecological imperative.

Crucially, these imperatives involve a shifting terrain in terms of the actors involved: corporations, non-governmental forces, nation-states etc. All the four imperatives of McWorld involve going beyond the nation-state as an “organizing or regulative principle” (54) and are based on the recognition for the need for interdependence among nations especially where resources are concerned. But foundationally, Mcworld is opposed to democracy. So that while the market imperative may “make claims for ‘democratic capitalism,’ it is not identical with the democratic imperative” (55). Similarly, high-technology “lends itself to surveillance as well as liberty, to new forms of manipulation and covert control as well as new kinds of participation, to skewed, unjust market outcomes as well as greater productivity” (57). As for the forces of Jihad (his use of the word is rhetorical), he observes:

OPEC, THE WORLD BANK, THE UNITED NATIONS, the International Red Cross, the multinational corporation…there are scores of institutions that reflect globalization. But they often appear ineffective reactors to the world’s real actors: national states and, to an even greater degree, subnational factions in permanent rebellion against uniformity and integration—even the kind represented by universal law and justice. The headlines features these players regularly: they are cultures, not countries; parts, not wholes; sects, not religions; rebellious factions and dissenting minorities at war not just with globalism but the traditional nation-state (58).
Again, the value of the nation-state is under fire. He notes:

A powerful irony is at work here. Nationalism was once a force for integration and unification...though it more often a reactionary and divisive force, pulverizing the very nations it once helped cement together (58).

Referring to the principles that underscore Jihad, he argues:

The aim of many of these small-scale wars is to redraw boundaries, to implode states and resecure parochial identities: to escape McWorld’s dully insistent imperatives. The mode is that of Jihad: war not as an instrument of policy but as an emblem of identity, an expression of community, an end in itself (59).

The issue is that both are opposed to the principles of democracy and Barber suggests why: “McWorld does manage to look pretty seductive in a world obsessed with Jihad. It delivers peace, prosperity, and relative unity- if at the cost of independence, community and identity (which is generally based on difference)” (60). On the other hand, “Jihad delivers a different set of virtues: a vibrant local identity, a sense of community, solidarity among kinsmen, neighbors, and countrymen, narrowly conceived. But it also guarantees parochialism and is grounded in exclusion” (61). He elaborates:

To the extent that either Mcworld or Jihad has a natural politics, it has turned out to be more of an antipolitics. For Mcworld, it is the antipolitics of globalism: bureaucratic, technocratic, and meritocratic, focused...on the administration of things—with people, however, among the chief things to be administered...For Jihad, the antipolitics of tribalization has been explicitly antidemocratic: one-party dictatorship, government by military junta, theocratic fundamentalism (62).

Upholding the principles of democracy though doubting the capacity of nation-states to deliver on this promise, and also recognizing his alternative propositions are ideals only, he concludes:

It seem possible that the most attractive democratic ideal in the face of the brutal realities of Jihad and the dull realities of Mcworld will be a confederal union of
semi-autonomous communities smaller than nation-states, tied together into regional economic associations and markets larger than nation-states—participatory and self-determining in local matters at the bottom, representative and accountable at the top (64).

I hold a skeptical view of globalization, represented in “McWorld,” especially in its homogenization tendencies though I also revel in the emerging new technologies. In empirical terms, I am bothered by the trade policies of an globalized economy that take farmers to the edge, to suicide in many cases in India (see especially P. Sainath’s work) but appreciate the resources of the internet, including the capacity to speak to friends and family for very little money across continents. While influenced by various histories, my orientation in feminisms (the plural is intentional) especially also makes me wary of the forces of “Jihad,” though I am energized by sense of community and cooperative movements such as the local foods movement, such as through my local community market, and am equally wary of high individualism and materialism that characterizes much of “McWorld” that impinges on my spiritual self. My spiritual sense itself I should add is eclectic, drawing from various different traditions, including Hinduism which I was raised with, and leaning towards non-institutional practices. I draw from all the models I was raised with: including my “scientifically” inclined father’s skepticism of anything that looks like “a cult” involving a celebrity figure or “God man” and quiet explanations of the “natural” phenomena behind events seen to have spiritual/supernatural participation, my mother’s sincere belief and practice in the rituals of worship and her irritation with my sister’s and my questions about the purpose of the rituals (her answer: because that is the way it has been done) and finally my
grandfather’s highly personal, sometime eccentric in my father’s view, deity/goddess-based worship, which perhaps has been the most influential of the three in me seeking out my own.

Then, there are the peculiarities of my own practical place in the world: in one country, India, I am elite (by the virtue of being upper-caste and middle-class, though on the lower end of that scale), and in another, the U.S. (through the fact of being a low-income graduate student, a “person of color” and a woman among other markers), a not-so elite. In my fieldwork, I was conscious of the commonalities I shared with my collaborators while also acutely conscious of my privileges (which were much more than the men of the villages could hope to gain). Having said all this, I share with Barber a commitment to democratic principles and do see that to be as strategic as anything else, typically emerging through negotiation and practice, though the jury is still out in my case about what alternative models to “McWorld” and “Jihad” I find most convincing.

As I will elaborate later in this chapter, I spend time observing many development initiatives both by governmental and non-governmental actors before picking MALAR, and I will make the observation here that while I speak of such things as the “language of development” it does suggest not any homogeneity in the actual practices, but rather neither government or civil society is a monolith. Indeed, I find Barber’s articulation of the shifting terrain of power in terms of actors very useful in this observation, which argues for new social roles for nation-states and civil society. I eventually choose to work with an organization with a well developed grassroots leadership because I saw that encompassing something of an insider perspective to the community, which I am aware is
a construction but I do not by any means mean to suggest theirs is a more authentic position than say that of a non-governmental organization consisting of members not originally of that community. Rather I attempt to understand “outsiderness” and “insiderness” and how my own position and nature of my questions influenced the material presented here. I will say though it was indeed MALAR’s commitment to democratic principles that drew me to them; I was felt extraordinarily lucky to have observed their movement up close. Lastly, I am particularly interested how these forces as their play out in empirical practice, and as Noyes has articulated, the way empirical practice always exist in tandem with the “social imaginary.”

Amidst all these elaborations, I also want to be cautious about the social agency of the individual and the community and limits of self-care, given that under certain social conditions (following Gayatri Spivak and Joan Radner) the speaker may not “heard” on their terms (issues I tackle in Chapter Six specifically, on the question of belief) or may speak in coded ways. I also remember often the words of Ivan Ilich who suggests that the study of health must go beyond identifying what resources are available and pay attention to a social environment could be a “sickening” situation. Ilich minces no words when he argues that the larger socio-economic forces can create an environment that is so toxic that it is indeed insulting to ask people to take care of themselves (Medical Nemesis).

Indeed, the focus on cultural meanings itself can fall into the danger of missing the fact that people’s lives might be at stake in the misuse of cultural practices and various kinds of “truth-claims.” Margaret Trawick in looking at the ethnic conflict in Sri
Lanka argues (as summarized in Lock and Nichter) that while it is useful to look at “cultural functional meaning” that should not divert attention from the fact that conflicts can be “perverse and out of control” (Lock and Nichter 15). Fabian makes a similar point when he observes:

Fascination with the communicative, esthetically creative, inspiring, and entertaining qualities of cultural performance all to easily make us overlook that the people who perform relate to each other and to their society at large in terms of power…If we further consider that increasing integration into a world system goes together…with pauperization that does not seem able to hit bottom, then we realize that there is nothing in the postcolonial situation that would make ethnography by and of itself more humane, playful, or fun, or that would make ‘performance’ a more germane concept to describe its nature. No, the kind of performances we find in popular culture have become for the people involved more than ever ways to preserve some self-respect in the face of constant humiliation, and to set the wealth of artistic creativity against an environment of utter poverty. All this is not to be dismissed off-hand as an escape from reality; it is realistic praxis under the concrete political and economic conditions that reign (17-19).

**Performance and Politics of Culture**

The integration of the politics of culture and performance perspectives itself is an evolving current within folklore studies and I want to highlight some of the challenges here, especially as it relates to the politics of culture with relation to gender. Folklore as a discipline saw a shift in focus beginning with the 1960's toward what is now understood as performance theory (with Paredes and Bauman's *Towards New Perspectives in Folklore*, Roger Abrahams, Dell Hymes especially). It represents a rhetorical-literary heritage (Kenneth Burke), dramaturgical perspectives (Victor Turner, Clifford Geertz), and readings in symbolic interactionism (Erving Goffman, Harold Garfinkel). In the last two decades, the discipline has seen another shift in which performances are understood in the larger context of cultural, global and transnational politics (Shuman and Briggs'
Theorizing Folklore: Toward New Perspectives on the Politics of Culture, Limon and Young especially), reflecting a growing interest in nationalism (Anderson, Herzfeld), the social construction of tradition (Hobsbawn and Ranger, Handler and Linnekin), and critiques of cultural representation (Said), especially in terms of post-colonialism (Spivak, Chatterjee, Bhabha especially), and in more general terms the post-modern articulation of social construction (Clifford and Marcus, Marcus and Fisher, Fabian).

While the definition of the “folk” always emphasized the study of race and gender groups, only in the past two decades did the politics of those groupings move to the center of scholarly focus. These are some important issues in these shifts: the process-oriented performance approach seeks to identify and articulate practices and their social meanings as emerging at the sites of performance.

However, if we are to view performances as expressions of cultural politics, these enactments represent embodied ideological expressions which are meant to have particular effects. Shuman and Briggs note: “Performance-centered approaches have fallen into the trap of locating folklore in face-to-face interactions without articulating their relationship to ‘macro’ processes like nationalism.” Works such as Beverly Stoeltje’s work are important in addressing “the social construction of the [face to face] units, in popular discourse as a means of furthering particular agendas.” Shuman and Briggs also they call for an understanding of “the increased role of mediated discourses, who do not require individuals to be physically co-present with each other (including studies following Benedict Anderson’s influential work on nationalism and the role of ‘print capitalism’ in creating a sense of commonality among people who may never
meet).” As I have suggested, my own interest is in understanding the emerging cultural values in face-to-face interactions but also understanding the larger social discourse in play.

Feminists have been interested in whether performances are catalysts of social change or put in the service of maintaining status quo, which brings to performance theory the idea that interaction between players operates according to certain set of value-laden intentions (similar to Lock and Nichter’s “new moral orders” in development programs). But if each performance is understood as unique, and always in process, as performance theory suggests, then the interpretive field in which ideology operates is expanded. There are then diverse forms of expressions being generated, but each of them carrying a different agency. Also, as Judith Butler has articulated, what we understand as “status quo” is really a dynamic environment which involves stylized repetition of acts of gender, that is, the performance of gender is enacted on an ongoing basis, and therefore open to negotiation (Gender Trouble and Bodies that Matter). Feminism has always been interested in the question of personal experience as the means to explicate feminist consciousness, that it is precisely that fact that one’s experience reflects those of others that a ground for collective politics may be forged. It is been equally interested in hegemonic processes of validating certain kinds of experiences over others.

Feminist folklore (its earlier form, “women's folklore” was interested in expanding the genres of study to include those by women) has raised questions about entitlement and agency, questioning local and indigenous practices in ideological terms, such as collections in like Feminist Messages and Feminist Theory and the Study of
Folklore. In folklore feminist criticism, traditions are seen as instruments of patriarchy but also as resources and forms of women's resistance, suggesting new ways to think about cultural agency and authorship, and how we understand performances as acts of communication. Studies in feminist folklore do not suggest that these issues go one way or the other, but there is tendency in feminist scholarship to spin master/unifying narratives about the nature of women's experiences. Criticisms of this tendency are in feminism in general are found in “third world”/ “indigenous” feminist scholars' critiques of “western” feminism, opening up an understanding of the field in terms of “feminisms” (bell hooks, Chandra Mohanty among others). Folklore studies sound the cautionary note to feminist scholarship on this issue by stressing contexualized theory, what Donna Harraway would recognize as “situated knowledges” (Simians, Cyborgs, and Women). In sum, in relation to this project, the interactions engendered by the forces of social change are fertile sites for new forms of contestations, alignments and configurations that are in process and open to revisions.

Amy Shuman problematizes these dilemmas by calling for a reassessment of the understanding between local and global. She notes: The concept of global feminism does not create a choice between the global (in the form of universal principles) and the local (in the form of empirical knowledge) but instead proposes to integrate global perspectives with a foundation of local knowledge (353). Shuman argues that there are “two obstacles” to these processes, nonetheless: “whether women identify with the universal category in question” but also that “it is an universalizing essentialism, and invokes binary oppositions with valued-charged oppositions” (353). Reviewing Gayatri Spivak’s
discussion of the prohibition of sati in colonial India by British authorities, “in terms of the politics of entitlement and representation (or who has the right to speak on behalf of whom),” she is interested in how sati becomes a “contested category” (353). She comments:

In order to have larger-than-local consensus about values, the entitlement problem, in which local knowledge and rights are paramount has to be subordinated to the desirability of the shared values. This is not the case with sati, where the entitlement of the speaker…is the prevailing concern. It is this type of cultural situation, in which entitlement concerns prevail over any possibility of global consensus, that a larger-than-local concept of culture is most needed (353).

The danger she rightly points is “otherwise, the local entitlement claims can appear to be truths, and we can forget that the representations are made in particular larger-than-local contexts” (352). She concludes that “what is required is not another version of the universal but a reconsideration of the local” (356).4

I follow her view in analyzing calls for solidarity among woman as strategies not as “natural” inclinations, though as I have suggested in my evocation of Barber earlier, the impulse towards “global” questions such as those related to democracy certainly does not go away for me. Neither would Shuman suggest it should, but rather she questions a romanticized view of local culture as corrective to homogenizing forces, such as those of “Mcworld” as well as “Jihad.” In tackling these issues, Chapter Five specifically takes up the notion of the politics of gender in terms of the dynamic between public and private looking at dietetics. My project, especially in Chapter Four, also raises the important issue of the co-optations and appropriations (and counter-appropriations) of discourse of

4 So that, she also argues, we are not going to solve questions related to social power in our representational practices such as in feminist readings which seek to include the voices of the people they work with “as is” because it is based on the notion of a ‘real’ local which our lens has hitherto missed.
health around women’s role in government health policies, and the “embedded” nature of women’s practices within the political economy of health. Another recurring theme I highlight is the idea of the collective power of women and here I am interested in Dorothy Noyes’s elaborations of networks in terms of its embodied presence, taking into the consideration “the coordination of collective action” and the “confluence of feeling [that] happens” when “individuals undergo the same experience in concert” (469). She notes how “consensus arises from copresence…[which] points to the bodily basis of community” (469).

**Locating Home Remedies and Lay Practices**

India’s living indigenous medical traditions is understood to comprise of two parallel streams-folk medicine and codified medicine. Codified medicine includes Ayurveda, Siddha, Tibetan and Unani systems, characterized by extensive documentation in manuscript form and sophisticated theoretical formulations. The folk stream, which includes medicinal practices of diverse communities across the country, is usually understood to be orally transmitted and its forms range from home remedies to deliveries, bone-setting, cures of poisons, treatment of mental diseases and conditions like hepatitis (Hafeel and Suma T.S). Home remedies (which formed much of MALAR women’s practices) are generally understood to include cures for simple ailments, health related customs, seasonal regimens, rituals, food and diet regimens, whose carriers are predominantly housewives (where the older women of the family are most well-versed,
which is why it is often known as \textit{patti vaidhiyam} or grandmother’s healing in the state of Tamilnadu).

Folk healing practices predominantly use locally available resources and can often be community specific or based on regional or local needs and in recent coinage by research centers in India such as the Foundation for the Revitalization of Local Health Traditions for healing systems in India have been referred to simply as Local Health Traditions (LHTs). In addition to “lay” practices as an overarching category, I find the category of “folk indigenous” healing useful for understanding the practices of MALAR women drawn from indigenous healing to highlight their specific place in the indigenous medical traditions, as distinct from Siddha and Ayurvedic practitioners and other professional indigenous folk healers (usually referred to as “indigenous” or “native” healing practitioners) for whom it is a full time activity, although there are overlaps in the practices. This is based on the fact that the women offer their own articulation of their work as home remedies - as \textit{pattivaidhiyam} as well as alternative term \textit{kaivaidhiyam} which implied the same set of practices. \textit{Kai} (where the \textit{vaidhiyam} refers to healing) refers to the hand, so indicates that something they do themselves. To them, these practices are extensions of their cooking, and see as a kind of “first-aid” but also it is a form of \textit{nattuvaidhiyam} or indigenous medicine as opposed to “English” (the local description for biomedicine, based on its original in the era of colonization). English medicine itself was also referred to as \textit{uusi marindhu} or medicine that involved needles—as opposed to \textit{nattuvaidhiyam} which uses herbs so is also referred to as \textit{muuligai marindhu} or herbal medicine. So this is another way to describe folk indigenous healing,
which stressed the difference between a medicine that provided instant cure (experienced through injections) and one that used herbs and had few side effects though it took time to heal.

“Local” health systems in my reading includes both biomedicine (with all its nuanced local descriptions) and indigenous medicine (indeed the two are also “blended” as in one recipe: a decoction that includes both Vicks vapor rub and holy basil) which is this is based on a local sense of what the categories mean, including where and why the distinctions matter. In other words, my interests are in where the boundaries between these systems are drawn by community members themselves, especially in terms of “self-help” as ongoing process and as it emerged in practice at the everyday level or what I term “localization.”

Further, the practices I observed are in fact not just “oral” or “written” but sensory, embodied, mnemonic and part of both the imagined and experienced spheres of understanding health care and healing. The practice is also very idiosyncratic, individualized, while there are many shared concepts and practices. The community members’ evaluation strategies of what is important in the practice of these traditions are also explored in this project—such as notions of expertise based on proper use of medicines, or the idea of *pakkuvam*, a theme detailed in Chapter Four.

Kanyakumari lies at the tip of the Indian peninsula, at the confluence of the Indian Ocean, the Bay of Bengal and the Arabian Sea and is named for the Goddess Kanyakumari, a popular deity in this area. It borders the state of Kerala at its northwest border and the district of Tiruvenvelli (Tamilnadu) which is to its north (and is the
ancestral home of my family). I traveled extensively in Kanyakumari for the first time in my life during my fieldwork. To me, it had the flavors of both Tamilnadu and Kerala, starting from the language. The Tamil (state language of Tamilnadu) was mingled with Malayalam (the state language of Kerala). In several villages closer to the border, people spoke only Malayalam although they also understood Tamil. Coconut so dear to the people to Kerala was a very important ingredient of the cooking. Yes, the culture of Kerala is very close to ours, I often heard, but we definitely belong to Tamilnadu. The district was carved out of the former Travancore-Cochin state (parts of which are now Kerala) according to the State Reorganization Act in 1956 and absorbed into Tamilnadu, by popular consent. The bulk of the economy is in the agricultural sector, mostly in rice, but there are also extensive fruit orchards, cashew, coconut and rubber plantations, in addition to tapioca and spices. I spent most of my time close to the border of Kerala where many these plantations were located. The district consists of Hindus, Muslims and Christians, with the Christians making up a little more than half the population (a fact attributable to the long history of Christian missionary work in the area).\(^5\)

Studying the “medical neighborhoods” of Kanyakumari was an extraordinarily sensory experience for me. As I began to ask questions to locate the folk indigenous healing practices of the women in households I found myself often guided a great deal by my senses of sight and smell. The capital of India’s Kanyakumari’s district, Nagercoil, is referred to by residents and observers of health services as “hospital city.” It is not hard to see why—the signs advertising hospitals were everywhere and several of the hospitals

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\(^5\) According to local academics, in a book they were compiling, though the National Census does not provide this information. The sizable Christian population was also evident to me traveling in the district.
were among the larger buildings of the city. In the six-seven month period I spent in the
district doing extensive fieldwork, I simply stopped counting the number of hospitals that
were there in every nook and corner. There were any numbers of hospitals offering
specialized services for ailments of seemingly every part of the human anatomy. I would
find myself asking who the signs were for, lay people or other specialists because details
of individual therapies were on boards facing the streets. Is it presumed that lay people
are now more aware of medical procedures or/and do the signs seek to establish authority
and expertise of “English” (which incidentally was the language used in many of the
signs with relation to particular procedures) medicine by making public some of the
“esoteric” language of medicine? In the main roads my buses were taking seemed to have
a disproportionate number of hospitals for kidney problems. Was there a logical
explanation to this trend? Though I did not get answers to all these questions, these
questions certainly had to do with my own position as a lay person and my desire to
understand that position critically but part of my effort was to articulate the role of home
remedies in the larger scheme of things.

I also thought a great deal about the countless number of pharmacies, both for
biomedicine and traditional medicine, which are the most popular though unofficial
source of medical advice and prescriptions. What also interested me was that there were
equal number of signs advertising health resorts, home pharmacies and clinics based on
the codified/professional traditional healing practices of Ayurveda, Siddha and
occasionally Homeopathy. I had expected this, however. Kanyakumari in popular and
mythological literature is well known for its rich source of herbs and physicians in
traditional healing. It also came recommended to me through health activists in the state as a district where traditional medicine was well established and very popular even today despite the reach of biomedicine. But all of these signs, they also noted, represented the increased commercialization and privatization of health services, in the last two-three years in particular, a trend that had also been noted in the neighboring state of Kerala, which borders Kanyakumari. Hospitals were simply good business. I also heard that specializations implied better services but in reality they were often did not meet those promises. The effect of the implementation of the World Bank’s Structural Adjustment Programs⁶ in the scaling back of government-supported health care since the early 1990s had aggravated the problem as well. So do lay people share in this critical knowledge of the logic or rather the illogical nature of this array of services and how do they negotiate these issues and choices and what is the role of self-care in this emerging context were my next set of questions. Through the course of my fieldwork in traditional health practices I learned that these issues in fact frame any discussion on traditional health practices.

The signs haunted me through the course of my entire time in the district, so that when I got sensorily overwhelmed by the endless string of billboards I could only think of home remedies as “the invisible” practices in the beginning. “On the ground,” conducting interviews and observing activities in homes, I discovered how it was widely acknowledged that in some form or the other, home remedies were used in every household. This was shared knowledge. The knowledge base of home remedies,

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⁶ Based on neo-liberal policies, or the culture of “Mcworld” as Barber calls it, discussed earlier in this chapter.
including social networks, patterns of use, production and transmission also worked differently. Where folk healing was “for sale,” the forms of advertisement were more embodied—medicine men and vendors sometimes displayed their wares in stationery buses, in demonstrations by vendors in traveling taxis from the neighboring state of Kerala. Folk healing is to be found in particular kinds of venues—including way-side book stalls, which often sold small collections of home remedies, and of course people’s in homes. All the indigenous healing practices shared a natural resource base and in addition to the pharmacies, in certain sections of the city, the shops selling herbs were very visible. To me, the most distinctive feature of these pharmacies and herbal shops were the sights and smells that emanated from them—especially the open displays of vivid colors that made up the herbs and spices. By the end of my time there, speaking to the MALAR groups, then individual healers, understanding the array of practices from midwife to veterinary care, it seemed that each patch of green had been revealed as herbs, and I walked more tentatively. Sensorily speaking, my journey had come a long way.

The process of ethnography, then, involves cumulative knowledge. Indeed, rather than suggest my lens involves an apriori set of values, I try to record how the interactions came to pass and how some of my assumptions were played out.

**In the Middle of Things**

Fabian provides an evocative image of performance that I want to evoke to further highlight notion that the ethnographer comes to a “research site” or “a community” in the middle of things. He notes:
As image keeps coming up as I think about the texts and performances…in that of the iceberg. Performance in the visible tip; rehearsal/repetition the submerged body. Such a spatial or corporeal image may at first seem an inappropriate evocation of process yet it helps to clarify an important insight. As the tip of the iceberg does not represent its submerged part, cultural performances do not symbolize the work of repetition and rehearsal. They are carried by that work; there is an unbroken, material connection which is metonymic, not metaphorical… That tip [of the iceberg] is not (certainly not only) a token of the submerged body. It is a part, a moment of a process (12).

Aware of the idea of performance as ongoing processes, I also noticed my own changing impressions of the performances over the five to six odd months that I was in Kanyakumari. I did at one point get obsessed about needing to capture some moments. The impression of women making herbs together in Vimala’s backyard as a single still image (or a freeze frame) came often to mind when I thought of what emerged as core to the reframing of health from a “people’s point of view” or “self-help” because in this image was the re-alignment in health narratives in embodied form and for me it provided an antidote to images of poverty so prevalent in global circulation in which people seemed helpless. I wanted to capture that image and retain that impression, with a narrative framing the image as a positive alternative in which people were not “the unheard” or a mere “risk” category.

An equally strong impression was women in groups in their weekly meetings. Each location was so different. Moving with my camera and using my body to stay still, I became very conscious of space—how the places they gathered were half empty and intensity that build up as the groups gathered, how this often stilled everything else around it with everyone’s focus on the group proceedings. No one group was like another.
and the nature of the conversations reflected that. But there were consistent ritual elements to the meetings, which I saw translated from district/MALAR headquarters to village level. Being at meetings over and over again, I began to feel a personal stake in the issues myself. I felt reassured when a coordinator carefully counted out contributions for the week. When new groups were started, I felt excited knowing the doubts in people’s eyes would become one of confidence that I had seen in older groups, and that they were becoming part of something important. The result was that I was never bored with the repetition of information but rather energized by them. In wanting a still image that was a metaphor for self-help but also getting “caught up” in performances in their metonymic sense, it was interesting to me that what I had become an advocate.

My own questions certainly changed the nature of these discussions. On two occasions, I came to wonder if the power of my intention could in fact make someone more ill. In asking people about their health choices, I realized that after a certain period of my being in the village, I knew when someone was ill and what their problems were, in the families and MALAR groups I spent most of my time with, to the degree that I felt on many occasions to be collecting so many histories of suffering and loss that one would think there was nothing else happening in the Mangaalimoodu. On one occasion, when talking to the nursery school teacher who was one of the village coordinators, in her house, I began to get concerned through the course of the interview that she might be getting very tired by the sheer effort of telling me about her life. It turned out she had serious back problems that got exacerbated in sitting and talking to me but she insisted that I had not upset her in any way in getting her to talk about her life. On the contrary,
she said, it felt good to share her experiences. At the end of that lengthy conversation, I remember writing in my field notes: “I have to say that I think hope is probably the best preventive medicine this family practices” as a general air of optimism was palpable in their house despite their challenges (and I will say an air of despondency was palpable in many other households). Yet, after this episode I began to first enquire at greater length how people were feeling before I conducted lengthier interviews. In the end, however, it became evident I could not find the interview with some kind of clean bill of health either and that I could only raise the issue of comfort with people but without exception people made time to talk to me and generously shared their experiences whatever their state of health.

On another occasion, I found myself in the awkward place of enquiring about a woman who I knew community members within the MALAR network were avoiding. I had met her in group meetings and had been impressed by her interest in herbal medicine. While making the rounds of groups with Vimala one day, a group of coordinators began to talk about a woman who had sores on her leg and needed to get injections from a hospital and I realized this was the same woman and made a mental note I should drop by her house on my way out of town. She was also trying oils from a folk healer but essentially no one was sure exactly the problem was. It turned out, in physiological terms, no one as yet what the issues were; in fact, it was not a “physical” problem. I learnt that the women “knew” or “suspected” that she was being adulterous and they essential saw this illness as some kind of punishment. What a terrible name it gives the rest of us, they said. So it was about their reputations as well and they felt inclined not to even talk to
her. On my way out of town, I felt like I was in a quandary as well: would my own reputation be in jeopardy or even more importantly, would I be putting the reputation of MALAR at risk in the community given I was their guest. I did not feel qualified to judge the nature of the claims against the woman though I was very aware of the intense response by the other woman all of whom I saw as models of equanimity and tolerance (especially Vimala) but wanted to understand the women’s point of view as well. But how could I do that without brewing a very big drama about who perceived what about whom? And what was the point to prove my own empathetic sensibilities or initiate a dialogue between the women? I recognized that my dilemmas were indeed influenced by my desire to prove a point about myself and that I did not feel equipped to handle a drama that might jeopardize my own position as a guest in the community.

As a younger unmarried woman, I was also unsure of how my authority on the subject would be received. I noticed the women standing outside her house when I walked down the road near her house. A ditch separated us and because her house was partially under construction it was going to be difficult to reach where she was so I did feel left off the hook in spending more time with her. So I stood on the road and essentially had a very public conversation about how she was doing and hoped she would get better soon. Her leg was swollen and she spoke briefly because of the pain. I rarely saw her after that because I became busy with other issues and her illness kept her away from her self-help group meetings for a while longer, and in essence I remained “stuck on that road with a ditch in between that I did not cross.” By the time I left several months
later, I noticed her from a distance walking normally and generally looking well, though I never heard her case being discussed again by Vimala and others.

**Translation and Transliteration**

The material presented here predominantly draw from my videotapes and written literature collected in the fieldwork though also from extensive field notes I maintained which included records informal conversations. Kanyakumari’s dialect of Tamil includes Malayalam (official language of the neighboring state of Kerala) phrases and accents. The material presented in quotes here come from transcriptions from Tamil translated into English, though I often used the transcriptions for later reference returning to the videotapes and directly translating from the oral Tamil to English first. This allowed me to capture the gestures and stresses in the interviews that I observed anew in each subsequent viewing. These features of the interview are selectively represented as in some instances my analysis focuses solely on content and in others I’ve highlighted how the form in which the information was provided had crucial bearing on the meaning of the material. I have presented my informants’ words though I would argue there is a range of literal meanings so many of my interpretations of what a person meant is based on the flow and tenor of the conversations as well as my own growing knowledge of the material at hand as my fieldwork progressed.

My family was an invaluable source of information in compiling the index of herbs and also deciphering large section of interviews especially where Malayalam was more predominant but also sharing family healing traditions from their childhood in
villages in rural and semi-rural Tamilnadu not different from the places I was traveling in.

In the absence of a standardized transliteration method for Tamil, I’ve relied on the options outlined in the website of the Penn Language Center at the University of Pennsylvania, which is a compilation of the several commonly used schemes (http://ccat.sas.upenn.edu/plc/tamilweb/trans/trans1.html). I have used a, aa, i, ii, u, uu, e, ee, ai, o, oo, au, ah for vowels and k, ng, c, nj, t/d, N, dh/th, n, p, m, y, r, l, v, zh, L, R, n, s, sh, h, j, ksh and sri for consonants. I’ve chosen the options without diacritical marks where possible. I’ve used this system except in quoting texts where diacritical marks have been used. For personal names and names of places I use anglicized versions that are commonly used. In written, formal Tamil there are no distinctions are made between s, sh and ch, p and b, k and g etc. (evident in spoken Tamil) so this is not meant to be strict transliteration of spoken Tamil, though a few of those distinctions based on pronunciation in everyday oral Tamil are used (as in alternating between dh and th and using s instead of c in tulasi and so on); rather this relies on some popular transliteration practices of written Tamil so as to appear intelligible to most readers.

The names of my informants have been changed in this report to protect privacy. At the time I conducted the fieldwork, between 2000-2001, one U. S Dollar equaled 40-45 Rupees (the currency of India).
On the move: Spatial Shifts

I want to conclude this chapter with an observational report on the sensory, spatial aspects of the MALAR movement. My typical everyday routine often included observing meetings. I had spent substantial time in the village of Mangaalimoodu and other villages within the same Block, of Melpuram, and had become familiar with the work of most of the coordinators in the Block and so could keep track on most activities. Towards the end of April 2001, the coordinators informed me that they had finally acquired a room for rent where the Block’s activities could be better coordinated—this was the first I had heard of this so was both surprised and excited to see it. So at the next meeting, the first one since they had moved, I decided to drop by. When I got off the bus, I noticed that the house that had been selected was well-connected to several bus routes. The place itself was nondescript, with the focus on the functional, like the MALAR headquarters. That space used to house a factory, and contained one large room that could hold 300 or so people with a stage on one end and two smaller spaces that accommodated the administrative staff. If we improve the property too much, our property taxes will go up, the President of MALAR had told me, and therefore the space was very simple. Here, in the Melpuram Block, the house owner renting out the room was a MALAR member so a nominal charge had been agreed upon, but security had been the biggest criteria.

I was met with a flurry of activities in the room that had been rented - a side extension of a house. Several groups in different parts of the room were tackling different tasks. Various places in the room had been organized for storage. I was struck by the sense of familiarity. It was as if the women had been using this place for a long time and seeing...
the number of activities that were going on—teaching and checking accounts, planning the annual Block meetings, discussing a home-based entrepreneurial scheme to name a few—it was so clear to see this was much needed. They felt they needed to have a common meeting ground that was not dependent on specific coordinators being at home (the earlier locale for such meetings). The numbers of groups were growing; the activities were growing…so the new space to accommodate these needs could not have come sooner.

In summary, from the perspective of the agent, it is clear that they are ‘situated within multiple contexts which are capable of rapid and dynamic change’ (Goodwin and Duranti 5).
CHAPTER 2

IMAGINING CONTEXT, EMBODYING NETWORK: NARRATIVES OF HEALTH-AS-A-RIGHT

_Psychological frames are exclusive, i.e., by including certain messages (or meaningful actions) within a frame, certainly other messages are excluded. Psychological frames are inclusive, i.e., by excluding certain messages certain others are included._

-Gregory Bateson, *Steps to the Ecology of Mind*

The history of the Mahalir Association for Literacy, Awareness and Rights (MALAR) is linked to large scale social mobilization engendered by mass literacy movements in the early 1990s, following the launch of the National Literacy Mission in 1989 to implement the literacy goals of the educational policy reforms of the Rajiv Gandhi Government then in office at the national level. The literacy programs in Kanyakumari district, MALAR’s home drew distinction in its achievement of an 82.1% literacy rate, the highest in the state, following total literacy campaigns in the district from 1991-92 (Athreya and Chunkath 1996).

In what should be have been a period of consolidation in the “post-literacy” phase, the programs were brought to a close. In Kanyakumari district, in the perception of the volunteers of the movement, which including middle class professionals, activists of
voluntary organizations, and village level participants, the literacy campaign’s potential had only just begun to be realized when it was closed. What was disconcerting to them was the manner in which the programs were closed by the government. While many of the programs had involved extensive collaboration between government officials and community members, the program reached an end in a brief meeting in which a unilateral decision was conveyed by government officials to community volunteers that the program was over.

In 1995, the Mahalir Association for Literacy, Awareness and Rights (MALAR) was one of the organizations (that I also refer to as networks) started, following this “abrupt” closure of the National Literacy Mission’s programs in Kanyakumari district. The biggest impetus of the volunteers who wanted to continue and sustain the literacy efforts was to start organizations that would be managed by community members and not by government bureaucrats—organizations that would be “self-sustaining” and “autonomous.”

In this chapter, I will argue these founding principles of the organization related to autonomy and sustainability are crucial to understanding the health initiatives of MALAR. Looking specifically at MALAR’s involvement in an international health campaign, the People’s Health Assembly, I will argue that the health initiatives rests on particular constructed histories or chronologies about visions for social change, which relate to notions of health. Further, these chronologies about health involve articulations about the nature of networks, such as MALAR. This includes how the networks seek, to
use Mahatma Gandhi’s words\textsuperscript{7}, to become (to embody) the change they want to see. The interpretive processes that underlie these chronologies, particularly how they articulate roles for the “actors” and networks involved, and in how they create a sense of context about the state of health in the country to locate the networks/actors, are the subject of this chapter. I argue that the chronologies must be understood as \textit{strategic} and \textit{political}.

This chapter asks: what is the nature of “action” in these chronologies, following Kenneth Burke’s idea of language as “symbolic action” (in \textit{Language as Symbolic Action}). Furthermore, I am interested in how this “action” is what “makes” the network, that is, the networks which are involved in the telling of these chronologies. I view these chronologies as helping to build the case for the network strategies. Following Dorothy Noyes’s elaboration of networks, I refer to the network as one made up “of individuals and geographic communities as nexuses for a variety of relationships and social ties, some intimate and long-lasting, others temporary but influential” (Noyes 456). To evoke Noyes’ elaborations, In the making is a particular kind of “community” or “social imaginary” which are the outlined in the chronologies of health, while at the same there is the embodied, “empirical,” interactive “network” involving actors engaged in particular kinds of social relationships that embody the principles evoked in the chronologies (450). The chronologies set up a series of idealized principles about health but also include the experiences of “empirical” practice of health, that is, the experience of “people” from various communities across the world, so that the “community of the social imaginary coexists in a dialectical tendency with the empirical world of day-to-day networks” (456-471).

\textsuperscript{7} ‘Become the change you want to see.’
I will look specifically at MALAR’s international health campaigns around health in terms of universal human rights or “health-for-all” principles. The chronologies of health are enshrined in the campaign literature and enacted in the embodied global, national and local campaigns. The chronologies envision roles for two set of actors: an international network of civil society groups and the state (or the government), as well as lay out the possibilities for partnerships between these set of actors. In other words, there are various “actors” involved (civil society, government etc) in the communicative “action” who assert their “agency.” I will uncover the role of “actors” conceptualized in the chronologies, as a way to highlight the network strategies involved. (Burke, *Rhetoric of Motives*)

**MALAR's History: Linking Autonomy and Empowerment**

As a background to the People’s Health Assembly, I want to introduce the history of MALAR. The People’s Health Assembly builds on the experiences on groups like MALAR but also expands the scope of their work. As noted earlier, notions of MALAR’s network in terms autonomy, democracy, and self-help are its founding principles. A booklet (written in Tamil) written by K. Kalpana and Thomas Franco, volunteers of the Tamilnadu Science Forum (and “resource persons” for MALAR, a concept explained later in this section) records the history. The need for an organization like MALAR is summarized in the Booklet: The failures of economic policies brought on by globalization and other economic priorities; the poor status of women, in various spheres including the commodification of women’s body in the media; and the increase in social
ills, especially its impact on youth. Further, the country is divided on the basis of caste and religion. The interconnected social, economic and political problems run deep. The solutions to many of these problems, [especially poverty], are available in the experience of organizations like the Grameen Bank,\textsuperscript{8} which through a micro-credit scheme have addressed these issues.

The Booklet highlights the role of women and women’s empowerment as central to MALAR’s mission:

With these issues in mind, MALAR was started in Kanyakumari district to enable women to achieve economic self-sufficiency and empowerment. The volunteers of the Tamilnadu Science Forum who had coordinated the Mass Literacy efforts in the early 1990s formed a committee to discuss the future of those energized by the movement. The government had abruptly shut down the movement. That experience of being at the mercy of the government as well as recognizing the potential of the thousands of volunteers who had been energized by the movement encouraged the committee to start MALAR in May 1995. Women were the singularly most important group to be energized by the movement.

The basic aims of MALAR include:

To provide continuous education to women.
Save them from moneylenders and encourage a savings habit.
To educate women on the potential of collective and cooperative work.
To educate women about health and hygiene issues.
To provide women whose lives are characterized by oppression and sorrow the opportunity and encouragement for self-sufficiency and empowerment and to increase their monetary capabilities.

The MALAR booklet connects local issues pertaining to social ills in local communities, the influence of the media, discrimination of women at large and difficulties stemming from globalization in making a case for the inception of MALAR. I will demonstrate that the People Health Assembly constructs a similar kind of history, in connecting health to

\textsuperscript{8} Microcredit bank, started in Bangladesh, in 1976, often referenced as a pioneering model.
wider social issues to make a case for its own inception. I call these histories 
chronologies of health, and argue they are vital in understanding that the kinds of 
programs and groups that may follow from them, or are declared to be built on them. The 
chronologies are therefore strategic and political. The chronologies involve, in the case of 
the MALAR booklet, making a case for the organization on the basis of the 
discrimination of women, but also simultaneously make a case for women’s capacities. 
The ability of local communities to organize local programs is also a key idea with regard 
to the inception of MALAR. In making the case for the capacity of local communities, 
the history of the Literacy movement is routinely cited. In referring to the involvement of 
local communities that stresses both their organizational capabilities but also their 
willingness and ability to learn, the notion of “people’s” capabilities and involvement is 
evoked. Below is a record of the history of the Literacy Campaigns that echoes the view 
of many local activists who participated in the campaigns and then later went on to start 
non-governmental organizations like MALAR in the district. 

The National Literacy Mission evolved out of the policies on education of the 
Rajiv Gandhi Government, that built on ongoing schemes in Adult Education, such the 
Rural Functional Literacy Projects, State Adult Education Programmes, and programs by voluntary organizations. In quantitative terms, the key objective of the Mission was to 
impart functional literacy to 80 million persons between 1991-95 (Athreya and Chunkath 90-91). According to critics of the Mission, the Mission broke new ground in terms of its 
sense of urgency with regard to literacy, but it still relied on the “center-based approach” 
of previous government campaigns and standard bureaucratized implementation
processes of government agencies, rather than a decentralized “people’s movement” (Athreya and Chunkath 92). In the state of Kerala, in the district of Ernakulam, a significant new direction in literacy movements that made such a decentralized and people-centered approach a priority occurred when the Kerala Sastra Sahitya Parishat initiated, funded by the National Literacy Mission, a decentralized literacy campaign which proved to be a huge success and changed the nature of Literacy campaigns in the country.

The Literacy campaigns distinguished itself in their reliance on volunteers from all sectors of society, including village volunteers with basic education and in adopting a “participatory approach” of all the stakeholders, encouraging personal ownership of the process (Athreya and Chunkath 33-34). Further, the use of street theatre or kalajathas was an important and inspiring aspect of the campaigns, in terms of mobilization and awareness building, as well as in building the organizational structure of the campaigns which included volunteers and full time personnel. These campaigns were based on assessments including door-to-door surveys to address the ground realities involved. Further, the campaigns involved well-developed training structures, in which volunteers trained other volunteers (based on a “pyramidical” system starting from “key resource persons,” “resource persons,” “master-trainers” at the district level and the “volunteer instructors” at the village level, who provided the literacy instruction). The campaigns also involved “decentralized teacher-learning process” where pedagogical tools were evaluated on an ongoing fashion drawing from grass-roots experiences and also included systematic monitoring (Athreya and Chunkath 35-38). The campaign was an inspiration
to other states, but had mixed results elsewhere, including in the state of Tamilnadu. However, it was very successful in Kanyakumari district in Tamilnadu.

In Kanyakumari district and elsewhere, given their effectiveness, many of the key practices of the literacy campaigns continue in the work of voluntary (or non-governmental) organizations that helped to organize the campaigns (such as the use of street theatre in the People’s Health Assembly discussed later in the chapter). MALAR’s work too builds on this momentum, though with some key differences. The Literacy Mission’s programs had enormous reach, given the government’s resources, while the reach of the MALAR network relies on its own volunteers and collaborators from other non-governmental groups.

MALAR’s network comprises of self-help groups to foster savings—each comprising a maximum of 20 women-formed who save money as a group (the idea of micro-credit or micro-finance). In addition to savings, MALAR uses the group meetings to hold discussions on social, health, and economic issues and continue the work of the Literacy campaigns. The MALAR booklet by K. Kalpana and Thomas Franco note, the self-help groups were started because the women would “have the opportunity to learn and become aware of their own positions while attempting to empower themselves drawing on the collective savings of a group, versus the limited power of the individual.” During my period of stay, the total number of groups was in the vicinity of 1000-1200 (with total membership totaling approximately 24,000).

In 2000, MALAR participated in events, at the district, state, national and international level leading up to the People’s Health Assembly (PHA), in Dhaka,
Bangladesh, a gathering of over two thousand delegates representing non-governmental and civil society groups, around the theme of “Health-for-All” (the foundational principle of the Alma Ata Declaration of 1978, resulting from the International Conference on Primary Health Care in Alma Ata, USSR, 1978). Like the Literacy campaigns of the 1990s, the PHA was also a mass movement and a time bound campaign although more open-ended about future directions, unlike the Literacy campaigns. Most importantly, the PHA was a “people’s” movement mobilizing against government policies. In other words, energized by a government supported project, the communities that make up the members of MALAR, had now become part of organized movements critical of the inadequacies of the development initiatives of the government.

An important aspect of MALAR’s policy is maintaining financial autonomy. The organization decided it would enhance their work without compromising their ethics to accept the contribution of a German well-wisher to pay for four members of its staff to make the journey all the way to Bangladesh to participate in the People’s Health Assembly as well as to visit the Grameen Bank and other non-governmental organizations in Dhaka, Bangladesh. This chapter follows sections of the PHA journey.

**Summary of Voices and the Ethnographic Journey**

The focus of the chapter is the literature within the People’s Health Assembly including the Charter and its articulation of “health-as-a-right,” with specific reference to India, where this literature engages with the impact of recent government policy as well as general conditions of health delivery, evaluated from a “people’s” point of view. The
campaigns involves many aspects of earlier campaigns such as the Literacy campaigns in its use of street theatre as mobilization and awareness building tools but, crucially, focuses on the power of “people’s” organizations as partners in the process of health reform—an ethos which is a rallying point in the context of the PHA, though clear roles for civil society and state/government are indicated.

I accompanied the PHA groups from the states of Kerala, Karnataka, Andra Pradesh, Tamilnadu and Orrisa from Chennai, Tamilnadu to the National level assembly in Calcutta, India, as part of the “People’s Health Trains,” that took the delegates from these states as a group to Calcutta. I also observed some of the preparatory forums in Tamilnadu leading up to the Calcutta meeting, the events in Calcutta and also MALAR members’ participation in these events. Several weeks later after the PHA, I was in MALAR’s home, Kanyakumari District in Tamilnadu a little after the MALAR staff had returned from Dhaka, Bangladesh and I continued to observe their initiatives over a six-month period, which is the subject of chapters that follow.

Following the distinction between “social imaginary” or “community” and “network,” I propose that there are two levels of actors involved (Noyes 450). One actor is what Erving Goffman has called in *Forms of Talk* a “figure,” or a “protagonist in a described scene, a ‘character’ in an anecdote”—such as “state,” “civil society,” “human,” “citizen” and so on in the PHA literature (147). Then there is the “addressing self” who is an agent engaged in the performance of narratives such a coordinator of organization within the embodied the PHA campaign, such MALAR members (Goffman, *Forms of Talk* 147). In speaking about the first set of actors here, I articulate that specific roles are
envisioned for them in the PHA literature. In speaking of the second set of actors, I will present their views based on my interviews with them to evaluate the nature of the campaigns. I argue that in the PHA literature, “people’s” experience is highlighted so that the PHA itself employs an agent-centered model. Then there is my own agent-centered model where I take into account the perspective of the participants of the PHA.

“Naming of the Situation”

What is the nature of “action” in the health campaigns? Kenneth’s Burke asks: “what is involved, when we say what people are doing and why they are doing it?” (Burke, Rhetoric of Motives xv). He notes that “in a rounded statement about motives, you must have some word that names the act (names what took place in thought or deed), and another that names the scene (the background of the act, the situation in which it occurred); also you must indicate what kind of person (agent) performed the act, what means or instruments he used (agency), and the purpose” (Burke, Rhetoric of Motives xv). Further, “any terminology is a reflection of reality, by its very nature as terminology it must be a selection of reality; and to this extent it must function also as a deflection of reality” (Burke, Language as Symbolic Action 45). His stress is on how particular terminologies “direct the attention” of the reader or onlooker to “symbolic action in a particular way, and to a different set of observations” (Burke, Language as Symbolic Action 45).

In speaking about health, I argue that the PHA narratives involve chronologies of health that involve Burke’s idea that “all terminologies must implicitly or explicitly
embody choices between the principles of continuity and discontinuity” (Burke, *Language as Symbolic Action* 50). The PHA literature begins with the idea there are problems or inadequacies in the current state of affairs on health in the country, constructing thereby a particular chronology of events about the recent past, and then advocate the continuity of certain principles and practices and the discontinuation of others. I argue these are chronologies about health that are making claims about various levels of “illnesses” followed by arguments for “cure.”

In terms of “action,” the *acts* involved are the commentaries in the PHA literature, the embodied mobilizations leading up to the Assembly and the Assembly itself. To justify their purpose, the *acts* employ chronologies that consist of selections and interpretations (and therefore deflections of other interpretations) of the state of health within their communities as well as at larger national and international levels and that is the *scene* or background to the *acts*. In fact, *scene* and chronologies of health are one and the same, though I am problematizing the nature of *scene* to mean something that is “strategic” not “natural.” The chronologies of health in the campaigns include particular policies of the government and their implementation but what is at stake is what can be accounted for in evaluating health- what ought to constitute the elements that make up the *scene* itself is an area of contestation. In reinterpretation of *scene*, the experience of “people” is evoked, that is, the experience of particular set of *actors* or *agents* is evoked. It is this sense that *scene* is vital in making the case of role of particular *actors*. The formation of the *acts*, that is, the formation and implementation of an organized campaign also testifies to the *agency* of *agents* in promoting the principles of the
campaigns. Both level of actors—the “character” in the anecdotes or chronologies of health and “addressing self” is indicated in the scene and the acts. The scene involves histories that consist of generic “characters” like “people” and the acts involve agents who are the organizations and participants of the campaigns who are “the people” but also have particular organizational and individual identities and enact the performances involved in the campaign. I make the distinction between these two kinds of actors because the reach of “people” in the chronologies of health go beyond the individuals who participate in the People Health Assembly itself and those same individuals also claim for themselves other kinds of identities that go beyond monikers like “people” etc. They come together under such banners for political reasons. By making this distinction, it becomes clear that the “actors” involved in the People Health Assembly represent particular social roles and identities. In other words, a selective of reality is involved.

Further, the chronologies of health articulated in the acts also evoke other evaluations or other chronologies of health, such as those representing state policy, as comparisons, a move that is meant to reveal that the scene, which is about what constitutes health and therefore what constitutes health intervention or development, cannot be assumed. The chronologies demonstrate the idea of terminologies as reflections, selections and deflections of reality but also points to the prevalence of multiple acts and their related chronologies by multiple agents (government, civil society groups etc) that are in play, co-existing and competing with one another.
“Giver of Names”

Another way to describe the campaigns from an agent-centered point of view and highlight the strategic nature of networks is to say that networks such as MALAR’s are ‘givers of names, definers of boundaries, and sponsors of collective effervescences’ (Noyes 472). I propose, linking the strategies outlined above following Burke and Noyes’s notion of network, that the *acts* described are those of community/network building. Indeed, the persuasiveness of the *acts* and their related chronologies of health are reliant on groups coming together, working for a common cause and building a sense of community. The *acts* build the communities and also this community building is part of the social change envisioned. The growth of “people’s” movement, the People Health Assembly argues, is part of the social change envisioned and the campaigns provide a demonstration of that.

Reformulating conceptualization of “Group” in folklore studies, Dorothy Noyes has argues that what we call group is a “product of interaction rather than its precondition” (Noyes 453). She elaborates on the theoretical trajectories:

The group—which in this context, I will give the more affectively charged name of community—is an “invention,” in the materialist tradition of Hobsbaum and Ranger (1983); an “imagining” in the more postmodern discursive realm of Benedict Anderson and assorted French theorists (Anderson 1983; Miami Theory Collective 1991); and we may argue from our own pragmatic tradition of Kenneth Burke and Dell Hymes, “the naming of a situation” (Burke 1957). Finally, calling on the phenomenological/experiential tradition of Victor Turner, community is a felt reality (466).

The networks of the PHA are “inventions” as they are based on particular histories of themselves in relation to the past, which is important if social change is to be sought. The
PHA involves creating a network of civil society groups based on solidarity and communality that will act on its principles, that is an “imagined community.” The articulation of health issues or “naming of the situation” conveys sense of urgency of these issues within a contemporary context. Lastly, participation within the network is indeed “felt” to be a transformational experience for the participants. Noyes notes while these are useful ways to look at groups, because there are “several definitions of collectivity” at play she proposes that “we distinguish between the empirical network of interactions in which culture is created and resides, and the community of the social imaginary that occasionally emerges in performance” (Noyes 450). In the case of the PHA, I argue that the “social imaginary” which involves what I have called chronologies of health emerges in performance but is also explicitly outlined in the PHA literature (Noyes 450). The embodied interactive “network” is already evident in the work of groups like MALAR, whose work then gets expanded through participation in the Assembly and the campaigns leading up to it. The impact on MALAR is more specifically tackled in Chapter Three. In this chapter, I focus on the People’ Health Assembly as a whole.

The People’s Health Assembly: Reframing Models of Health and Health Implementation.

The People’ Health Assembly was a gathering of “more than 1,400 people from over 90 countries [who] met for five days in December 2000 in Dhaka, Bangladesh to finalize a People’s Charter for Health that calls for a radical transformation of local, national and
global systems to enable people to play a greater role in dealing with the determinants of their health.” The principles of the PHA revolve around the idea of “people’s participation for a healthy world.” The literature on the PHA, distributed at the national level campaigns in which I participated and also available on the World Wide Web (http://phmovement.org/pha2000), are the sources of information for this chapter unless otherwise indicated. The literature makes the following arguments:

Strong people’s organizations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people’s civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

In appealing for a “people-centered health sector” the Charter of the PHA calls for changes including the “provision of universal and comprehensive Primary Health Care (PHC), irrespective of people’s ability to pay” and argues “health services must be democratic and accountable with sufficient resources to achieve this.” These practices come from the values that “the attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class” and follow the “principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, [which] should be the basis for formulating policies related to health.” Most of all, health must be seen as a priority, and encompassing a range of issues that are social and economic in nature: “Health is primarily determined by the political,
economic, social and physical environment and should, along with equity and sustainable
development, be a top priority in local, national and international policy-making.”

I want to note the role of actors are perceived to be important to these goals and
are reiterated in so many places that one might say it is the mantra of the PHA
movement. They include the state and civil society groups or “people’s groups” and the
chronologies of health are along the lines of: “Governments have a fundamental
responsibility to ensure universal access to quality health care, education and other social
services according to people’s needs, not according to their ability to pay…[Further] The
participation of people and people's organisations is essential to the formulation,
implementation and evaluation of all health and social policies and programmes.”

At the country and regional meetings leading up to the PHA in Dhaka,
Bangladesh, a series of events and campaigns were organized across each country, what I
would call a series of synchronized rites of community building (elaborated later in the
chapter). In the case of India, nineteen organizations formed a National Coordinating
Committee (NCC) to coordinate the campaign activities leading up to the Dhaka
assembly. The National Coordination Committee prepared a set of 5 books, which were
translated into most of the major Indian languages. The records on the website, written as
the movement was building, notes: “These books cover the major issues in health care
and provision of basic needs that face the country today and look at how Structural
Adjustment and Globalization policies have led to a worsening of the health status.”
Further:

The NCC has also prepared a Draft People's Health Charter to be adopted at the
National Assembly [and conducted] Training Workshops and Formation of State,
District and Block Coordination Committees Block and [created] Primary Health Center Level Surveys and Enquiries. Most states have prepared three questionnaires for a household level and village level and a Primary Health Center level survey. The household surveys are being conducted in 2-3 villages in each block (each block has about 100-200 villages).

It is noteworthy that the PHA involved mapping of the facilities of governmental health care at the grassroots level to aid the case of the People’s Health Charter which seeks larger structural change. This provides a condensed version of exercises by which people’s groups could perform a watchdog role to the government, but it also makes the case that people’s experience of the health care is important. District Conventions and Policy Dialogues include:

Kala Jathas - These are street theatre campaigns where a troupe of artists travel from one village to another performing skits and drama. This mobilizes people in large numbers. In a day, a troupe on tour can easily cover 3-4 villages. Several states are planning this in their districts.

State Conventions and Policy Dialogues include:

People's Health Trains: After the State Convention, the delegates from each state will board a train to Calcutta for the National Assembly. The South Train is the Ernakulam Patna Express - all the 700 delegates from Kerala, Tamilnadu, Karnataka, Andhra Pradesh and Orissa will travel by this train. The trains themselves are planned as a media event - at each station the delegates will get down, distribute leaflets and shout some slogans and meet with the press and then get back into the train. The trains are also planned as moving workshops with classes for the delegates.

The events at the final culmination on Nov 30th - Dec 1st are as follows:

Two Thousand Delegates from different states are coming for the Assembly, which will be held at Salt Lake Stadium in Calcutta. The first day morning session will be a plenary - with opening remarks and the main points of the People's Health Charter being highlighted. The afternoon session will be 20 parallel Shamiana\(^9\) Workshops.

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\(^9\) Large tents
on various themes. In each Shamiana will be a number of resource persons from across the country who will lead the discussions. Each Shamiana workshop will focus on a particular issue and will develop ideas for intervention. On the evening of November 30th will be a poster exhibition - where different states are given space to display their campaign activities and case studies. This event is open to the public. The second day forenoon session will be 6 large sub-conferences with emphasis on case studies and people's initiatives. These sub-conferences will look on the possible follow up actions to the PHA Campaign. In the afternoon of the second day after the formal adoption of the People's Health Charter, a massive rally with about 35,000 people is planned. This rally will culminate in a public meeting.

The Shamiana (tents) sessions included a very large range of issues. Indeed, the list appears to be overwhelmingly large. I will observe that the range of argues reflect the interests and experiences of the participating organizations, that is the “actors” is terms of the “addressing self,” who are involved in the performances of PHA and form its empirical embodied “network.” They have come together under the banner of a “people’s” movement but as is evident from the list below there are many sectors in health. I would argue the suggestion in PHA is that in each of these sectors, the idea of “people’s” perspectives are valuable and also that some of the sessions represent marginal groups whose voices are typically “unheard” in debates about health, such as tribal groups, disabled people etc.

The Shamiana (tents) sessions included discussions on the following topics: female infanticide, child malnutrition, medical professional reform and regulation, community health worker and community based monitoring of health, disaster management, eradication of child labor, violence and women’s health, indigenous medicine and folk traditions, rational drugs and diagnosis, drinking water, sanitation, environment and health, health among displaced and adivasis,\textsuperscript{10} population control and

\textsuperscript{10}Tribals
issues of contraception choice, addressing issues of sexuality with emphasis on HIV and population control programs, trends in medical and vaccine research, microcredit and rural enterprises, control of major communicable diseases, mental health, human resource development for health care, WTO and disinvesting in health, and the working group to finalize the People’s Health Charter.

Particulars in the State of Tamilnadu:

Over 1,100 delegates from 20 districts of Tamil Nadu arrived early 26th morning for the State Convention of the People’s Health Assembly, which was held in New College Auditorium. Early this year, 32 organizations across Tamil Nadu came together to form the State Coordinating Committee (SCC). These are inclusive of TNSF, TNVHA, CHAT, TNMSRA, FORCES, Women’s Collective, FEDCOT, CRY, AIDWA, Prepare, ICCW, and CASSA. The SCC coordinated the village and block-level surveys, awareness programs and campaigns, policy dialogues and over all people’s empowerment. The total number of people who where have been reached by these efforts in Tamil Nadu is estimated at 40 lakhs\(^\text{11}\). People who participated in workshops across the state is approximately 10,000. This survey has taken place in 67 blocks in 18 districts. About 121 Primary Health centers and government hospitals have been surveyed. The village level survey was conducted in 805 villages and the household level survey in 22,988 households.

Furthermore:

15000 letters addressed both to Public and Private Sectors Doctors have been sent by post. A set of 3 posters highlighting the theme of the campaign have been displayed in 18 districts. On behalf of the PHA campaign November 14th was observed as Girl Child Day and protest, marches, and meeting were held in front of Scan centers that offered foetal sex determination services. Signature campaign was also conducted in all the districts. Five Kala Jatha teams were trained and performed street plays highlighting people’s health issues in 25 districts. 18 districts have conducted district level conventions in which they have presented a charter of demands to the health officers of their district.

\(^{11}\) One lakh equals 10,000.
Local-level participation in the District of Kanyakumari, MALAR’s home included:

In Kanyakumari, 17 [organizations] got together, conducted village level awareness workshops and collected statistics. About 30 villages and 5 blocks had intensive workshops while several others were included through survey collections. A district level coordinator group met monthly to plan, report and distribute reports on these activities which was followed by block level meetings. *Kalia-kulu* (arts based groups) presented awareness programs, including street theater in six places…Household level, village level, and primary health care and district level hospitals surveys were conducted. Conclusions include: around 30% of villages have water scarcity, 60% still use open toilets; malaria and diseases from rat infestation spreading in some places; elephantiasis and tuberculosis spreading in some areas; 90% are going to private hospitals, including for childbirth, and to government doctors only for polio and other vaccines. This is due to poor facilities in government facilities. Child birth deaths on the rise, and [there are] inadequate items in the ration shops.

Why the need for this movement and why this at this particular juncture? In other words, what the chronologies of health? Key points on this issue in Charter include the arguments that “globalization has had an adverse effect on people’s health especially the poor whose livelihoods are at risk.” Further, “health, access to drinking water, medical facilities, and the related issues of food and job security, is a right” which are principles that were as set out by the Alma Ata Declaration of 1978 have been unfulfilled. In fact, government policy which has been “giving in to the forces of the marketplace” and diverted the focus of development to population control alone, has contributed to the problems.

The chronologies of health involve solutions, since the solutions also identify the problems in various aspects of health. What is needed are an array of policies, guided by notions of rights and involving specific modes of implementation, including very broad recommendations including “land reforms, education for all, an environment that promotes human dignity, environmentally safe neighborhoods, availability of low cost
medicines, and people-managed health care system, [and the] protection of traditional knowledges.”

At a “practical” level, Charter call for actions that include better management and implementation of current policies, new roles for local people, and new regulations, which are all alluded to in the same breath:

Better maintenance of health facilities; health officials monitoring by local (panchayat) government bodies; primary health care management should involved representatives selected by local people; quality treatments, extension or primary health care to include larger number of diseases; greater inclusion of specialists at least at the district level and formation of primary care centers in urban areas; allocation of fixed percentages of government spending to health and particularly rural care, and not moving towards charging; increasing staff and improving standards and tackling corruption in the medical system; imposing standards for private practices of medicine; regulating fee structures through coordination with consumer and medical professionals; regulating untested medicines and illegal medical experiments; maintaining low costs, cutting advertising for medicines; keeping checks on international drug companies; better government research that is state controlled but accountable to the public; prevention of compulsory family planning, valuing especially the women’s right to deciding family size and safe birth control means and encouraging men to share in family planning; conserving traditional medicines, including native plants and support home remedies and increased research in this area and wider participation for lay people in decision making; containing the rising tide of infectious diseases, and gaining local support to monitor diseases like TB, STD and malaria etc; better sex education and strengthening preventive care.

Tackling women’s health is stressed:

Tackling lower nutritional access for them, prevention of violence against women, including female infanticide and discrimination against the girl child, facilities for care of children and nursery programs, especially for working mothers; treatments of daily health problems like menstrual problems, not just delivery care, prevention of child labor and execution of prevention laws.

Other recommendations include issues that are often unrepresented: Medical help for work-related illness, and mental health care, and increased and safe opportunities for the disabled.
John Janzen has noted that “the idea of health for all recognizes the central role of value charged ideals and goals in culture at large and in health,” so that the perception of health in these movements is “not merely the absence of disease but ‘well-being of body, mind and society’.” Janzen notes, as with any chronology of health, in terms of strategies, “health-for-all” (or “health-as-a-right”) movements are “value related, goal oriented and particularistic and associated with particular techniques and social arrangements” (230-231). While “positive health values” may be seen “elusive” as with all “health-for-all” narratives as Janzen has argued, it is clear that these are evoked in the PHA and it is useful to examine the use of this concept and what model of health and health implementation is being offered (248).

The PHA positions itself as bringing together “voices of the unheard.” The practices and strategies constructed are we might call vernacular or the unofficial practices (they see themselves explicitly as opposed to many official narratives and demand a change in those policies). The preferred term is a “people’s movement” (rather than “anti-something”) which emphasizing the notion that these movements are about the role of different actors. As suggested by the Charter, the idea of people-centered is the principle, where the end goal is the “well-being” of people, rather than profits. It is also about “health for all” people.
Health-as-Right and its Actors

My argument is that while “rights” as a concept may be seen as “elusive” the use of the concept in arguing for shifts in particular social relationships is significant, that is, it is a powerful, unifying message (Janzen 248).

Rachel Kumar has noted, historically speaking in the Indian context, “the history of welfare activities in India cannot be seen as akin to social programmes of welfare states” (79). Following her proposals, I would argue that “health-as-a-right” is in some sense a new idea in terms of policy, even though in principle the declaration of Alma Ata may be widely recognized. Kumar elaborates, in a way relevant to my discussion of the role of “actors,” that is, the “state” and “citizens”:

The welfare state is motivated by a conceptualization of rights (both as liberal and social rights conceptualization) which is absent in the case of India. The aim of development intervention in India is not to maximize welfare, or enhance the rights of the collective, but to provide a foundation for the project of modernization and growth. Other than moral grounds, citizens cannot make claims for development interventions from the state. So the state is one of paternal benefactor…[and the relationship of the state and citizen is] one of giver and receiver, benefactor and beneficiary (79).

Further:

With the adoption of the New Economic Policies (NEP) [in the early 1990s], India has become a neoliberal state. The fundamental philosophy of the neoliberal discourse is that it extols the citizen as a rational, self-interested, competitive and productive individual. ‘Rights’ of the individual are represented in terms of non-interference, as s/he makes choices…[In India, the period of economic reform has involved] deregulation in trade practices, greater efforts to link up with the international economy, increased emphasis on export-oriented growth and efforts to provide an efficient administration. In terms of its welfare activities, despite decrease in expenditure, it has not reneged on its obligations of providing state-subsidized health and education…but rather the focus has been on increased ‘efficiency’ [which has] reduced the number of subsidized services and [involved] standardizing their quality…One consequence of such a rethinking is that welfare will assume a competitive dimension and resources will be distributed among
various groups either on the basis of identity politics or by how the state defines its
development imperatives (79).

Fundamentally, my interest is in how the PHA’s campaigns argue for a shift in values and
shifts in relationships between “actors.” In the light of “people’s” interests and
experiences, the PHA builds the case that particular policies such as the Structural
Adjustment Policies of the World Bank represent values which the state must move away
from. Based on this evaluation, there is a call for certain kinds of “practical” solutions.
The PHA sees itself primarily as a “social mobilisation exercise.” The hope is that it will
create a process to “flourish as a force for change and a forum for people’s voices.” So
the actual implementation process (in the sense of a program rather than a set of
recommendations) of these goals is not alluded to, even among participating groups, who
will each determine their own course of action.

An important feature of the PHA movement is that it evokes another kind of
larger imagined community, as articulated by Noyes (following Benedict Anderson)\textsuperscript{12},
that is not that of the nation but that of civil society groups with common interests and
acting together at the international, national and local levels. The Charter emphasizes the
role of civil society groups, as watch dog groups but also as being involved directly in the

\textsuperscript{12} My interest here is in the use of ‘imagining’ as an analytical category, though I tackle other particularities
of the nation-state, especially in my discussion of Sangeeta Kamat’s work later in this chapter. However, I
do want to note some of the nuances on the history of the nation-state in India in terms of imagined
communities. As Partha Chatterjee has demonstrated, “the most powerful as well as most creative results of
the nationalist imagination in Asia and Africa are posited not on an identity rather on a difference with the
‘modular’ forms of the national society propagated by the modern West” (Chatterjee 5). See especially
\textit{Nation and its Fragments}. Furthermore, in \textit{State and Politics in India} he notes there are social movements in
India that he calls “sub-nationalisms” (which he says are akin to civil society movements, and therefore
significant to my discussion) where “a dense social space unpenebrated by the state allows the reproduction
of subnational ‘imagined communities’ that co-exist with the pan-Indian national ‘imagined community’” (Chatterjee 501). In other words, alternative imaginings are not new within the nation-state, but then neither
has the various nationalist (and their transformation into nation-statism) formations followed universal
rules to begin with (as per Chatterjee’s critique of Benedict Anderson).
process of health delivery. It rests on the principle that each of these “actors,” state and civil society, has the means (if they choose to take the course of action suggested) to play their role. While the commends the global network of non-governmental actors and calls for their role as partners in delivery of health services and education, I would argue the locus of much of follow-up work is still seen to rest with the government. I would argue that this goes right to the heart of where one is perceived to have “rights.”

Recalling Kumar’s summary about the Indian policies with relation to “rights,” what constitutes rights in the neo-liberal state means something different than what is implied by the “health-as-right” and “health-for-all” movements—the neo-liberal and the rights based proposals are competing narratives, and also each are based their own variant chronologies of health. It is interesting they are both “global” or “international” narratives brought use within a national context. The debate is between different kinds of global-local synergies (global corporations with state and national governments, or non-governmental locally based groups networked globally etc). I argue, fundamentally in the PHA, despite an increased role for non-governmental groups and new synergies that are beyond the nation there is an appeal for retaining some form of social contract between “people” and the government; the danger is the erasure of this link and therefore the loss of even “moral grounds” (from Rachel Kumar quoted earlier) to claim rights. The actor is “human” (following from the idea of fundamental human rights) but also must be acknowledged as “citizen” for social change to be realized. Simply put, there is a great deal of dispute over the role of the nation-state in the era of globalization because its role has changed (as I note in my summary of Benjamin Barber’s work in Chapter). In the
PHA, there is a call for the nation-state to address the rights and role of citizens in these changing circumstances. In the PHA, the role of civil society organizing at a global level is seen as one that will put pressure on the leaders of various countries externally and internally. With relation to health, this view echoes Margaret Lock and Mark Nichter’s summary of Stacy Leigh Pigg’s work in their observation that “growing links between local and transnational NGOs having a progressive liberal democratic agenda create new spaces where the moral tenants of ‘national identities’ may be revisited and challenged in the context of discourse on health and development.” (Lock and Nichter 9).

Sangeeta Kamat’s analysis of non-governments in Development Hegemony is particularly useful here in understanding the state-civil society relationship in the context of development work in India at greater length. Her arguments relate to the way, following Antonio Gramci’s work, state and civil society are “imbricated in one another.” She notes that there have been “two viewpoints about the history of non-party formation in India” where one “states the relative autonomy of civil society itself from the state” the other “the spread of state ideology throughout civil society.” The “former points to the political state separate from and in opposition to state meanings of development” and in fact “the revolutionary potential of these organizations are based on such an understanding,” while “the other point, position taken by Left parties is that grassroots organizations are ‘carriers of elite interests’” although it is the role of foreign funding alone that often “bears evidence of the ideological consensus between the ruling classes and the grassroots activists” (Kamat 30).
Kamat’s sense is that we need frameworks with which we can see that participants in civil society groups are “actors in their own right not merely stooges of imperialist powers” but also we must “account for the relationship between grassroots organizations and the state…because these organizations exist within the dominant political economy and cannot be projected as autonomous from it” (Kamat 31). She highlights the importance of “particular discursive practices and social relations” and given “particular contexts are unique and original…hence, deserve independent study and analysis in order to both understand them and challenge them.” This reiterates both the actor-centered and context-specific approach that I have adopted here. Kamat’s work very useful in articulating what is an ongoing engagement between civil society and the nation-state. While the civil society groups of the PHA seek to draw attention to their particular goals and vision for the country, so to speak, transforming the way government works is part of their mission. Furthermore, as many activists noted to me, the choice of venue for national assembly in Calcutta, India which is capital of the state of Bengal, whose Communist government provided both logistical support and publicly endorsed the Assembly and its goals, was hugely responsible the success of the PHA. Kamat’s view is also useful in urging a cautionary note about accepting at face value movements as representing viewpoints outside of existent conversations and relationships. In my reading, this is about understanding how such movements, to rephrase in the

13 Her summary of Gramsci’s work includes “how the stability of a regime of dominant classes is ensured, not only through coercion, but also through the consent of the dominated classes, through interpellating certain interests of the dominated classes with those of the ruling classes.” She elaborates: ‘He [Gramsci] emphasized that hegemony or the organization of consent worked primarily through the differentiated and dispersed associations and institutions of civil society that appear autonomous from political society, that is, the state (1971:12-13,261). Therefore to understand the particular hegemonic processes of a specific historical epoch, one has to study in detail the political, economic, and cultural relations between discourses of state institutions and those of autonomous groups or classes of civil society” (Kamat 32).
language of frame analysis as expounded by Goffman, select from frames that already exist [“Fronts are selected, not created,” he has noted in Presentation of Self in Everyday Life (28)]. I argue the PHA stakes out particular kinds of partnerships between state and civil society (so the work of civil society groups are hardly seen an independent of the state) while at the same time evokes a civil society community that is transnational, and representing what the state cannot and/or will not hear (implied in “voices of the unheard”). In that, the PHA provides a vision of relationships and social structures of what that inclusion might look like, including descriptions of ongoing, embodied activities at the grassroots. It is also representative of the struggles involved in how these larger visions, or chronologies of health, might be accommodated within the nation-state.

The Politics of Defining Health and Health policy

I will explore, briefly, an historical understanding of health reforms in India to observe there are many prior narratives of health in which the same dilemmas are played out and to articulate further Goffman’s notion that “fronts are selected are selected, not created” (Presentation of Self 28).

In articulating historical notions of health policy reforms, much of my information comes from Public Health and the Poverty of Reforms: the South Asian Predicament. My purpose here in not to evaluate the studies on health policy but rather to highlight the themes that are relevant to my analysis of the PHA. As a general background to the history of development in independent India, Debabar Banerji points to the ideological nature of process, with several competing philosophies in play:
The development strategies of newly independent countries in the post-colonial world was ‘two-pronged,’ involving firstly, social reforms like land reforms, protection of minorities…provisions for education for all, and building of basic infrastructures to provide basic services in health, transportation, electricity, water etc, and secondly, promotion of technology to increase capacities of the various economic sectors. With the oil crisis of 1973 especially and the introduction of restrictive monetary policies, South Asian countries negotiated with the World Bank and the International Monetary Fund to implement Structural Adjustment Policies to [keep] lines of credit open. From creating autonomous, self-sufficient societies, the focus shifted to foreign exchange reserves and creditworthiness (29).

He notes that there were two basic responses to the [South Asian] national governments’ acceptance of the Structural Adjustment Policies:

One lauded the step as bold, desirable and necessary for South Asia’s successful entry into the twenty-first century and its globalized modernity. The other saw it as a step backward in the region’s effort at independence, self-sufficiency, and building a less iniquitous society. Both viewpoints accepted the innumerable problems of the present system of government, but with a difference. While the former believed in promoting private initiatives and removing bottlenecks of government rules, the latter asserted the importance of regulatory mechanisms of the state, which required reform not rejection. This second view not only upheld the primacy of the state in protecting the interests of the under-privileged in the process of development, but also put at center-stage the unfinished task of social and structural reforms initiated during the early phases of national reconstruction. On the other hand, the proponents of SAP [Structural Adjustment Policies] placed their faith in the process of globalization, mechanisms of free market, and international cooperation (29).

Banerji’s own sympathies lie more with the latter model, with the view for the importance of independence and self-sufficiency for South Asian nations and his suggestion is that the models based on Structural Development Policies provided a way to dismantle any semblance of public health. In this reading, the failures of SAP (and of course, of prior governmental policies) were a huge factor in the emergence of non-governmental agencies, especially international agencies, in the development process. He notes:
In spite of almost two decades…unsatisfactory progress in reforms the structures of poorer nations, the pressures of the policies continued. All the talk of ‘safety nets’ notwithstanding, the general experience was that the social sectors were the first to collapse. To cope with this threat, international organizations with a philanthropic image, such as the WHO, were mobilized to talk about equity. Equity in health through mobilization of multiple agencies such as NGOs, the private sector, and the public sector became the popular slogan, with the public sector being projected as a mere partner (30).

The changing roles of the different actors involved, non-governmental organizations and the state are indicated here, where the non-governmental organizations perform somewhat of an unflattering function in this reading: as formed to enable a “sanitization of equity” which as in fact “a veil to hide the relentless aggression of international funding agencies to break the backs of the fragile South Asian countries” (Banerji 30). I will note this is similar to the understanding the non-governmental organizations as “carriers of elite interests” as noted in Sangeeta Kamat’s analysis of non-party formation in India, especially where any form of foreign funding is indicated (30). I will argue that articulating who the stakeholders are and how their roles are perceived is invariably strategic and political.

The history of health reforms in India suggest that there have always been many competing plans and view points in terms the nation’s priorities and policies in health and it is important to note the conditions under which some narratives come to hold power (and indeed appear to be the “natural” placeholders). Movements such as the PHA, in constructing alternative chronologies of health as well as mobilizing to carry forth their principles, engage in questioning government policies which been taken as givens. The PHA also questions certain cause-and-effect ideas of the chronologies as givens as well (such as “the market place will bring more efficiency to the system” which is a neo-
liberal line of argument). The PHA argues that the experience of people is important and is often different from these official narratives.

The idea of health-for-all or health-as-right itself has a complex history within the Indian context. Imrana Quadeer’s work on health reforms is particularly useful here, based as it is with a premise similar to mine, in asking what the underlying principles in play are:

The health care system is rooted in the political economy of each country and its links with the global processes of economic and political change…[and] ideas about public health influence the patterns of shifts by generating awareness and therefore public support or resistance (131-132).

Looking at notions of Primary Health Care, which are echoed in the Health-for-all movements, she explores how it was been valued within the complex processes of the political economy as well as through the lens of various scientific movements within public health:

PHC has its origin in a stream of seventeenth to twentieth century classical epidemiological studies that observed the links between human health and the total environment- social, economic, political, physical, and biological. This emerging holistic view of disease however was overshadowed, first by the sanitary approach of the Chadwickian model and later by germ theory, both undermining the ‘predisposing’ host factors and promoting ‘eternal’ causality (Hamlin 1992). The germ theory promoted linear therapeutic disease control programs and individualistic and institutional care to the detriment of focus on the host and the social environment factors. The debate was revived only after the second half of the twentieth century when despite all available technology, Third World countries remained riddled with disease…A combination of repeated failures of technocentric approaches, research that emphasized the links between socio-economic and demographic factors and health transitions, and available country experiences led to the 1978 Alma Ata Declaration (119).

It is interesting to note that there seems to be little disagreement about the need to address health conditions in developing nations, but rather the debate is around the means to
solve them and also how to characterize them. Again, highlighting the political nature of health policy, Quadeer elaborates:

Soon after [the Alma Ata] conference where the PHC [Primary Health Care] was hailed as a step forward, the World Health Organization- the very organization that helped it to evolve- was forced to question and criticize the concept. It was argued that handling complex systems would be impractical and too costly as compared to specific medical technological interventions…[In other words] the political nature of PHC defined its limits. International institutions concerned with monetary controls acknowledged the importance of PHC but attempted to further transform its nature. By the eighties, the International Monetary Fund and World Bank were freely using the debt trap of Third World countries to compel them to accept a set of new economic deals, of which health sector reform was a part…[South Asian countries] adopted bank-driven, narrow, technocentric intervention strategies in the area of population control, reproductive and child health, and the treatment of communicable diseases. They opened up the medical care to the private sector, first by depriving it of funds and second by taking advantage of people’s dissatisfaction of it (119-120).

The PHA argues there are inefficiencies within the national health system (exacerbated by SAP policies) and critiques the prioritization of family planning over other goals in particular echoing many of the arguments above, but also opposes the road that sees privatization as a solution. The PHA demands a return to the principles of Alma Ata and an increase in government intervention. Speaking of the period of colonial India, once again focusing on the politics of health policies, Quadeer notes:

In the early period of British rule, apart from providing health care to the army of the East India company, its medical officers extended their services to British civilians…This rudimentary Indian Medical Hospital Service (IMS) was consolidated after the Mutiny of 1857. Though sanitary commissions were appointed by 1869, the work of sanitation remained confined to the cantonments. No investments were made for the general population on the pretext of not imposing reforms on people. It was only the threat of revenue and trade caused by epidemics such as malaria, cholera, and plague that finally changed the colonial policy in favor of interventionist strategies (123).
In terms of guiding principles, she observes:

The discipline of health in the early nineteenth century Britain was dominated by the sanitarians. In the subcontinent, however, only the cantonments were the focus of sanitary activities; the rest of the country received very little attention….The ‘hopeless climate’ of the tropics was initially considered the reason for high mortality. Later, mortality was seen as preventable and it was argued that India could be helped. This shift in thinking, however, was not universal…When the germ theory replaced the sanitarian’s popularity, it enabled the medical bureaucracy in India to avoid expansion of sanitary activities beyond the cantonment…The causal theory of indigenous local conditions that gave rise to disease was thus never given up. Similarly, while the science of nutrition influenced British Welfare policies to introduce feeding programs for the vulnerable, in the subcontinent the idea was entertained only after the vast devastation caused by the Bengal famine of 1842 (126).

It is pertinent to note that images of “backward” disease-stricken India continues to be a pervasive metaphor in the current context as well. As I have noted in Chapter One, this characterization of backwardness within India is associated with the poor. The history of health policy outlined above also raised important questions about how policies exacerbate or create the problem, rather than the “hopeless climate” or the capacity of citizens. Quadeer concludes, in her elaborations on Colonial India:

We see then that in British India the policy of health services was not necessarily guided by the trends and principles of public health as they evolved in Britain. The military and political interests shaped the services till the forties…As a result, health services that evolved were fragmented and imbalanced (126-127).

With relation to health movements in the national movement period (or period of anti-colonial struggle) in India, she notes, many competing models existed including a “people’s” model for health reform:

The Indian national movement not only compelled the British government to set up the Health Planning and Development Committee in 1944…it also set up its own subcommittee in health under the National Planning Committee in 1944…Three additional exercises of this kind through the forties were the Gandhian Plan of Economic Development…the People’s Plan of Economic Development of the Indian
Federation of Labor…and the Bombay Plan for Economic Development….Striving to achieve a broadly common objective, each differs in its thrust and strategies. The Gandhian and People’s plans along with the Sokhey Committee emphasized the role of agriculture and health of the people in the rural areas. The Bombay Plans focused on urban services for industrial growth and proposed to deal with rural problems ‘through proper instructions and education’ and well-organized propaganda. People’s plan held the state solely responsible for health. The Bombay Plans held it responsible for infrastructure but not for controlling the private sector in health. Both the Sokhey and Bhore committee promoted banning private sector [so it would] wither away with the growth of the public sector. The notion of technological excellence remained common to the two ideological opponents- the Bombay Plans and the People’s Plan. Both visualized the best hospitals and technologies for disease control…both saw doctors and nurses as the key personnel in health care. Only the Bhore and Sokhey committees talked of short-term training to health officials, while the Gandhian Plan emphasized people’s care in self-care (127-128).

In these plans, not only are there varying roles for the state and other actors and varying focus in each plan it is interesting to note that there were areas of commonality as well. Quadeer comments:

It is not difficult to see then that within their economic policies and ideological positions, these groups were groping to achieve different levels of the same objective with differing priorities and perspectives (128) (my emphasis).

It is clear that the dilemmas raised by the PHA are not new and that its own position involves selection and interpretation of the current context of health. While the PHA participants presented a common front with a Charter of their own, they are aware of competing with an official model and as well as several prior models, including the Alma Ata declaration itself, each with their own inadequacies but advantages.

To return to Quadeer’s historical account of health reforms, after independence, in India, she notes there was a division between sectors which proved to be cumbersome:

The first and Second Five Year Plans gave priority to building infrastructure, water supply and sanitation, and maternity and child health (MCH)…the central problem of poverty was left for economic planners after recognizing the link between poverty and disease. This separation led to a disjunction between nutritional planning,
agricultural policies, sanitation, control of communicable and occupational disease, and welfare sector planning (128).

The problem was also in the delivery of these goals, which highlights the issues of social power of the actors involved:

The ruling party’s domination by the bourgeois-landlord combine ensued half-hearted land reforms and freedom from taxes on agricultural earnings. Except for setting up heavy industry, the public sector remained low key…in the absence of adequate agricultural growth, both sectors tended to stagnate and pushed the state into more dependency on foreign aid on unfavorable terms…These failures and delays were explained by trickle-down theories, failure of rains, and high rates of population growth (128).

Significantly, government planners recognized that there were some losers as the result of their policies but that was rationalized as part of prioritizing the “nation’s” growth: While the disparities increased, the working class was asked to have patience and “work for nation building” (Quadeer 128). Speaking of developments that led up to the adoption of neo-liberal policies, she notes:

The health sector could not remain isolated over the Third and Fourth Five Year Plans. Not only did the rate of expansion of infrastructure slow down, there was also a shift from peripheral health centers and training paramedical professionals to hospitals and specializations. Vertical technocentric programs were accepted for disease control and maternal and child health services were kept separate from the vertical Family Planning Program (FPP) with the fear that they may suck all the funds given their very poor status. Force and coercion became the landmarks of FPP and the height of arrogance was reached during the emergency when officially inflicted atrocities became the main reason for the downfall of the Congress government in 1977…After this experience, some adjustments were made in terms of expanding the primary health center network in rural areas under the Minimum Needs Program, Community Health Guide Scheme at the village level, a move towards integrating services for nutrition, MCH, FPP, and malaria into general services…As population control remained the priority at the national level, this integration converted the FPP into the ‘black hole’ of health services which sucked into it the resources of all other programs. The last in the series of these comprehensive strategies was the acceptance of the Alma-Ata Declaration in 1978. The crunch came in the eighties. The national debt by then of the order that the Indian ruling class could no longer keep the
common man hopeful while caring care of itself. The Five Year Plans were undermined to give space to market forces, welfare sectors were drastically pruned and handed over to the public sector, and dependence replaced the goal of self-sufficiency in the name of globalization and one world! (129).

Quadeer rightfully concludes with an exclamation mark. I will observe that Quadeer is providing one interpretation of health policy. Nonetheless, I would argue that the above litany of health policies suggests a great deal of schizophrenia, with varying purposes and goals. I would argue this is the PHA’s reading of the health scenario as well. One on hand, government policies has involved adopting a “health-for-all” principles, though always under funding them or prioritizing some programs over others, such as the case of the Family Planning Program (FPP) and then finally abandoning the key goals of the Alma Ata principles altogether. However, there are clearly some effective programs, as well as a history of resistance towards coercive programs. Indeed, in this scenario, engaging with the government and seeking to transform its goals would necessarily involves a complex dance in which some collaborations can be forged over some policies and in other cases not at all.

**Imagery of Illness and Cure**

An understanding of the language of “illness” and “cure” in development discourse articulates the above chronologies of health in an interesting way. I follow here Arturo Escobar elaborations on “the language of ‘crisis’ and ‘disintegration’” in development discourse (in his case predominantly development discourse of international agencies and national governments, though as he himself suggests, can be also seen in
social movements calling for change) that pervades these claims that I have outlined above (10). He is interested in how this language is what “creates a logical need for external intervention and management” so that “accompanying the imagery of crisis is an implicit analysis of causation-sometimes external, more often internal” (10). In other words, to return to my evocation of Burke’s ideas earlier in the chapter, the articulation of the scene provides the justification for the acts. The construction of the scene, or chronologies of health is strategic. Escobar notes that development rhetoric is fused with notions of needs:

The definition of needs presumes the knowledge of experts who certify ‘needs,’ and the institutionalization of ‘social services’ by the state…most often, the interpretation of people’s needs is taken as unproblematic, although it was easily be shown to be otherwise. There is an officially recognized idiom in which needs can be expressed: the means of satisfying ‘needs’ position people as ‘clients’ in relation to the state (225).

He argues that “social movements [calling for change] necessarily operate within dominant systems of need interpretation and satisfaction” (225). This is certainly the case with the PHA, which also creates its own chronology of crisis and needs and call for particular interventions, and also seeks to construct roles for various “actors.” Further, the characterizations of “ill health” echoes standard categories used in international development discourse, such as literacy rates, birth rates, minimum wage etc. In one of the informational articles, included in the PHA booklets at the Assembly, Amit Sen Gupta commenting on the “obsession” with family planning as a solution to poverty, argues that population growth rates follow overall socio-economic development. He notes: “Kerala’s success in achieving results comparable to the developed world- vis-à-
vis both demographic and health indicators—have been widely attributed to factors such as minimum wages, land reforms, high literacy rates, and access to universal health care. Much of Tamilnadu’s success in pegging down birth rates in recent years in being attributed to improved child survival rates due to massive statewide feeding programmes for undernourished children and improved communication facilities.” He concludes: “Both experiences strengthen the maxim that ‘development is the best contraceptive’” (PHA Booklet 58). While development indicators of state policies are used by the PHA, the underlying principles and methods to achieve goals are the bone of contention—and a chronology about health involving the incompatibility of certain principles in development are set up by the PHA—such as the “forces of the marketplace” versus the “rights of people.” It is also interesting that all health systems are seen to be valuable—both the biomedical, on which most of governmental health care is based as well as all forms of indigenous medicine which the PHA would like the government to further support. I point this out to suggest widely ranging as the agendas of the PHA are, the frame of health-as-a-right is essentially about social actors in the health scenario. It does not, for instance, involve a critique of the epistemologies of the health systems involved. Shiv Viswanathan, for instance, notes the prevalence of health movements in the Indian context which have undertaken such an agenda. He writes about nationalist movements during the colonial period where activists and practitioners questioned the hegemony of modern science itself in their critiques of state policy (94-145).

Escobar notes the crucial issue is that social movements while they “operate within dominant systems of need and interpretation,” also “tend to politicize those
interpretations” and that “this process contributes to the consolidation of alternative social identities by subaltern groups” (225). In case of the PHA, while it uses the language of “crisis” and “disintegration,” to quote Escobar, and some of the same indicators of development, it draws on and reframes different set of social identities, that is roles for “people” based on their “human rights”

**Dynamic Performances**

As elaborated in Chapter One, the scholarship in development studies, including Auturo Escobar and Jonathan Crush’s work, has been interested in looking at the “texts of development” such as policy documents, in the way they “have always been avowedly strategic and tactical-promoting, licensing and justifying certain interventions and practices, delegitimizing and excluding others” while also calling attention to the need to understand “the subtleties of contextual presence of [development] texts” (Crush 6).

The PHA’s “texts” suggests that its strategy involves the synergy “combining advocacy with community action” ([PHA Booklet 25](PHA Booklet 25)). I will note these “alternative” health development narratives as also “avowedly strategic” (Crush 6). In terms of embodied practices, the PHA is part of the process of new visions of health implementation and conceptualization. Based on my conversations with participants, it was evident that participating in the PHA was a source of validation for grass-roots experience (and reflected especially in the community documentation, in the surveys of local health resources). It also provided a forum for groups that come from many different places to explore the possibilities for coalitions. In the [Shamiana](Shamiana) sections, the
focus of the discussion was on sharing individual experiences and here particularities and differences did emerge, even while the common themes of ill-effects of globalization and government policy and implementation were acknowledged and perceived to the “common enemy.” I often heard: we now have a common enemy and have to work together, whether we are Catholic or Communist, the two groups that often represented the two ends of the spectrum in terms of divergent politics. There were also particular government policies that one organization chose to highlight that was different from other organizations’ source of dilemmas. It is my conclusion that the events of the PHA were about learning from other organizations’ experience working with similar programs rather than reaching a formal consensus on particular strategies, although there were often agreements. Participation in the PHA generally seemed to be about validating some experience of each organization. The PHA also provided the organizations a sense of the collective, with the “social imaginary” of “people movements” taking “empirical” form in the form of the various organizations involved. Performing in the campaigns together, engaging in similar rituals across the country and the world, brought forth the sense of the collective into embodied form. As Noyes has noted:

If individual acts of identification create the reality of social categories, the reality of a community with which to identify comes from collective acts…We may say of the collective identities generally that although they are often reactive, responding to external ascriptions and oppression, they become realities with the taking of collective action (468).

As I noted, the PHA embodies the dance between “social imaginary” and the empirical “network.” In seeking to understand the cultural meaning of these health initiatives, I have been conscious of a certain distance I was trying to create from what
was in front of me. Primarily, I want to understand the “truth-claims” in any movement but I have tried to demonstrate that behind these claims are rich traditions in terms of values and principles and enough examples of precedence, so it is not as if they come from nowhere. My interest is in how the experiences of “lay” people are translated in exercises like the PHA, and what kinds of strategies bolster those experiences. But these are issues I felt very compelled by at a personal level. My own observation about health care in the 90s in India, based on conversations with family members who still live is India, include increased health care costs brought on by privatization, the rising costs of which are very noticeable to my family which is middle class and has always used private health care only. My family was also noticed the growth of health resources that are geared towards the care of the very wealthy in the form of large specialist hospitals. New sectors in health care have opened up rather than necessarily an increased efficiency in the one that already existed, which is often the claim made for privatization (that it will bring efficiency). In the village of Mangaalimoodu where I did most of my follow up research with MALAR, the question of globalization, interestingly, often related specifically to increased privatization of all government services and it was a great source of anxiety. A private sector job was primarily seen as an insecure one, with no guarantees about how long one would be able to work. It was not surprisingly, therefore, to see young men eagerly seek out positions in the two sectors that continued to be bastions of the government: the armed forces and the police force.

From another position, I live in the United States, the only developed country without some form of universal primary health care, and on a graduate student income do
feel very vulnerable in this scenario, and understand the value for a safety net for the poor where profits are not the priority, that is, notions of “health-for-all.”

There are some powerful myths that are being questioned here in movements like the PHA, and it is by no means an easy task to ask these questions. Even as a child growing back in India, I was keenly aware of big focus on family planning and sanitation in national policy and the poor as its targets and as the reason for “the country’s backwardness.” Indeed, the family planning songs on TV (entirely government-owned at that point) are something my sister and I can sing still. I would say it was very much part of my own schooling to believe in the inexorable and inevitable winds of modernity and progress, in a heady cocktail with all things “scientific.” I was also lucky to have received early a somewhat alternative schooling (entirely private I should add) and was encouraged to question what I now recognize as seemingly “natural” categories about all cultural norms.

In the context of the PHA, I was shocked by the accounts of medical negligence and then later also witnessed first hand the squalor of government hospitals (where I also met dedicated some medical doctors so I should say I see these as systemic failures), and see a great value in systemized “citizen’s documentation and reviews” and forums that engage directly with the government (which I too agree should remain a key “actor” despite its shifting role) or help to create a large civil society based public presence of some kind around these issues. In the meantime, to put things in a more personal perspective, my thoughts are with several grandmothers of Mangaalimoodu who I know stand in line to get medicine every day because of a government practice where patients

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have to come everyday to get their own medicine lest a black market develops. I have a memory of sitting in the shade of a grocery store near Mangaalimoodu waiting for a government doctor to show up at a nearby hospital for many days, having made friends with the owner of the grocery store and most of his primary customers. You have come to do research and look at the effort you have to make to meet these doctors, the owner used to joke, so imagine what the poor patients have to do. Yes, I know, I would say, having just spotted one grandmother of a family I had been spending time with in the long line of patients outside the hospital, knowing how much of an effort that was for her.

My own politics has been in remaining an observer though I have also been an occasional participant in large national and international level campaigns: they are powerful symbols of a vibrant imagined community of civil society groups for me, though my own more ongoing participation has been more been situated in the grassroots, within organizations with a more local reach. As many organizations within the PHA testified, it was clear to me these large national and international campaigns demand allocation of resources and time that could be used in everyday work but it does create a sense of critical mass, the consequences of which are hard to judge, but it always energizes its participants. Rather than predict or prescribe future directions, in this project, I will stay with my concern of what the PHA movement involved and how it evaluated its own success, which interestingly, in the view of many activists, was in the fact that it took place at all.
CHAPTER 3

NETWORKING RITES/RIGHTS: LOCALIZED HEALTH INITIATIVES IN MALAR

Performance is a mode of social production...specific products include texts, decentered discourse. To decontextualize and recontextualize a text is thus an act of control, and in regard to the differential exercise of such control the issue of social power arises.

-Richard Bauman and Charles Briggs, “Poetics and Performance as Critical Perspectives on Language and Social life.”

At the national level in India, the booklet of the People's Health Assembly (PHA) notes that while “coordinating committees and working groups are set up at the national level, the recommendations [of the PHA] are viewed as guidelines” and “all organizations...[are] encouraged to take [up] independent activities” in their follow-up (26). Encouraging diversity in health implementation is part of the PHA’s strategies. I will argue in this chapter that local reframing of the PHA’s importance by MALAR’s coordinators is vital, in fact, to what kinds of “independent activities” (PHA Booklet 26) MALAR can and will undertake.

In looking at health initiatives in MALAR in Kanyakumari, I employ the term localization to describe the performances involved. In general terms, localization involves the processes of making relevant and persuasive various health practices at the local
level. Therefore, I use the term localization to describe the processes where notions related to a global movement are used at a local level, but also to argue that local knowledge (in this case knowledge related to health) is always “larger-than-local” (Shuman 345). I argue the MALAR health initiatives involve integrating new campaigns into ongoing dynamic dialogues that are already “larger-than-local” (Shuman 345). In this chapter, I follow the MALAR journey from global to local in a more spatial sense—I journeyed from Calcutta, India, where the national level meeting of the People’s Health Assembly (PHA) was held, to Kanyakumari district, Tamilnadu to observe MALAR’s independent initiatives, which is the subject of this chapter.

I will argue the processes of localization refers to “interactive aspects” of the MALAR network and that “whatever the particular configurations [of the interactive aspects of the network, it] must be understood as strategic rather than natural to a given situation” (Noyes 457-459). I will also argue it is useful to see “particular configurations” of the MALAR network as being borne out of the politics of culture (Noyes 459). I follow Amy Shuman’s idea of “larger-than-local” culture, where local culture is not a “natural, essential phenomenon” but “is always marked and always part of a larger-than-local context” and that it is important to understand the political interests in play in the production of local knowledge (Shuman 345). My reading also engages with studies from medical anthropology addressing health interventions or health development in developing countries in terms of global and local cultural dynamics, such as the work of Stacy Leigh Pigg in her elaborations of localized (or village-level) processes of international development initiatives in Nepal. Looking at the history of Nepal’s
development initiatives, Pigg argues that “development creates a conceptual space of cultural contact [which] fuses the local and global” and that particular “local social and representational practices” emerge “at the juncture of these systems,” a process she calls “the nepalization of development” in the context in her work in Nepal (“Inventing Social” 491-492). I borrow this idea of development initiatives as involving “a conceptual space of cultural contact” out of which emerge particular performances that embody local and global negotiation. I am particular interested in these performances as processes, in which local global negotiations are ongoing, which is implied in the idea of “nepalization” as well (Pigg, “Inventing Social” 492). I will also argue, following the ideas of “larger-than-local” community knowledge and the strategic nature of networks (to evoke Noyes’s “Group”) that these performances emerge out the conditions of social power (Shuman 345).

Of particular relevance to my analysis is the idea of “contextualization” which begins with the notion that “communicative contexts are not dictated by the social and physical environment but emerge in negotiations between participants in social interactions” (Bauman and Briggs 68) (my emphasis). Indeed, another way to describe localization is as contextualization with particular attention to social power in local global dynamics. Following an agent-centered model to communication or performance, my lens tracks in the performances in MALAR initiatives, in internal dialogues, specific health programs as well as my interviews with MALAR coordinators, the process of contextualization in how they involve “an active process of negotiation in which participants reflexively examine the discourse as it is emerging, embedding assessments
of its structure and significance in the speech itself” (Bauman and Briggs 69). In MALAR, the process of taking the lessons from global campaigns and a host of educational resources and reframing them in the context of the network’s mission but also taking seriously how the information is imparted within the network, is a self-conscious practice. My interests are in how these shifts are marked in explicitly political terms.

I will argue that while MALAR is involved in campaigns that involve collaboration with many organizations, it draws very specific distinctions between itself and other groups in its internal initiatives. Further, notions of “health-as-a-right” and “self-help” is viewed and implemented programmatically at the local level in distinct ways by the network. I will argue that the health initiatives develop out of the “complex linkages” of the MALAR network involving “boundaries that are regularly drawn and redrawn” and that these “linkages” relate to issues of social power, which includes MALAR’s relationship to other groups and how MALAR’s coordinators speak about their own engagement with empowerment (Noyes 454). Looking specifically at the health initiatives centered around herbal medicine, I will also look closely at the importance of experience and notions of the collective in the process of reframing health. The value of experience and collective efforts are important in sustaining interest of the members in the programs, in making claims about the effectiveness of herbal medicines and cultivating expertise for its coordinators as teachers. I will argue what comes to be recognized as locally or culturally valuable in the programs is not based on a
predetermined set of terms, but emerges in dialogue, and this is the crux of local knowledge.

Margaret Lock and Mark Nichter note, since the 1970s anthropologists have been “asked to investigate ‘cultural barriers’ to health programs” and over the years have come to understand how “the language of ‘cultural barriers’” is used to “deflect attention from the failure of a program or used as a justification not to implement certain programs because they may be seen as culturally unacceptable” (13). Recent studies like Stacey Leigh Pigg’s, Lock and Nichter note, have invited us to better understand “the extent to which public response to state health interventions is a feature of how a program has been implemented and the social relations of program management, identity politics, and public trust” (13-14) (my emphasis). “Public response” denotes participation of the recipients of development initiatives or “people’s participation” as MALAR and its partners call it, though MALAR and its partners also argue that “people” are not passive recipients. Pigg emphasizes that all health interventions must be seen as political and that the inclusion of “public response” is part of the strategies involved (Lock and Nichter 13).

In her study of AIDS initiatives in Nepal, Pigg observes that “in the bland bureaucratic language of international AIDS intervention efforts, all local values and meanings are ‘cultural’ and all services, methods, models, and interventions should be ‘appropriate’” (“Too Bold, Too Hot” 58). She argues:

But the notion of culturally appropriate AIDS intervention is an ambiguous promise. It simultaneously offers the particularistic hope of practical actions, each perfectly suited to its context, and a contradictory commitment to transcendental solutions, in need of only minor re-packaging for export. Every important
question about knowledge, power, and cultural meaning in relation to bodies and their health goes begging when a phrase like ‘culturally appropriate’ stands as our only way of stating the issues presented by the facts of difference and equality (“Too Bold, Too Hot” 58).

In other words, “claims about cultural values and suitability have been political claims from the beginning…because claims about culture can be used as easily to censor as to express a perspective” and that it is therefore important to understand the complicated ways “international public health priorities intersect with local social experiences and debates to produce claims about local norms and values” (Pigg, “Too Bold, Too Hot” 59). I emphasize the complex emergent dynamic of “larger-than-local” (Shuman 345) knowledge in the context of MALAR’s health initiatives to stress the dynamics between local and global “produce claims about local norms and values” (Pigg, “Too Bold, Too Hot” 59).

Studies like Pigg’s emphasize the strategic nature of interventions by international health agencies and question the claim such interventions make that they are value-neutral and the local (alone), that is, the recipient country or group, is “cultural” or value-laden (Pigg, “Too Bold, Too Hot” 58). Interestingly, in folklore scholarship, these same arguments are reiterated, but from the opposite direction, in studies critical of recurrent viewpoints in the discipline that wish to claim the “local as a solution to either universal hegemonic truths and values or to diversity” (Shuman 351). Amy Shuman notes, echoing Pigg’s analysis: “The mistake is to set up the larger-than-local [or the universal or global] as an obstacle to understanding that can then be remedied by local, situated knowledge as if a truly local culture were a knowable quantity, if only we can had better methods of observing and/or describing it” (351). Shuman notes that “the problem is not methods of
observation, description, or analysis” (351). She concludes that “an alternative is to account for the ways in which local boundaries are drawn in order to protect particular positions” (351).

In the case of MALAR’s initiatives, the claim is that “people’s” own experience should be taken into account in the process of development. The MALAR members’ evaluation is that people are not as involved as they would like to be with government officials over health matters but also that with the decrease of governmental intervention in public health based on recent changes in health policy a sense of a social contract between the government and “people” has been put into jeopardy. But what does “people’s experiences” involve? The MALAR coordinators argue for their own sense of where changes are needed in their local communities and more specifically what kinds of local attitudes to health need revision. I will argue that in their own initiatives too, MALAR coordinators are strategic and political and what are “people’s experiences” emerges in dialogue. In a general sense, MALAR’s initiatives are strategic. The mission of MALAR is based on increased awareness about social issues and the focus is on providing greater social and financial support for women. Notions of social change are explicit, with a focus on how changes need to be enacted to make women’s lives better. I will argue that in many cases the changes envisioned involve a reiteration of local knowledge, which also needs to be understood as strategic rather than “natural to…[the] situation” (Noyes 459). For example, community knowledge is integrated into the health programs, in the use of herbal medicines especially. Education about herbal medicine is seen as necessary. One, it is necessary because in the context of less governmental
support in health and the increased dominance of expensive privatized health care, any
form of self-sufficiency is important. Two, for many everyday health concerns, herbal
medicine is seen as the healthier option compared to biomedicine as herbal medicine is
seen as having less side effects than “English” or “injection” medicine (local distinctions
about biomedicine, as noted in Chapter One). Community knowledge of herbal medicine
is validated but it is important to note that it is being reframed in terms of “self-help” but
also the stress on the healthy effects of herbal medicine. While these ideas are echoed by
many families that make up the MALAR membership, I will observe that this feeling is
not universal and part of MALAR’s effort is to restate these claims about herbal medicine
and convince people about their value.

In looking at MALAR’s initiatives, I follow Bonnie Blair O’Connor in her
interests in studying medical traditions not to evaluate their effectiveness but in
understanding how evaluation is done by patients and folk practitioners (O’Connor xvii).
I am interested in how evaluation about the specific health practices that are
recommended in the MALAR initiatives is done by MALAR members themselves
(though I would observe it is also useful to ask what pre-determined set of assumptions
underlie an interest in efficacy because that interest assumes a certain notion of change
and effectiveness). I will demonstrate that evaluation can be understood especially in the
process of localization as emerging in interaction.
Post-PHA at MALAR: Local Reframing

The focus of this chapter is the evaluations of the coordinators of MALAR. Coordinators include the four members who make up the Executive Committee, who oversee the operations of the entire MALAR network in the district, the block level\textsuperscript{14} coordinators who oversee the working of all the self-help groups in each block in the district and the village level coordinators who oversee the operation of five or more groups at the village level. I had heard about MALAR’s work for several months before the People Health Assembly (PHA) from various activists and then met their coordinators in the PHA train from Chennai to Calcutta. During the train journey, MALAR’s health coordinator, Vimala, spoke at length to me about the MALAR health initiatives, especially their programs promoting herbal medicine.

I also met several others groups from Kanyakumari district at the PHA, including other groups who had being founded, like MALAR, after the Literacy Mission campaigns has been shut down. MALAR and several other groups in the district had been involved in the collection of surveys related to government health facilities and organizing informational programs on the issues discussed in the PHA, including hosting street theatre programs organized by state-level groups. The Tamilnadu Science Forum was the vital link between each district, in creating the educational material and coordinating similar activities in the state, while organizations like MALAR helped to implement the programs within each district as well as host groups that were traveling the state through the course of the build-up to the PHA meeting in Calcutta.

\textsuperscript{14} These are government administrative categories. States are divided into districts, which are divided into blocks which are then further divided into villages or panchayats.
The coordinators of MALAR who participated in the PHA imparted the information within their organization but also simultaneously experienced the movement at a personal level and also brought back specific evaluations. This process of critical participation was a pattern I noted in many of MALAR activities, whether it was an once-a-year event like the International Women’s day rally at the district level or programs initiated by national women’s groups such as the All India Democratic Women’s Association (AIDWA), which whom MALAR has an ongoing relationship. In MALAR, I observed a strong sense of solidarity and great sense of commitment to the issues of these other campaigns, especially those related to women’s empowerment, but both informally and formally, the coordinators of MALAR always articulated their own role and constantly asked questions about whether their mission was addressed in these activities and what their experience of participation was. My own sense of this process is this: there is a great deal of openness (thirst I would say) for information but a strong sense of organizational identity influences the use of the information – there were certain recurring ‘MALAR’ ways of assigning value, which are included in my observations of localization.

The first person I met when I arrived in Kanyakumari District was the Secretary of MALAR, one of the four members who went to Dhaka, Bangladesh to attend the People’s Health Assembly (PHA). Below is a record of our informal conversations and her presentation later that day to the block level coordinators and Executive Committee members at MALAR’s headquarters.
Shobana: Sheila, it is really nice to see you again. I am looking really forward to seeing firsthand what you are doing…

Sheila and I take the bus to MALAR’s main office, and arrangements for my lunch are made.

Shobana: So, from Calcutta, after the national People’s Health Assembly, you were able to join the Indian delegation to Dhaka for the international gathering, correct? How did it go? I am sorry I had to miss it.

Sheila: We spent a good part of our time in Bangladesh visiting the Grameen Bank and other organizations actually…

We approach the single building in the middle of a grass patch of an acre or so of land that used to be a storage space and factory and is now MALAR’s headquarters. Today Sheila will present her report about her impressions of the People’s Health Assembly, how the lessons learnt can be applied to MALAR and her vision for MALAR for the next five years.

Sheila quickly summarized her observations for me on our way: What the Grameen Bank is doing is really commendable, especially in their small industries project, where the distribution and marketing is very well organized. But I was troubled by the fact that poor people, the participants in the savings schemes do not have a say in the functioning of the organization, in the bank itself—it seemed to me like they were like slaves (she repeated this several times), in bondage, although they were making reasonable wages.
I had spoken a few times with the MALAR coordinators during the People’s Health Assembly (PHA) and was aware that because the presentations had employed either English or Hindi MALAR’s coordinators had not understood many of them. Two of the coordinators were fairly well conversant in English while two others had much lesser degrees of knowledge, including Sheila, though none was conversant in Hindi. Sheila told me that she came back feeling very determined to learn more English as she felt that was important for her to be able to interact better with people from across the country. You should talk to me in English only, she requested, so I can get some practice. I laughed and told her I had come down to Kanyakumari looking forward to speaking Tamil more exclusively instead of Tamil and English in combination that was my usual inclination, but with her, yes, I would speak in English more. Language issues apart, it was clear talking to Sheila and other coordinators that they saw the PHA as having a great deal of value in terms of representing a large number of organizations who held common ground over many health issues and had similar experiences as a result of globalization in health, economic and social spheres. However, MALAR’s greatest learning experience came from their visit to the Grameen Bank and a few other organizations in Dhaka, where they had been able to observe many organizations’ activities in the course of about three days and speak to organizers of the organizations.

In the meeting at the MALAR headquarters, Sheila began by summarizing the key themes of the PHA. She highlighted how MALAR was part of a movement made up of groups from 94 countries, that many in-depth discussions were held during the Assembly which centered around health problems given the growing disparities between rich and
poor due to globalization and the indifference of the government, as well as the strong
voice of opposition to the policies of the World Bank that was growing in meetings such
as these. She notes that MALAR’s role in the PHA was a worthy effort and that it had
become very clear to her MALAR was not alone in its struggles.

She continues: While in Bangladesh, the members of MALAR were able to observe
the activities of renowned organizations like the Grameen Bank, BRAC, ASA and
PROSHIKA. She goes on to say, while these opportunities were educational, our
conversation first needs to begin with evaluating MALAR’s growth in the past five years.
Her presentation included selective aspects of past events to help build her case about
what the future ought to involve.

“MALAR in the last five years” she announces, and lists her points which involved the
following:

1. Reiterating the goals of MALAR of building on the achievements of the Literacy
movement, “in continuing the education of women in social, economic, cultural and
political issues, to build a model organization like that of SEWA in Gujarat and the
Grameen Bank in Bangladesh, without the support of foreign or government aid.” In
other words, she reiterated issues of autonomy.

2. Providing an account of its financial achievements and structure: MALAR includes
over 1000 groups, which covers 20,000 families, and holds a total savings (based on
weekly savings of Rs. 5 from each member) of Rs.1 crore,\(^ {15} \) with Rs. 2.5 crores in loans,
with many strides made in loan advances, including increases in loans from both within
the organization, banks and the government (with various levels of interest and loans

\(^ {15} \) 1 crore equals 10,000. At the time of my fieldwork, $1 equaled 40-45 Rupees
offered to groups based on years of participation). The issues here relate to fairness, that is, members of MALAR have invested their trust and money and have been rewarded and in an equitable manner, based on years of participation of each group.

3. Providing an account of its activities beyond savings, “in providing avenues for people to become aware of government schemes and to access them, providing information from around the world to MALAR families through newsletters.” She emphasizes democracy within the organization but also its commitment to keeping its members aware and informed about larger social issues.

4. Acknowledging the role of the organization “in helping solve social problems and the fact that the organization functions as an open-book, where members have access to all records.” Again, there is an emphasis on democracy within the organization but also an acknowledgment that group efforts have been able to solve more than financial issues.

The themes above are reiterated in her evaluation of the Grameen Bank that followed.

Sheila begins by noting the achievements of the Grameen Bank: Savings of Rs. 738 crores with Rs. 9817 crores in loans, working out of 22 branches; their involvement in developing industries such as silk with export avenues; their system of operation—how families are selected for membership, how the groups are organized, the regulations about accounting, bank deposits and loans etc. She comments: MALAR’s savings and loans in 5 years is comparable, a fact we should be proud of. Further, there are other areas were the Grameen bank is backward: creating social awareness is not their goal (including awareness of government schemes for rural development). The decisions about loans are taken up in Branch meetings but these are not made public, as is the case with all the
accounting there. While the bank itself has grown into a 22 storey building the profits are not shared with the poor members. The rates of interest are higher despite the influx of foreign aid. Further, there are few job training opportunities for individuals, and because of the cultural norms in the country, there is a lack of equal rights for women.

As to the application of these lessons in MALAR, she again stresses MALAR’s own goals are for social change, not just an increase in finances. Taking cues from the Grameen Bank and other organizations, she says, I believe we can grow our organization if we solve some issues: make it compulsory for our members to participate in weekly meetings; ensure savings are made every week so it becomes a habit; be disciplined about bookkeeping and accounting at all (village, block and district) levels and maintain deadlines; fully utilize all available training programs; pay more attention to developing small scale industries with a view toward self-reliance; conduct better supervision of individual groups, including in providing information and awareness. What we need, in summary, she says, is better “organization and planning,” a sense of “conscience and sacrifice” given “there are so many models across the country for us to take lessons from."

Her presentation does the following: reiterates and underscores the goals of social awareness and the desire for an accountable and democratic organization that is also self-reliant, stresses better organizational skills, and capacity building in new areas like small industries, especially in making the work profitable. In follow-up conversations, she told me there was no shortage of ideas for small scale industries (or “cottage” industries, operating from people’s homes, like soap-making) and women get training and are
willing to work but they run into problems with marketing in a highly competitive environment and MALAR is struggling to find solutions. In her presentation at the MALAR headquarters, she also calls for more discipline and cultivating “habits,” suggesting that MALAR’s initiatives must become ritualized activities that have to be ongoing. While not explicitly dealing with health, my general impression from her presentation was that she felt MALAR was on the same track in terms of principles as the People’s Health Assembly (PHA) and the issue now was how to increase the number of programs. However, the interconnectedness of social, economic and health issues is implicit through her presentation. But it is her desire to strategically position MALAR within the larger network of non-governmental groups working on similar issues and to elaborate the differences that is significant, which I would call a network strategy involving “boundary construction and maintenance” (Noyes 454) – by making how “we are this, not that” and “why we need to be is this not that,” and “we are this but need to stretch to become that.”

I would argue the PHA further ignited the desire for social change, but the question within MALAR was not whether one needs social change or not, but rather what is the model we have going and how can we improve it. Drawing attention to the models in place (rather than just the issues) is one important meta-narrative device that “index[es] not only the features of ongoing social interaction but also the structure and significance of the narrative and the way it is linked to other events” (Bauman 15). Incidentally, MALAR members are invited to go to other districts and share their experiences to help other women start self-help groups. Activists also come to observe
activities in MALAR for the same purpose. In other words, the organization itself is becoming a model to study and imitate. Speaking of models of self-help groups, it is worthwhile to understand the role and popularity of self-help groups as a tool for development in developing countries and MALAR’s own successful interpretation.

**Empowerment Model of Self-help groups in MALAR**

Linda Mayoux elaborates that in the history of self-help groups, there have always been competing models. Growing out of a concern for women’s participation in economic activity, “at independence [from colonialism] some new national governments were concerned with issues of female poverty alleviation” but with the identification of the “informal sector” in the 1970s and 1980s, there was wider interest in increasing women’s access to financial resources. But the programs failed to address gender inequalities in the work place and were also criticized by feminists and left groups for failing to provide full time employment for women to allow them to enter mainstream sectors and for being vague about social welfare (Mayoux 2-4).

The micro-credit enterprise “evolved with the purpose to make income generation schemes more effective and by the 1990s was being promoted by agencies across the political spectrum” (4) (my emphasis). However, there have emerged two distinct approaches to micro-credit development: “a market approach, which aims to assist individual women entrepreneurs to increase their incomes; and…an empowerment approach, which aims not only to increase the incomes, but also the bargaining power of poor producers through group activities” (4). These are “divergent interpretations”
Mayoux observes. She elaborates: “There are divisions between: instrumentalists [who support the “market” model], who, although they may have moved on from the idea of conventional income generation projects, see attention to women as a means for achieving wider goals, e.g. growth or poverty alleviation and feminists [who value the “empowerment” model], who see gender equity itself as an inseparable part of any wider development goal” (5). Further, Mayoux notes: “the emphasis in the market approach is on ‘economic individualism’”...[while] “the empowerment approach emphasizes grassroots ‘community and solidarity’”(5-6). In the market approach, it is assumed “that economic resources will ‘trickle down’ to other women through increase in employment...[while] in the empowerment approach, the wider impact of poverty is assumed to occur through ‘trickle-up’ and ‘trickle-out,’ as increased incomes decrease vulnerability and ‘empower’ people to pressure for change” (5-6).

MALAR’s approach is close to that of the empowerment approach, reflecting some of the features of that approach as outlined by Mayoux which is “to encourage group formation of poor women as a means of empowering them to pressure for change in [addressing] wider inequalities and the wider development agenda” (6). The “programmatic characteristics” of this model include entrepreneurship training and access to credit, while “the sectoral and macro-level strategies” seek “to challenge wider systems of inequality and the wider development agenda” (6).

Mayoux suggests these are general guidelines and in practice there are many interpretations. MALAR members view their organization as constantly growing and needing to grow though, as noted, are generally committed to the ideas of the
“empowerment” model of self-help groups as defined by Mayoux. The emphasis in MALAR is also the processes that will need to evolved or retained to move forward. Because MALAR is linked to a variety of actors, governmental and non-governmental, to conduct its everyday work in finances, it is important to note it is the recipient of both the market and empowerment imperatives, so there is always the challenge, as is evident in the PHA literature as well, to negotiate contesting notions of the network’s role and identity, such as the state’s conception of the network’s role and the network’s own conception of itself.

I want to elaborate on the idea that the principles of microcredit are interpreted differently within each organization. K. Kalpana, activist for the Tamilnadu Science Forum (TNSF), based on her extensive work with MALAR and other self-help groups linked to the Science Forum explains in an article in the website (http://www.aidindia.org/aipsn/savings/s_malar.html) of a sister organization, the Association for India’s Development, that “the credit cooperatives organized exclusively for women have, world-wide, demonstrated a tremendous potential for organization building through intervention in everyday struggles of poor women, rural and urban.”

What the scheme of microcredit does is the following, she notes:

Microcredit seeks to meet the credit requirements of the poor and acknowledges that the formal credit mechanism - largely the banking structure, has patently failed to do so and that the informal credit sector of usurious moneylenders [offering] 60-120% interest rates that has filled the gap has exacted a high price in the form of rural indebtedness. Its strategy is to organize a Self Help Group [SHG] of 15-20 local residents in a neighborhood, usually women, who meet monthly to save and circulate their savings as low-interest loans within their group, whenever a member needs a loan. The peer pressure exerted by the groups and the local context of its operation usually ensure prompt repayment of loans. The safe savings mechanism that the SHGs promote also meet a desperate need of its members to save safely, as
their savings capacity of Rs.5 or 10 a week cannot be accommodated by today's rigid banking structure.

Self-help groups are particularly effective because of their local nature and sense of trust in one’s neighbors which also takes the form of “peer pressure” to be accountable. In the case of MALAR, “what is truly remarkable,” according to K. Kalpana, is that “it demonstrates that it is possible to work towards sustainability and financial independence without compromising organizational autonomy and integrity” despite MALAR’s modest start “with a Rs.2000 loan assistance from the district TNSF [Tamilnadu Science Forum] unit to print savings pass books and utilizing the mass volunteer base generated by the literacy movement.” Further, Kalpana notes, that along with savings, continuing social awareness, “creating a unified consciousness about social structures and vested interests which perpetuate patriarchy and poverty is an openly-declared priority for MALAR” but “this feature cannot, however, be assumed as intrinsic to credit cooperatives.” She concludes:

No linear, facile relationship can be assumed between microenterprise credit assistance and automatic poverty alleviation. But even studies sharply critical of the ‘salvation through micro enterprise’ myth celebrated by World Bank and similar international organizations do testify to its proven potential for mobilizing women. But mobilizing them for what purpose and towards what end is very much in the organization's hands.

In other words, it is in performance, in practice, that the potential of self-help groups is realized but also their role, in terms of political and social empowerment, is something that has to be actively addressed by individual organizations, that is, taken up as a core principle and practiced. Indeed, it could be said that because no “linear, facile relationships” can be assumed about the effects of development initiatives such as micro-
credit schemes, it becomes evident that reiterating core principles in ways that MALAR coordinators do is important to their effectiveness. In many events I observed within MALAR, I was also struck by how personalized the growth of the network could be, that is, there is close identification of individual members’ personal growth with the organization’s growth. Indeed, I would argue that the politics of self-help relies on people developing personal stakes in the issues at hand. Below is an example of MALAR’s coordinators’ dialogues about their personal stakes:

MALAR’s meetings included the routine weekly meetings for each individual group, made up of 20 women on an average, a monthly meeting for the village coordinators where the content of the newsletter was discussed, problems from particular groups tackled and brief informational talks held, and annual meetings for each block as well as for the whole network, which tended to be commemorative events. I was able to observe all these meetings as any other interested member of the general public could have. On some occasions, I also participated by invitation, in meetings that were organized in an impromptu fashion to tackle special needs and involved only the main office bearers. The topic for one such meeting was: where are we as an organization and where should we go? Account for your own history within the organization and speak about where you see grounds for improvement.

This meeting was for block coordinators, who had all worked in the organization for several years. They were invited to “speak from the heart, to be really open.” Indeed they did. Interestingly, I was also invited to “just” listen in, not to formally document the proceedings and my account here comes from memory based on strong impressions that
certain ideas made on me. I was struck over and over again with people articulating in the meeting, often in very emotional ways, how the movement had given them hope-my desire to be better educated, my desire to use my education more while balancing my responsibilities to my family, my ability to help my family financially, my new found sense of esteem, my pride in my role in my community as a leader, my awareness of the world, my being acknowledged at a place like a bank as having financial and organizational capabilities, my being able to convince my family how education for women is so important etc. Other themes included acknowledging their power as a collective, being able to take on those perpetuating social injustices in their communities, like the abusive husband or the shop keepers selling illicit liquor. They all also recounted many MALAR members shared these experiences. But they were also deeply concerned about particular issues that kept returning over and over again in the field—including pressures from other organizations’ self-help groups who were often presenting themselves to members in their community in competitive ways—such as by offering meals in initial meetings. They were also concerned about the slow progress of home-based and small businesses— inability to market products, to sustain growth, add resources, as well as the slow progress of loans from banks for home improvement projects.

Some others were very concerned with their institutional roles—as they got promoted in the organization and their roles became more focused on planning and administration, they worried about loosing touch with the realities of the field and wanted to commit more time again to working directly with individual groups. The issues of
competition, economic growth and other issues that concerned the organization were not new to me and the solutions that were often reiterated in the newsletters and other meetings were discussed in this meeting but hearing the issues alongside these expressive personal narratives highlighted for me the following: the sense of the passion, desire and also anger at having been helpless or having been seen as such, that had helped to start the movement as well as the strong and varied feelings tied to the huge strides that had been made. I sensed that in the recognition of how much could be achieved there was both apprehension and confidence.

**Rites/Rights in On-going MALAR initiatives**

I spent a considerable length of time with MALAR’s Health Coordinator, Vimala, understanding MALAR’s initiatives. I recount here her discussions with me about her vision for MALAR in the post-PHA phase specifically. This is based on a formal interview conducted well into my fieldwork (end of April 2001), though she had already discussed many of these ideas with me at length informally. Essentially, she spoke about how MALAR’s ongoing health initiatives resonated with the themes of the PHA but she also had her own visions for what could come next. What we need, she notes, are health coordinators whose job it would be to focus on awareness building, follow up on training opportunities that we currently offer, conduct more detailed documentation of local health needs and establish better links with the government Village Health Nurses.

In her vision, the lessons of the PHA involved setting up new roles within the organization what would provide more focus to the health work, especially in monitoring
health needs. But that would require setting up a new kind of financial base, she notes—since developing new positions like health coordinators does not generate income some other means have to be developed to fund the position. From her point of view, what is at stake is not merely a better informational structure and training (which includes consistency of programming within the groups, issues she also highlighted), but also some level of organizational and financial re-structuring, that includes new roles that would not be income generating. That move would be a new direction for MALAR. The question that lurked here was this: can we grow while maintaining our values of self-sufficiency? She also stressed the need to be democratic but also the need for disciplined activity. This echoed Sheila’s statements of the value of cultivating “habits” among MALAR members. In other words, mobilizing for “rights” starts at the level of MALAR’s own organizational structure and involves the creation of particular “rites” or ritualized activity implemented across all the groups of MALAR that is part of the responsibility and “right” of its members. In terms of these rites or ritualized activity, MALAR exemplifies Noyes’s notion of networks as the “givers of names, definers of boundaries, and sponsors of collective effervescences” (472), involving “specific techniques of community making” (468). I submit that these techniques are foundational to the process of localization in how the process of community building and social change involving the integration of global and local issues, are intricately linked.

The purpose of MALAR’s programs, Vimala tells me, is to create awareness among people about what health means and what resources they have access to.
Vimala: The government says that it is providing people the basic health facilities 24 hours a day.

She notes this is the theory not the practice in government health care.

Vimala: [They claim] they provide free treatment, in every location, that 24 hour services are available but in how many hospitals are they doing this? [The fact is these services are] not available.

Shobana: Mostly people go to private hospitals only?

Vimala: They go to private hospitals because they are not getting proper treatment in the government hospitals, even in the [district] head quarters in Nagercoil. The maintenance and care is very poor so people go to the hospitals where they get more care and better treatment. Even if they spend money they don’t mind…We have to create awareness in people that it [access to better basic health care] is their human right. Only then, the facilities offered to poor people will get better.

Speaking of particular programs in MALAR as illustrations of these principles, she notes: “Health camps by the government should be done in a better manner…The Lions club and Rotary club also conduct many camps…[but] then further care and follow up is lacking, so when [the clubs] come to conduct camps [such as tuberculosis camps]…we have to tell people what the effects of T.B.[tuberculosis] are and provide them with good health education. Only then they will see [the] value [of these other camps]. Other wise they just gather to get some free medicines. We have to change this mentality. They should know why the camps are conducted. This awareness should be created in their minds. They should know and understand that it is their right, a human
right [to have better access to health care]… We have given lots of training in MALAR regarding this… It is really useful. They [MALAR women] go and tell other people.”

The principle in play here is that changes in attitudes lead to change in practices. It is also MALAR’s own framing, that is, how to understand health programs conducted by other organizations that will enable MALAR women to use information better—that is, in play is the process of recontextualization of existent health initiatives within the framework of “self-help.” The stress is on creating more community awareness. In line with the narratives of the People Health Assembly (PHA), Vimala highlights the disconnect between theory and practice in government health delivery. The actors from the state are very particular, such as the local Village Health Nurse, from whom she would like to see more involvement and dialogue with the community. The need to understand the value and nature of various locally available health resources extends to the services provided by other non-governmental groups as well, such as the Rotary Club.

Further, she notes that what distinguishes MALAR from other local organizations is the focus on self-sufficiency with a vision and a plan for growth, based on other inspiring models across the country include SEWA. What also distinguishes MALAR from other institutions is that it is not reliant on foreign aid, therefore no one can dictate what it does. Given that the government is reneging on its responsibilities in basic health and education, groups such as MALAR see it as their responsibility to address these gaps and attempt to educate people directly.

The impetus is to define one’s organization in relational terms, making very specific kinds of distinctions between MALAR’s own focus and other groups’. This is
very significant at the local level. In the space of two-three years since MALAR’s own inception, there has been an exponential growth in Kanyakumari District in non-governmental organizations involving self-help groups. There are about 50 non-governmental organizations in total, according to a local official count that NABARD (National Bank for Agriculture and Rural Development) had compiled that I reviewed, with self-help groups within each organization ranging from 10 to 1200 within each organization/network, with MALAR as the biggest network. In almost every district level meeting, where reports from the grassroots were discussed, I often heard about other groups who were in competition with MALAR and MALAR coordinators returned over and over again to the argument about the importance of not having foreign funding. The coordinators tell MALAR members: This means sometimes we have less number of loans but we are more likely to survive in the long run. Consider this, coordinators tell members: MALAR has already been here for you for so many years. In five years or ten years or even longer, to support the next generation which is already participating in our programs, will other groups still be around? They point to MALAR’s demonstrated record and realistic planning (based on long-term credit availability through internal mechanisms and the occasional support from government entities rather than “foreign funding”) to build trust with members.

Incidentally, based on conversations with local academics and activists from other organizations, I verified that it was the case that several other organizations had some sources of funding that could be considered “foreign” such as though church groups and international AID agencies but many groups did not. While the organizations involving
self-help groups were monitored by agencies like NABARD especially in order to qualify for government assistance at the financial level, organizations worked autonomously and transparency was not cited as a priority among most organizations, so there certainly was a great deal of ambiguity among community members about which organization they could trust and why they were joining particular ones.

This returns me to the questions raised by Sangeeta Kamat [elaborated in Chapter Two] on how civil society groups are viewed in terms of their sources of funding, in that grassroots organizations are seen by Left parties as “carriers of elite interests” on the basis on foreign funding alone (30). I want to highlight here, while the issue of independence from foreign funding is a fact within MALAR, it is interesting how this argument is evoked to address local issues of competition between different civil society groups, and how it is at the “empirical level of interactions” at the local level that the tension between civil society groups resides, while at the level of the “social imaginary” envisioned in the PHA literature there is a sense of solidarity (Noyes 450). Further, in MALAR, the argument is presented in terms of sustainability or long-term health of the organization. As the founding principles of the MALAR network suggests, sustainability is a concern, given the experience of community members with unreliable state programs such as the Literacy Mission campaigns. While MALAR has been able to grow substantially and sustain that growth, the question of growth is an ongoing concern, with few direct, clear answers or directions.

All of these principles that the network is founded on are constantly reiterated, such as in the presentation by Sheila discussed earlier, that is, these principles are
emergent in performance as well revisited and “recontexualized” (following Bauman and Briggs’ elaborations on performance) as the organization grows. Indeed, my most enduring memory of the activities of MALAR surround its constant dynamism—which involves always revisiting lessons from the past, asking the same fundamental questions from their original mission again in the light of new events, and creating new directions. These narratives also pertain to social power—that is, localization relies on the social status of the agents involved, more specifically, to actors’ own perceptions about the network’s identity and status. As I have demonstrated in this chapter, MALAR’s sense of identity and manner of operation often comes out of its engagement with local politics, and also emerges in it how interprets the general goals of microcredit schemes and self-help groups specially to address questions of empowerment. As Bauman and Briggs have noted “to decontextualize and recontextualize a text is thus an act of control, and in regard to the differential exercise of such control the issue of social power arises” (76).

**Experiential, Collective Education: Use of Herbal Medicine**

MALAR conducts the reporting of its finances and related information primarily through a monthly newsletter. The newsletter also includes small segments of world, national and local news, (food) recipes and herbal medicinal remedies, and stories based on social issues followed by questions for discussion. At a monthly meeting at the MALAR headquarters, the primary coordinators of MALAR or the Executive Committee along with some block level coordinators who coordinate large number of groups read out the entire newsletter and open the floor for discussions and comments. This exercise
is meant to familiarize the coordinators who work at the individual group level in villages
with the content of the material but is also serves as a model- on how to deliver the
contents. In the village groups, sections of the newsletter are read every week so there is
enough material for each weekly meeting for the month. In addition, coordinators and
some interested members attend many workshops (mostly within the district) related to
health organized by other non-governmental organizations, including the Voluntary
Health Association, which is an old national organization involved in training programs.
Some of the workshops offer training in making specific herbal medicines while most are
informational and touch a broad number of topics related to health. MALAR groups from
each block take turns working closely with the Executive Committee to prepare the
newsletter. The financial news comes from MALAR’s own records, while news is
gathered from newspapers predominantly, while the stories and health news come from a
wide variety of sources, though typically through a network of non-governmental
organizations involved in the health sector such as those participating in the People’s
Health Assembly (PHA).

The herbal medicines and recipes are based on local community knowledge but
they are also often borrowed from workshops that MALAR coordinators have attended.
Therefore, one aspect of community knowledge used in the newsletters refers to
information garnered from local women who are considered to have expertise in home
based cures though several of the recipes are known widely as well (common knowledge,
in other words). But the newsletter also draws from the work of professional healers. In
the case of Mangaalimoodu, home of the health coordinator Vimala, the local Roman
Catholic church had been conducting classes on herbal medicines well before MALAR so
the knowledge of people like Vimala who worked for the Church’s health projects before
joining MALAR comes from many places. The church’s workshops as well as those of
other non-governmental organizations employ the services of professional healers,
including Siddha/Ayurvedic practitioners or use information generated by them, so there
is a re-circulation of community knowledge that comes from a wide range of practitioners
from the indigenous healing network, though the knowledge now reaches different sets of
people in systematic ways outside of healers’ families which would be their typical paths
of transmission. This re-circulation suggests how community knowledge is not static and
involves the use of community knowledge in strategic ways by a variety of community
groups of which MALAR is only one. This is another level of localization, which
involves the circulation of local knowledge. While MALAR draws distinctions between
itself and other groups, it is also clearly intricately linked in a chain of activity involving
the circulation of local knowledge, a chain that, in fact, MALAR finds very useful.

From what I gathered, most of the herbal workshops involve local healers, since
the point of the workshops was to get people to use local resources. A popular recipe in
MALAR groups, used in the cure of excessive white discharge in women, involves
Indian aloe which is not widely available locally but usually bought or brought in from
neighboring districts so this notion of local resources is not a strict formulation but it is
indeed the case that most of the herbs are easily available locally, in people’s yards,
rubber and rice fields or in local herb stores which in the district are quite abundant. The
key within MALAR is the following: there is a system in place about how the
information will be transmitted, even though they may come from a variety of places.

Another level of localization with regard to community knowledge involves
distinctions about different kinds of herbal medicine. In MALAR, distinctions are made
between medicines that are easy to make and more complicated medicines. Tonics,
decoctions, in addition to the food recipes are seen as something that women already
typically do and can make at home on their own. The village coordinators read out the
information in the group and there is some discussion which often involves clearing
doubts or repeating the same information. The newsletter provides a commonality of
content among MALAR groups but it is accessible in written form only to the semi-
literate and literate coordinators and group members who also take turns reading from the
newsletter. Typically, most of the group members, whether literate or not, receive the
information in oral format, as the coordinator reads it out loud. It is assumed that this
process works for medicines which are easy to make.

Most oils and other formulations like ointments are seen to be more complex and
while they are mentioned in the newsletters, are also made in groups. This is significant.
Vimala notes that unless you can demonstrate the actual process of making the medicine
and also involve MALAR members in the preparation, including getting them to share
the costs and make the medicines on a regular basis in their groups, these more
complicated formulations will not be done at home, based on orally imparted information
alone. The emphasis is on experience and the value of working as a group. Finances are
also a consideration. Vimala notes many families make their own hair oils (which I was
also able to document) but when the oils involve many herbs, the costs are higher because more base oil is likely to be needed or some herbs need to be purchased rather than gathered from backyards. When the recipe requires many ingredients, Vimala says, the women are not likely to try them on their own even if they are familiar with the process of making them.

A fundamental aspect to the use of herbal medicine is that it reiterates the value of community knowledge. So where one aspect of self-help at the local level (or localization) involves reframing health information from governmental and non-governmental sources, such as in health camps on tuberculosis, another also involves validating and repeating older practices of local knowledge, such as in the use of herbal medicine. At play in these initiatives on herbal medicine is a “traditionalizing” process, which involves “identifying aspects of the past as significant in the present” (Shuman and Briggs 109). In other words, initiatives on herbal medicine are “invented” traditions (following Hobsbaum and Ranger’s work The Invention of Tradition), involving a process of selecting resources from the past “to inculcate certain norms and behaviors by repetition” (1). This is another aspect to localization, in which resources of the past are brought to bear in the context of the present, involving specific “rites” or ritualized activity.

Citing Johannes Fabian’s articulation of performance, I will reiterate the workshops and group-based herbal preparations are performances which involve “giving form to” community knowledge (Fabian 3). Speaking of the emergent notion in performance, Fabian says: “a performance does not ‘express’ something in need to be
brought to the surface, or to the outside, not does it simply enact a preexisting text.
Performance is the text in the moment of its actualization” (4). Further, he notes, performance are ongoing processes. In other words, localization is not static.

I would argue that the idea of local knowledge as “cultural barriers” in development programs that have to be overcome comes from the point of view that fails to understand that initiatives such as those of MALAR are performances that are constantly revisited even when they are repeated, and embedded with evaluation and response by community members in complex ways, rather than static, seemingly definitive set of communication practices, purportedly ones that contain determinable set of ideas which one could call community or “public response” (Lock and Nichter 14).

Below is an example of a dynamic performance, based on highlights from my observation of herbal oil preparation in a MALAR group in Mangaalimoodu.

Highlights:

Vimala has been the health coordinator of MALAR since its inception, and oversees all the groups in the Melpuram Block of which Mangaalimoodu is a part with two other coordinators, and also coordinates directly five groups in Mangaalimoodu. One of her oldest groups in Mangaalimoodu are getting together today to makes an herbal hair oil. They have gathered in her backyard. The group consists of twenty women. Four of them, including Vimala have come together today, although, they tell me, all of the women usually come when they makes herbal medicines together. Somebody was having a wedding and many people in the village were attending the wedding, but the fresh herbs
had already been collected and would go to waste and I have come with my camera so they have decided to go ahead to make the oil for their smaller group.

They are making *kaayathirumeni* herbal oil, which is used for treatment of headaches and general aches and pains in the body. Vimala has discovered that using this oil everyday has also helped her sinuses. When I arrive at Vimala’s house, I see her at the well hauling water into buckets and washing out various cut plants. She greets me with her usual “hello, how are you, have you had something to eat” and starts to explain the process to me. In her backyard, Vimala has put together a temporary stand of bricks in which to place firewood, on which a large mud pot in which the oil will be made stands. A small open shed stands on one corner of her backyard where there is a large stone mortar in which the plants will be pounded and their juices extracted. As the herbs are brought in, with just the water on them from washing them out, two women take turns to pound them using an iron pestle, stopping regularly to remove the extract. The juicy extract is removed from the mortar through a scooping motion, usually with the hand or the cleaned out shell of a coconut; every aspect of the process, it strikes me, is methodical. What is significant is that every method is the same at those of cooking. Indeed, what women learn in the group discussions that is new are particular formulations or recipes; the ingredients and the processes involved, such as grinding, mashing, heating etc are known to them. Today after collecting the ingredients, the process involves extracting the juices from fresh plants and boiling them with a base of coconut oil over a fire.
Vimala’s son gives a helping hand with the pestle so the women can take a break. As they work, Vimala explains to me what ingredients they are using. There are green, “fresh” herbs that she has had the women in the group collect from their neighborhoods and wherever they might find them in the village. From these, they will pound out the juices. And then there are “dry” herbs—which include dried green herbs as well as other material such as tree barks and sea shells that they have purchased from the herb store. These will be pounded into smaller pieces and added in their entirety.

Vimala lifts each ingredient so my camera can capture it and identifies them for me and explains why some particular ones are added. In the case of the ‘dry’ herbs, she says, the herbalist at the store provides you a standard set of herbs depending on what you want to make. She identifies them for me: *karung jiirakam* (nigella sativa/black cumin), *athimathuram* (glycyrrhiza glabra/Indian atees), *caṇḍhanam* (santalum album/yellow sandalwood), *jathikkai* (myristica fragrans/nutmeg), *pavazha putRu* (myristica fragrans), *jiirakam* (cuminum cyminum/cumin seed), *jathi pattri* (myristica officinalis/mace) and *dhevadharam* (cedrus deodara/Himalayan cedar).

Vimala stresses that it is the fresh herbs that have significant value. Today, they include: *kuppaimeni* (acalypha indica/Indian acalypha), *kaithoni* (eclipta alba/trailing eclipta), *cangku kuppi* (clitoria ternatea), *maral* (sanseviria roxburghiana/bow string hemp), *karukappilai* (murrayakoenigii/curry leaf) and *veli paruththi* (pergularia daemia). *Veli paruththi* is good for bruises used on its own. You pluck it from the root, because the root has great value too.
The preparation continues. I ask what kinds of places in the village these herbs can be found. Vimala’s son decides to take me on a tour—and at any rate, the women think they might need more of veli paruththi so we go look for it. We pause at a neighbor’s house. Some houses have distinct fences but usually rubber trees and other kinds of vegetation mark the places between the houses. People’s houses have side yards, or back yards, which are sometimes partially covered with concrete. Then there are the wells, outdoor sheds, storage places and toilets that are separate from the houses, and then there are areas where there are no houses for sizable distances, only vegetation. Maagalimoodu is located on gentle hills, so the landscape here undulates, quickly falling into sleep slopes in some places. I was always struck by how in some areas the houses are close-knit and then in other areas, there seemed to be nobody for miles. This is significant because MALAR coordinators walk across many villages to supervise their many groups and at least on one occasion I left the coordinator was nervous about taking paths she was not used to. If you were not there, she told me, I sometimes ask that someone walk me to the bus stop. But in general, most of these varied paths seem well known to local people.

To my eye, the rubber trees are the outstanding feature, but it is in days like today, I learn to pay attention to every tree, shrub and what seems like mere “grass” or “weeds”-everything that you walk on. Many of these plants are known to locals as having curative properties-they are herbs and they are everywhere. Vimala’s son identifies one such backyard where is no concrete, just grassy vegetation, in which he spots what we are looking for. The house owner is standing outside so he tells her we are making oil and can we take some veli paruththi and she nods, in a manner that indicates that this is
routine. Vimala’s son picks about twenty stalks. My camera catches everyone’s attention for a few minutes—Vimala’s son explains I am from the city of Chennai and have come to study how herbs are used in the village- people nod, smile and then return to their chores.

We return to Vimala’s house where the juicy extract from the “fresh” herbs is being gathered in a mud pot. I see that the herbs you use would be considered public property and you can gather herbs from anywhere, I say. That is generally true, Vimala says. At any rate, it is not often that we make these oils and gather so much at one time. But there are the exceptional cases of people do not like to share. This makes one of the other women, Bai, laugh and has everyone laughing as well when she confesses that she went yesterday to one such woman’s house and helped herself to some herbs in a sneaky fashion—she kept pulling them from the ground casually as she was in conversation with the woman. Vimala who is considered a teacher in the group, someone who people respect, and who I spent a good amount of my time with during my stay, looks at me and laughs. I understand, of course, because I know her so well by now, that this is hardly something she encourages but Bai’s subversive act is funny and it is hard to resist joining in the laughter. This incident also reflects on how these events are social events- the women in the group enjoy getting together to make these medicines.

The hardest part of the labor is the pounding. After the work with the “fresh” herbs is over, after being mildly pound, the dry ingredients are placed on a sifter and the finer sections are extracted. The women converse and catch up on the news in each other’s lives while all the time there is a discussion on what needs to happen with regard
to the oil- pound that more, that ingredient will not get easily pounded, don’t add more water to the fresh herbs or their potency will be less, and so on. Even the size of the firewood is discussed. As the day wears on and the preparations come to a close, the conversations get softer as the women get into a more restful mood.

Some of the “fresh” plants have to be cut as they are too large. When they are pounded, they are then transferred to a bucket and the last of the juices are squeezed out by hand. Very little is wasted. Then the extract is sifted, using on a muslin cloth, to further clear out any fiber. A neighbor’s children are watching the process intently, examining and playing with the different materials involved and they are also given tasks. A boy who appeared to be no more than ten yielded an axe and helped to cut down a large piece of firewood—he was being watched over by an adult and he acted with surety. This was by no means the first time that I noticed that not just was there a role for children and teaching involved in cooking and the making of medicine but that children performed complex tasks and they showed great interest in this work and appeared to know as much as the adults.

The mud pot (compared to a kitchen utensil made of metal) will take longer, Vimala tells me, but it is better. She begins to assemble the dried outer cover of coconuts inside her temporary blocks of bricks, as it is one of the sources of fuel for the fire. The juicy extract is added first to the pot, followed by the coconut oil and then the sifted dry ingredients are added. The oil in my estimate appears to be about half a gallon, the juice extract about four cups and the dry ingredients about one cup. The ingredients are not measured out; as with most Indian cooking, it works on the principle of estimation and
the judgment of people making it. This is hard work, Vimala says. That is why we do this in
groups. And it is also cheaper to do this in groups. We can also alter some of the herbs and
use as many good herbs as possible. So this oil can be made several ways—the more the
number of ingredients, the greater its potency. However, the process remains the same and it is very important to follow the correct process—if the oil boils for too long, one can catch a cold using it so the oil can cause illness if not made properly. This is a notion from indigenous healing related to correct method known as *pakkuvam* (which Chapter four also takes up in detail). Vimala explains: Three stages are to be noted in the process of making the oil. At first it appears thick and slushy, and then it reaches a muddy stage and then the scum settles at the bottom and acquires the consistency of sand. At this stage, you must remove the oil from the fire. You should keep stirring the entire time the oil is on the fire.

The whole process took up almost the whole day. As the day wore on, Vimala took care of her cooking tasks in the kitchen which stands adjacent to the backyard and another woman helped to clean while a third watched the fire. The scum at the bottom crumbles in your hand, Vimala continued to me while conducting her other tasks, and that is the other way you determine when the oil is done. All the instructions are for my benefit as this is oil that this group has made many times before. During the whole process people are paying attention, however. It is clear *pakkuvam* was about knowledge of the process and also the ability to identify and make decisions each time the oil was made, which denotes one key feature of the emergent quality of the oil making performances. For instance, each batch of oils took a different amount of time to make,
even if the same ingredients were being used because each time the quantity of extracts would change and thereby change the whole process. In this process of observing, *pakkuvam* is another layer of localization, which stresses notions of correctness and attention to each performance that borrows from theories of medicine within indigenous healing. When the oil is done, it is removed from the fire and when it is cooler poured into bottles. Vimala noted that the way to use the oil was on the hair and on parts of the body where there is experience of pain.

**Diverse Pedagogies**

Bauman and Briggs have noted that “competence, the knowledge and ability to carry out the decontextualization and recontextualization of performed discourse successfully and appropriately, may be locally conceived of an innate human capacity, learning skill, special gift, a correlate of one’s position in the life cycle etc”(77). In my observation, personal desire for leadership, literacy skills and length of participation were important features of coordinators conducting their work but diversity of skills was stressed in MALAR. As mentioned earlier, some level of literacy was important for coordinators to conduct their work. Indeed, this is one of the factors in selecting women to become coordinators (usually they declare interest or are invited by community members). Many women who have no formal literacy learn to sign their names in the group, which they see as an achievement, so the MALAR movement does continue to extend opportunities in basic literacy skills though the idea behind MALAR is also that by working with other literate women, women with no formal education can access
information found in written forms and not be hindered by their lack of reading or writing skills.

Stemming from the ethos of the Literacy movements, there is also a belief in people’s innate capacities—so that, it is believed, if people are given encouragement and some opportunity in the context of just their immediate neighborhood, that will generate a whole empowerment movement. Thus, a sense of self-worth is emphasized. While MALAR’s Executive Committee members, in the block and district level meetings, stress a greater discipline in the activities of the coordinators of MALAR, I observed they were very gentle in their demeanor at the village level dealing with members and they spend great lengths of time talking about why women should come forward and take leadership roles. There was regular supervision of village groups by block level coordinators but village level coordinators were encourage to take more initiative (especially since some of them would also become block level coordinators some day). I observed each of them would use their own talents in coordinating the groups and expressed the contents of the newsletter without fear of being corrected. Several coordinators recounted being reprimanded was routine in other non-governmental groups they had worked in prior to working in MALAR.

Some MALAR coordinators were extraordinary in their ability to recognize where to be assertive or gentle or where to challenge a group in a discussion or do the bulk of the talking, paying attention to village level issues while always having a larger vision of where they would like the MALAR movement to go. Another ethos that is emphasized in MALAR with relation to microcredit was that the women who comprise the individual
groups have to understand that while the ethos of trust was important to maintain they have to assert their rights in the group, in record keeping especially. This meant making sure the coordinator was handling the accounts properly. I saw little evidence of women asserting themselves without invitation in most village groups. People were not given to questioning anyone (other than make persistent enquiries about when more loans would come available) and generally trusted the village level coordinators. I saw the village coordinators themselves be very assertive and ask tough questions in the monthly meetings in the MALAR headquarters and wondered if because members in the villages did not have that experience they were less inclined to participate in critical dialogue about the organization and its strategies, and that longer lengths of participation made a difference. This was a point of view that several coordinators validated. It was also the case that some women were more inclined than others to take up leadership roles and participate in discussions about where MALAR should go.

**Education in Dialogue**

Vimala is a particularly skilled coordinator. In this section, I will demonstrate how her skills make the localization of heath initiatives particularly effective. Many members often refer to Vimala as “teacher.” Her experience in herbal medicine but also in various forms of health literacy goes back close to ten years prior to her working in MALAR, accumulated through work for the local Roman Catholic church’s health programs, including outreach programs for leprosy victims and other educational forums for the whole community. In MALAR, Vimala found greater opportunities for leadership
where as health coordinator for the whole network (an Executive Committee member position) she is able to determine and implement many new projects. Below is an account of a group meeting she conducted based on the MALAR newsletter where information about herbal recipes takes the form of a song. Specifically it is a tune employed in lullabies, indicated by the use of the words *Arraro Ariraro*, a standard lullaby refrain. It is a lullaby also because of the use of words like *kannai* – “little one,” “my dear” or “beloved” in the song. It is a song which Vimala and other coordinators recently learnt at a local workshop conducted by the Voluntary Health Association and they decided to include it in the newsletter.

About ten people have turned up for the meeting. Two more come in as the group discusses the contents of the song. The meeting is held indoors at one of the member’s house. Vimala sits on a chair with a table in front of her. In the record below, I use Vimala’s name and refer to all the others as “woman” based on the practical constraint of needing to focus my camera on Vimala since she was the primary speaker and recording others’ voices in the background and therefore not being able to connect voice and face later while reviewing the tape.

Vimala: We will begin [today’s meeting] with a song

She starts to sings. In the account below, each new sentence reflects a short pause indicating an end of a sentence in the song, characterized by a change in tune.

Vimala: *Arraro Ariraro, we will speak, with our song, about some beautiful medicines*

*Arraro Ariraro, we will speak, with our song, about some beautiful medicines*

*Listen on, kannai (my dear/beloved), about the harmless/gentle practice of medicine.*
For all diseases there are good herbs

Fresh herbs and in that there are different varieties

There are good herbs

Fresh herbs and in that there are different varieties

Arraro Ariraro, we will speak, with our song, about some beautiful medicines

Arraro Ariraro, we will speak, with our song, about some beautiful medicines

Listen on, kannai (my dear/beloved), about the harmless/gentles practice of medicine. For all diseases there are good herbs

If you have pain in the eyes you express it, kannai (my dear/beloved)

Bind the katRazhai over your eyes and it will cure the eye pain

For all diseases there are good herbs

Fresh herbs and in that there are different varieties

There are good herbs

Fresh herbs and in that there are different varieties

For all diseases there are good herbs

Fresh herbs and in that there are different varieties

If you have stomach pain I will burn the vasampu and I will give it to you

If you have stomach pain I will burn the vasampu and I will give it to you

If you have dysentery use the jathikkai; I will get shave off [some of it] for you

For all diseases there are good herbs

Fresh herbs and in that there are different varieties

Arraro Ariraro, we will speak, with our song, about some beautiful medicines
Arraro Ariraro, we will speak, with our song, about some beautiful medicines
Listen on, kannai (my dear/beloved), about the harmless/gentle practice of medicine
For all diseases there are good herbs
Fresh herbs and in that there are different varieties
There are good herbs
Fresh herbs and in that there are different varieties
For cures for knee pain there is the mudakaruthan creeper
For cure for knee pain there is the mudakaruthan creeper
To cure asthma there is aadathodai plant
For all diseases there are good herbs
Fresh herbs and in that there are different varieties
Arraro Ariraro, we will speak, with our song, about some beautiful medicines
Arraro Ariraro, we will speak, with our song, about some beautiful medicines
Listen on, kannai (my dear/beloved), about the harmless/gentle practice of medicine
For all diseases there are good herbs
Fresh herbs and in that there are different varieties
There are good herbs
Fresh herbs and in that there are different varieties
For the cure for swelling in the leg there is the juice of uumathai
For the cure for swelling in the leg there is the juice of uumathai
To cure cancer there is nithya kalyaNi
For all diseases there are good herbs
Fresh herbs and in that there are different varieties

Arraro Ariraro, we will speak, with our song, about some beautiful medicines

Arraro Ariraro, we will speak, with our song, about some beautiful medicines

Listen on, kannai (my dear/beloved), about the harmless/gentle practice of medicine

For all diseases there are good herbs

Fresh herbs and in that there are different varieties

There are good herbs

Fresh herbs and in that there are different varieties

Vimala: Did you all sleep? [she laughs as this is a joke; the song is a lullaby]. Was the song good? Why did you all not sing along? Okay, what is this about?

Several women nod and agree they like it.

Vimala: Do you know the meaning the song?

She then proceeds to repeat the contents of the song focusing on the use of herbs.

One woman provides a prompt: What was the cure for eye infection?

Vimala: If you have pain, redness and swelling in the eye and when some people suffer due to infection in the eye, you go to the hospital and you have to pay fifty rupees to the doctor for consultation. Whatever be the disease they ask us to do tests.

Another woman: That takes two or three days.

Vimala nods. In my reading, the song is made personal when Vimala says we all get this particular disease, which establishes how the diseases in question are common place ones that affect everyone. She also demystifies the cures by demonstrating where the herbs that cure them are found and making them too appear commonplace.
Vimala: At the time when there is pain, redness or swelling, we can take sotRukatRazhai (aloe vera/ Indian aloe), though plain katRazhai is recorded in the song. Cut it, wash it and clean it well, because there is sand in it sometimes. A small piece is enough. Shave one side of the katRazhai [while] the other side can remain as is. Keep the shaved off side on the eye [she indicates how to place the herb on the eye as she says this]. We can tie it on the eye [with the help of a cloth] when we go to sleep in the night. In the morning the eye pain, redness or swelling will go and we will be cured.

A woman adds: When you lie down then you have to tie this.

Vimala: [Yes], we have to lie down [when we sleep] and then we tie it to the eye. Then there will be rest for the eye. Because we will be sleeping at this time. So the effect of the medicine will go to the eyes instantly. In this way the pain, swelling or redness will change. This is a medicine. You see how this is explained in the song?

Vimala is providing the actual recipes, while the song lists only disease and herb. She is also clearing doubts. She again stresses how beautiful the song is, in revealing medicinal cures that are extraordinary, which is a refrain in the song.

Vimala: Next, for stomach pain. Small children cry due to stomach pain which they cannot explain and therefore we cannot understand why they are crying. That is difficult for us. For those children we have to take vasampu (acorus calamus/calamus)…Some people grow it in the house. Otherwise we can buy it from the [herb] shop….We have to burn that over a fire and take the burnt residue and mix with honey or milk or breast milk and give it to children. The stomach pain will go away. Vasampu is good. Some children stammer, for this [too] vasampu is good.
The women chat amongst each other, repeating what Vimala has said, to clarify what the recipe entails. Again, Vimala has made the issues very personal by suggesting how hard it is for us as caregivers not to be able to help a child.

Vimala: They say you get a sweet voice [by consuming vasampu]. With some people their voice is rough and for this the vasampu is good. It is good for people who cannot talk…

Several women laugh as Vimala appears to be joking by exaggerating. She grows serious again and says: But it is indeed good.

Vimala: For stomach pain if you give [vasampu] with breast milk or honey this is very good. Now two medicines are over. Next for dysentery…

A woman [interrupting]: Stomach ache?

Vimala: No, no, dysentery specifically. We can get jathikkai (myristica fragrans/ nutmeg). In the forest the bats shake the tree and it can be found on the ground. It will be small and round. Buy it from the shop and shave [off the outer part] and mix with honey or milk and give that [to the patient]. This is good for small children. We can use this as first aid when the children cry instead of taking them to the hospital. This treatment serves as first aid. We should give in the initial stages then it will be cured. There is no side effect.

A woman says forcefully: Yes, it does work.

Here, Vimala provides detailed information about an herb though also returns to local sources where it is found. She has also defined the key elements of herbal medicine
that many MALAR initiatives stress: first aid, and its lack of side effects. In response, one woman reveals her positive experience and knowledge of the medicine.

Vimala: Do you understand? When you give injection and take the [biomedical] medicine to cure diseases then some other diseases will appear. So herbal medicines are better. Now we have studied three medicines. For eyes, *sotRukatRazhai*, for stomach pain *vasampu* and for dysentery *jathikkai*.

The women repeat after her, talking all at once to each other. In this way, repetition is employed constantly by both Vimala and the members. Repetition is another key feature of localization in the MALAR initiatives.

Vimala: Now we are going to learn more things that are useful to us. For knee pain, where we get pain from a sprain, for this we can use *mudakaruthan* (*cardiospermum balicacabum*/ balloon vine).

A woman says: It is called *uzhingcai* also.

Vimala [concurs by nodding and then continues]: It is called *mudakaruthan* because it removes the sprain [*mudakkuk*] and the pain that causes hindrance and restraint [to movement].

The same women [from previous response] notes: For pregnant woman we can add in the porridge [meaning use of *uzhingcai* in porridge].

Vimala takes the women’s cue and offers more details.

Vimala: Take *uzhingchai* with the root and wash it well in water. Then put this in water and boil it. The water will reduce to half. Then drink this water.
Several women start talking all at once and it is hard to hear any one. But generally they are repeating and discussing what she has just said. Generally, this audience seemed to focus on clarifications, but displayed familiarity with the herbal medicine as well.

Vimala [when the voices have died down a little]: This is good for knee and hip pain [points to both areas]. There are many reasons for pain and sprains. If there is bone loss we have to take care some other way. This is [primarily] good for sprain and regular kinds of pain. Further, we can make a juice with this leaf. It looks like malli leaf (*coriandrum sativam/coriander-leaf*). These are good medicines. We can take them as food. [There are] no side effects and bad effects. Used in the same way, for those who have sprains and pain due to a beating, *mudakaruthan* is good.

A woman asks: *Akka* (older sister), what about asthma? [This is either her own concern or something she remembers from the song. Further, this is not a rhetorical question that is meant to aid Vimala but she likely looking for solutions; she is interested in all the details of the cure, based on her expression of listening very keenly].

Vimala: Next, for asthma and for children who have breathing problems due to heavy congestion in the chest, *aadathodai (adhatoda vasica/ vasaka)* is good. You know that right? [indicating this is common knowledge]. Take the *aadathodai* [leaves from several branches], a good length of it, though it is very strong [and hard to cut]. Smash the *aadathodai* and take the juice, about one cup of juice. Take *karuppatti (borassus flabellifer/ palmyra sugar)*, put it in water, boil and filter it, then mix the syrup with the juice of *aadathodai* and boil them together well. Remove [from the fire] at the correct
consistency when it becomes like a thin wire or thread like. If it is overdone it will become hard. So remove at the correct consistency and store in a clean bottle. For adults, give one big teaspoon and for small children quarter of a teaspoon. It is very strong. We buy cough syrup, don’t we? This is better than that, much better. For a severe cold this is very good. Instead of buying cough syrup we can use this medicine.

A woman asks: Is this good for the heart?

Vimala: [No], this is not suitable for the heart. This is for cold and for heavy breathing due to congestion. It won’t be effective for the heart. Did you all get a handle on this?

For swelling in the legs due to water retention in the knee and ankle, uumathai (dhatura metel/ dhatura stramonium /thorn apple) is good…Some people make cigarettes with the powdered leaf and flowers and inhale it and they get relief in their breathing. Some people take the juice out of the leaf and apply over the swelling. This is also good medicine. But we can take the leave and make an ointment by mixing with honey wax and other herbal medicines from the store. It will be like Vicks [Vapor Rub]. This ointment, if we apply over the swelling two or three times, we can get relief. It is a little difficult to prepare. It must be made with the juice of the leaves. Take the juice and add honey wax and other herbal medicines from the shop. Mix well and boil till [the consistency] becomes like an ointment. Some people get swelling in the joints in the hand and leg. If you apply this over the swelling it will be as effective as an injection. This [medicine] is available in big herbal pharmacies…For cancer they say that the root of nithya kalyaNi (lochnora rosea) is good. We have to grind it and mix with water and drink that. But we don’t know how far it will be effective.
One woman: Some say if you take it in the initial stage you get relief.

This is an interesting movement, in which Vimala expresses her skepticism about a cure and acknowledges the nuance provided by another member of the group. The last two recipes prior to this one have been more complicated but Vimala shows great deal of confidence explaining them. She acknowledges the ointment she describes is indeed complicated but the recipe is provided anyway in great detail so it cannot be assumes no one will try it. She goes on to explain her own understanding about cancer.

Vimala: It [nithiya kalyaNi] does not allow the cancer cells to grow. When we get cancer the cells grow unnaturally and enormously. This is when the cells become cancerous. The after effects are very serious. Initially there won’t be any pain. So sometimes you cannot diagnose initially. This herb prevents the cells from growing. We don’t know exactly how.

She remains tentative about this one cure. It reflects a general pattern I noticed with Vimala: she keenly grasps many issues so can teach anything effectively but also does rely on her own experiences of various cures as well, and promotes in groups herbal medicines she has already worked with herself at home or in workshops. Though MALAR’s primary coordinators and some advisors check the recipes in the newsletter to see if they seem viable since each block takes turns preparing them, ambiguous information does make its way into the newsletter. In this dialogue, one cure is acknowledged as ambiguous by the coordinator and not promoted emphatically.

Vimala [speaking more about cancer]: However if we use garlic in our food in large quantity it is good [as a preventive for cancer]. It will reduce the fat in our body. It will
prevent diseases and also the cancer cells [from growing]. Do you understand? All these medicines are written in the form of a song [which I sang for you]. Will you be able to sing this now? We can get lots of ideas from it. Do you understand [all this information]? Is this enough [for this week]? Next week, I will read the story from the newsletter. It this enough for today?

**Individual Interpretations**

When speaking to individuals and asking people in groups about their health practices, the responses and degrees of use of herbal medicine was wide-ranging. In this section, I will present some of village coordinators’ responses.

In the case of Uma, participating in MALAR programs had energized her interest in her own family recipes. She herself is a member within one group that assists Vimala but takes a leadership role. Each group, while it is coordinated by a village level coordinator, also has its own designated leaders to conduct meetings when the village coordinator cannot be present, though these leaders tend to be low key. Uma is an exception and would have been a village coordinator but her work at the local cashew factory does not permit her to spare the time. I include her response here as she is considered a teacher in her group. In this excerpt, drawn from several long formal interviews with her, her knowledge of recipes constantly comes through. The conversation moves back and forth from recipe to details about her own family traditions. Early in our first interview, she recognizes I am interested in a detailed account of her knowledge and goes into her house and returns with a notebook.
Shobana: What have you written down in the book?

Uma: It is about home remedies.

Shobana: Where did you learn this from?

Uma: My grandfather taught me all this.

Shobana: Is there any difference between [what you have learnt in the MALAR groups and here]?

Uma: No, not much difference. A little difference [in how herbs are used] but not much.

Uma continues, directly getting to specific remedies. The point of bringing the notebook was to show me she had written down many remedies though in the interview she tells me every recipe without referring to the book.

Uma: When you get wounded or have itching, use the leaf of uumathai (dhatura metel/dhatura stramonium/thorn apple). Also take the juice from the leaf and add garlic juice and a little kuppaimeni (acalypha indica/Indian acalypha). Mix them together and place it in a mud pot and boil the mix well. When the mix thickens it will be like wax. Then apply this over the wound or itch and it will be cured.

Shobana: Did your grandfather do it this way for you [meaning was this administered on you]?

Uma: Yes, he has administered this recipe [for every one, that is].

Shobana: When did you write this all down?

Uma: Earlier [years ago].

Shobana: Was your grandfather alive at that time?
Uma: No, he passed away suddenly. At that time, I did not see his books and I did not know about them. Then after joining this group, they taught me about medicines then when I went to my [parents’] house I saw his books and wrote down the medicines from his book into my book. When my children get wounds or have itching I apply this medicine [that she just described, recorded above]. So far they have been doing well. There is another medicine for this. Take juice of *arukam pullu* (*cynodon dactylon*/couch grass) by grinding it and mix it well with the other herbs [including] *mayil thuththam* (*cuprum sulphas*/copper sulphate), *karung jiirakam* (*nigella sativa*/black cumin), *vempaLa pattai* (*agrostistachys borneensis*/the bark of the tree) and grind them all nicely together and then apply over the wound.

Shobana: It is like *arukam pullu* oil. I know that is good for the body.

Uma: Yes. Wound and cuts will be cured. But people don’t do this [don’t understand its value, a refrain I heard from her often]….Then for [excessive] white discharge for woman.

Shobana: What have they said about this [in the book]?

Uma: This my grandfather taught me [there are cures in MALAR groups as well, so she is now making the distinction between which recipes she has learnt from which source] Take *veLLai erukku* (*calotropis gigantea*/swallow wart)...The leaf are like petals, like a sun flower, umbrella shaped. It is not available here [in the village]. They bring it from Marthandam [neighboring town]. It is very bitter so only if I want it I will touch it. [If somebody else wants it], I will ask them to grind it and mix it with cold porridge water [or water of soaked rice] or milk and take it for seven days [She is revealing that she
often teaches her neighbors, one of whom, in fact, was present through many of our interviews]. This is too bitter. This my grandfather taught for white discharge and this is [also] good for skin diseases and curing poisons in the body. Then *chiru thumpai* (*leucas aspera*/thumbe) is good for migraines. My grandfather taught me this [too]. Take the *thumpai* leaf and grind it with a little mustard. Just two will do. Apply it on the forehead and the headache will be cured.

Shobana: So, he [the grandfather] was a Siddha practitioner?

Uma: No, he was a folk healer [that is, not linked to Siddha particularly, but a practitioner of herbal/indigenous medicine in more generic terms]…When I was young he passed away [though she clarified later she also worked with him on some cures, which is why she says often “my grandfather taught me this.”] He had a book from which I have information about these medicines. The book he had written in was eaten away by ants and it was in a bad condition. After my marriage when I came here [to this village], I met the Sisters [nuns from the local Roman Catholic Church, so Uma like Vimala also learnt from their programs prior to joining MALAR]. They taught us about the medicines so when I went to my [parents’] house again, I searched his cupboard . [The book] was torn…It was in a bad shape so I have written what ever I could write in my own book. From my book, I prepare all the medicines and give it to my children. [She essentially repeated how she retrieved her grandfather’s knowledge suggesting how valuable it is for her].

I would argue that MALAR’s and other prior health programs in the village validate family knowledge. In Uma’s case, it led to the retrieval of old material in her
family and also led to reinvigorating her childhood interest in herbal medicine. Like Uma, each coordinator highlights what is important about the recipes and what aspect of herbal medicine is particularly relevant to them.

Sindhu says: The key to health is healthy living through cleanliness. That [cleanliness] is very important.

Sindhu, a village coordinator, knows some basic herbal medicines but has learnt many of them through MALAR. While cleanliness is a mantra she returned to many times in our interview, her sense is that people need to have belief in herbal medicine (in the sense of faith in or conviction about the value of the medicine) and only then they tend to try the recipes suggested in MALAR in their homes. She agrees that making medicines in groups has been very useful in encouraging people to use herbal oils etc.

Speaking with Sindhu alerted me to a fact about herbal medicines taught in MALAR: many coordinators would talk about proportions of each ingredient in very specific ways. I often elicited this from people while talking about personal/family recipes. The coordinators, in speaking about MALAR’s remedies, no doubt because of their experience in teaching, elucidated certain details very well such as proportions without my asking. Below is an example from my interview with Sindhu.

Sindhu: There is a tonic made from *vallarai* (*centella Asiatica*/ Indian panny wort)...Do you know *vallarai*? [I nod.] We have to grind that and take the juice and filter it so the dust is removed. Then take ginger juice in equal amount-- for one kg [kilogram] of juice of *vallarai* you need equal amounts of ginger juice.

Shobana: Does this involve oil?
Sindhu: No, we have to add karuppatti (borassus flabellifer/palmyra sugar). For one kg of karupatti, use one kg juice of vallarai. To the vallarai juice, add the ground ginger juice. Then make the syrup of karupatti. Filter it well. And then add to the juice of the herbs vallarai and ginger. And then mix well. And when this mixture is boiled well it will become like syrup or acquires the consistency of syrup.

Shobana: How do you know it has the correct consistency?

Sindhu: When we boil the juice the vallarai will change color. The correct consistency is reached when it become like a thick thread, like in a syrup. At that time remove from the fire and cool it. And store in a bottle. And give it to children.

Shobana: They say it is good for the brain.

Sindhu: It is good for the brain and in general you will be healthy. It is good for everything.

Shobana: Has your mother given this to you? [Her mother is also a MALAR member so I wondered if this was also a family practice but it turns out Sindhu learnt the recipe much more recently through MALAR]

Sindhu: No, but I have given it to my children.

Shobana: You have given them. Did you learn this in the workshops?

Sindhu: Yes, in the workshops.

Interestingly, not all the coordinators necessarily incorporate the practices of herbal medicine learnt through MALAR at home. Everyone I spoke to had their own family recipes that they all continued to use but did not always incorporate new information from MALAR at home. Kavita, another village coordinator in
Mangaalimoodu, says she is aware of the value of herbal medicines and I observed that she talks to her groups with great sincerity about it. In an interview in her home, she told me she does practice first aid using herbal medicines, but that her case reflects an even more foundational problem, which is malnutrition, which she thought first needs to be addressed. I had asked her what she thought were the important health problems for women in the village. Below is her response.

Kavita: Food scarcity

Shobana: Food

Kavita: Food scarcity is very prevalent. But they don't speak about it outside [the house]. In the house, people suffer due to food scarcity.

Shobana: They don't tell anyone outside.

Kavita: They don't tell anyone outside. There are many poor people here. They suffer a lot in their homes. The drunkards [the men] don't take care of the family well. All these issues are prevalent. They discuss all this in the group, though.

Shobana: About that? All these problems come up in the groups?

Kavita: All these problems, yes, they talk about it. But not much. They feel shy to talk about this. They cannot say that there is no food, and there is difficulty in the house. But there are many difficulties. Particularly, there is a food problem.

Shobana: Herbal medicines are taught now, using the newsletter. Does anybody in your group use them?

Kavita: [In earlier times] people did not go the [biomedical] doctor. The old people, in their leisure hours, taught small children and they prepared herbal medicine.
Shobana: They did that.

Kavita: Yes.

Shobana: They had faith in that.

Kavita: They had faith. Ginger is good for stomach. Ginger is a good medicine [she is, in other words, providing an example of why herbal medicine is good]. They [women in the older days] knew lots of medicine.

Shobana: What do you do at home?

Kavita: If the children get stomach ache or if they catch a cold, heat some [coconut] oil with chukku (zingiber officinalis/dried ginger) in it.

Shobana: To be applied over the head.

Kavita: To be applied over the head

Kavita’s perception is that herbal medicine is associated with another generation. More importantly, she highlights the challenges to health that goes beyond preventive care or first aid—there must be some food to eat, in the first place. In my observation, the information in newsletters generates conversations about health issues and a host of social issues in the groups. However, as Kavita notes, women are sometimes embarrassed to admit the extent of their poverty. One could say the MALAR programs have many indirect effects, that is, they become catalysts to address perhaps more pressing health problems, such as food, rather than the ones mentioned in the newsletters themselves.

What is also important here is Kavita’s framing. Many newsletters do address the use of herbs in simple rice porridge recipes to compensate for lack of other foods, but it is significant that to some members of MALAR thinking about home remedies is a luxury
when they compare that to having nothing to eat. In these diverse responses from the coordinators, it is clear that localization also involves “differential access to texts, differential legitimacy in claims to and use of texts, differential competence in the use of texts, and differential values attached to various types of texts” (Bauman and Briggs 76). What emerges as “larger-than-local” knowledge about herbal knowledge in coordinators’ responses is diverse, ranging from “invented” traditions, which involves integrations of resources drawn from the past, given contemporary relevance, which are combined with new practices (that is, new for the individual) as in the case of Uma, to assigning a place for herbal medicine in a list of priorities or “order of resort” (O’ Connor 27), as in the case of Kavita. The methods of description are varied in the community—such as descriptions in exact proportions, as in the case of Sindhu, which MALAR’s initiatives influence. Further, MALAR’s own initiatives are influenced by individual members’ prior experiences and other local programs. In all cases, in group dialogues as well as in individual responses, experimentation (or experience) and the ongoing nature of dialogues are key features in the contextualization of health, in which particular aspects of health and healing practices come to be seen as valuable locally.
EMBEDDED EMPOWERMENT: ONE WOMAN HEALER'S NEGOTIATIONS OF MULTIPLE HEALTH SYSTEMS

Institutional power relations shape healing in local contexts but never totally define it... Indigenous healing is both sustained by and sustains forms of social relationship that bring into question the primacy of people's identity as citizens.


This chapter looks at the theme of social relationships and identity linked to health in the context of one healer’s practices. The focus is on the practices of Bai, a village level MALAR coordinator in the village of Mangaalimoodu. Her practices include a wide array of healing modalities, from child care, midwife practices, presentations on tuberculosis and AIDS to MALAR groups, to facilitating polio drops in a government health program, practices that include both indigenous medicine and biomedicine. This chapter will focus on an individual’s embodied experiences of negotiating multiple health systems. This chapter explores at greater length the notion of localization of health systems, in exploring how Bai engages with the resources of various health systems to address local needs (needs, which rely on what counts as health) as well as elucidating
and evaluating what is available at the local level. I will explore what kinds of social relationships are central to these negotiations.

I am also interested in this chapter on social relationships in terms of issues of gender, especially with relation to the discourses of state policy. The focus is on Bai’s own articulation of her role within different systems, what aspects of each system she highlighted for me and how she frames the values and value of her different practices.

**On Interviewing Bai**

The clusters of houses in the village of Mangaalimoodu are divided in several places by large tracts of rubber plantations, making some groups of houses fairly isolated. Bai lives in one such “outpost.” She is one of the coordinators of MALAR in the village. I had heard about her skills as a midwife and about her knowledge of herbal medicine from other MALAR village coordinators. A bus in the early morning took me to her house and the only bus back was in the early evening, so my meetings with her lasted nearly the whole day. All my information from her was based on interviews, conducted through the course of three visits. This chapter looks at the longest of the interviews. Her responsibilities as a MALAR coordinator include coordinating five groups in her neighborhood in the village. Her work involved conducting the business of savings and loans and holding discussions on social and health literacy based on the MALAR newsletter.

Bai also helps her husband, a local pastor with the Baptist Church, in his educational work in the community. Furthermore, she assists the government health
system’s Village Health Nurse (VHN) in maintaining records of births, and monitoring the participation of mothers and children’s in government vaccination, nutritional and other related programs. She is also a folk healer and midwife. The recipient community of her services is the village community in the vicinity but Bai’s focus is always on expanding her connections within the community in this immediate neighborhood but also within and outside MALAR, especially with government health officials in the district.

Bai’s expertise comes from experience and knowledge from her family as well as through training programs. Bai inherits her knowledge from within her family from various uncles and a grandfather, who have passed the tradition in both oral instruction and written texts. The written texts are in Malayalam which she speaks and writes fluently. Her knowledge of spoken Tamil is comparable though she uses written Tamil only in official documents. She spoke to me in Tamil, which like many people in the area is laced with a Malayalam accent. Sitting in the front room of her house (an equivalent of a closed porch), in her interview with me, she explained her practices from memory and also by consulting her notes from several of her books, which she had brought out because I was visiting. While many folk indigenous healing practices are transmitted predominantly in the oral form, it is clear from Bai’s case that there are also written records in local languages, written down by practitioners themselves.

Bai spoke in a moderate pace. Many times she would lean forward slightly and lower her voice, and speak in a tone of utter assurance, and also pause at the end of the description of many cures, with a “did you understand that?” or “was that clear?” I found
the variations in tone and pauses very engaging - she was giving me the specifics of cures but sharing her experience with evident pleasure. As she described the cures, often her hand gestures would also provide additional cues. When the cures required that herbal mixes be shaped into a ball, her hand would indicate that shape, or the hand would count out the number of days a dosage would need to be given, or point out to which parts of the body was getting treated. For many cures, the fingers of her hand would open up and pause, like a stop sign to accentuate the correct method, indicating an “it’s done like this.” The healer’s hand revealed its experience and expertise in this manner, and made for a good accompaniment to the lessons!

As Charles Briggs has articulated, the meaning of an interview is “an interpretation which is jointly produced by interviewer and respondent” (Learning How 3). I would say our interview was part pedagogy, with Bai as teacher, and part sharing of information within participants of a broad activist network. There was an assumption of some basic knowledge on my part of indigenous medicine, based on my cultural background as a Tamil.

In my fieldwork with relation to individual healers, my questions were directed towards what each healer knew within the larger tradition. It was understood that while I was familiar with many practices I was an outsider to these parts of the state and I was here to learn about this particular community. There was a shared assumption about the diversity of practices among people in the same state. For example: On one occasion, in an interview with another MALAR healer, the regional differences in food preferences based on taste, that is, between the people in the area and my family’s, came to the fore
and I was also asked several times on other occasions about what herbal medicines my family uses and how they cook. I was directed by MALAR members of the self-help groups to particular women who were perceived to be more knowledgeable, such as Bai, so there was also recognition of the range of experience among healers as well. I presented myself and was understood to be familiar with herbal practices (especially in the context of food) though was not an expert, that is, one whose practices might be extended to taking care of community members. From Bai, I would get lengthy descriptions of the cures with fairly basic questions like “tell me some of the folk medicines you know” suggesting her prior experience in such exchanges, that is, through her teaching.

It became evident to me through the course of the interview, for Bai the interview was also an occasion to share concerns about lack of resources in her work, specifically a medical kit. Most MALAR meetings and events are open to the public, but my role was perceived in more specific ways than a lay observer. I was a volunteer/activist for the Association for India’s Development (AID) (in its Columbus, Ohio chapter) an organization linked to MALAR through the TamilNadu Science Forum. In this interview, this detail did not come up, but it was almost always raised by coordinators in their introductions of me to their groups. So in general I was perceived in most interactions to be part of a network of volunteer “resource persons”\textsuperscript{16} who act in advisory capacity to MALAR, but also help to direct logistical and infrastructural resources for MALAR (for e.g., one of MALAR’s office computer was donated by another chapter of AID) as well as, such as in the People Health Assembly movement, organize informational workshops

\textsuperscript{16}This system borrow from those used in the Literacy campaigns. See Chapter Two for detailed discussion.
and educational material. I was also here as a researcher, a category of people that the MALAR network is also familiar with, and this too was part of my own and the coordinators’ introductions of me. I found that it was expected that I would offer critiques if I had any and in fact, explicitly was asked more than once; critique was perceived to be part of my role. To provide one example: After the Block level annual commemorative event, one of the Block coordinators Vimala (also MALAR’s Health Coordinator) asked me what I thought of the event. I congratulated her on putting up a very organized event and said I saw how important it was for the members of self-help groups to be able to see the scope and growth of their organization every year and celebrate their efforts. I noted many speakers, both from within and outside the community, spoke about the problems facing women, especially violence against women in passionate language. I wondered if it might have been good to also hear about positive events and models. Vimala nodded and agreed, knowing what I meant for it had been an intense experience to hear the speakers.

I also found myself in the middle of fights or meetings conducted in a hurry, usually because of low spirits and fatigue. It was my impression that while there were the rare cases of incompetence and malpractice with accounting in the network which were dealt with very swiftly and stringently, the occasional inability to keep up with the required work often was the result of people feeling discouraged in the face of poverty. I do not remember any occasion where coordinators shut down groups because of lack of enthusiasm that could not be revived. Some days, there was simply too much to do or people were too shy to talk to me so I would postpone posing my own questions to the
group and merely observe—that is, clearly my presence would sometimes tire people and I would change my plans on those occasions. As a general rule I found MALAR extraordinarily open to my participation. My respect of the work that MALAR did was a known fact and I felt that also made people open to speaking to me. Bai was also keen to highlight the gaps in her work and the kind of support that would help her work. Bai directly engaging me with the question of resources that she would like to acquire came from this sense of mutual comfort and sense of my roles.

The nuances involving my roles emerged in interaction. In one particular confrontation within a group, the women members of a group were upset with their village coordinator who had not watched out for them during a trip to the city of Nagercoil, the capital of the district, to participate in a rally for International Women’s Day. They had luckily met with other coordinators, whose help had brought them back home safely. The discussion centered on their own personal reputations in the village: The men think we are going off to have fun as it is, and the last thing we needed was being abandoned (though only temporarily) without money in our pockets. Luckily, the women had made it home safely and without worrying their families. For me, this conversation was an important learning moment in understanding the link between women empowerment and morality or “reputation” of women as faithful, dignified, and able to represent the family well in public. As tempers cooled in the discussion, and some members acted as mediators and apologies were rendered, my own questions about what health resources the group’s members used to tackle various illnesses at home which shifted the focus away from the controversial incident and started a brief discussion, was

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clearly a welcome break. In fact, the most visibly upset of the members from earlier in the meeting were among the most involved in the discussion. One woman who had acted as a mediator moved closer to me at one point and said: Sorry you had to come in the middle of a fight, because we usually are a tight-knit and happy group. I said: Well, you had a problem you had to deal with, and this was educational to me, to which the woman responded: You know, mental tension and headaches caused by men’s attitudes is a biggest problem we have around here. Many women around her agreed. I had heard about alcoholism and domestic abuse as causes for ill health, but the idea of mental stress as one of the explicit manifestations of “social problems as ill health” (a connection made by MALAR women) was a new kind of articulation for me. She was also implicitly commenting on how the women’s group was perceived: It was useful in the community but also it could be a threat so while the sense of solidarity that the group afforded was important to the women they also had to constantly juggle with not being seen as disruptive; that juggle involved “mental tension.”

Incidentally, my own participation in the MALAR dialogues was not seen as a threat in the community, though I would argue this was not necessarily because I was a young woman. Since I faced no explicit claims against my participation, I did not ever find out what could have been a trigger. I could expound at some length on these incidents but the main point of raising some of these issues here is this: the context of the fight allowed particular questions about health to come to the forefront. I bring this incident up also to say, in addition to how open the MALAR network was to me and how they understood me through particular category of outsider who was a “resource person”
and a “researcher” it was also the case there was no script as to how the interactions would take place and what issues could get raised in my interactions with MALAR members. With Bai too, the specific nuances that emerged in the context of our interaction are significant. As Richard Bauman has noted while there may be many similar and conventionalized performances that may be noted in a community, “all performances are not the same” and therefore “one wants to be able to appreciate the individuality of each, as well as the community-wide patterning of the overall domain” (23).

Integrating Health Systems

This chapter builds on ideas in the scholarship on folk medicine that relates to the experience of patients and folk healing practitioners in integrating multiple health systems. I will focus on the primacy of “family and community relations and the requirements of reciprocal responsibility” which Bonnie O’ Connor has articulated to be a recurring feature of vernacular17 health systems or indigenous medicine/health systems (O’ Connor 22). Focusing on the practitioner’s point of view, though also alluding to patients’ point of view, I will demonstrate particular notions and expectations of relationships that emerge in all of Bai’s work, through her engagement with both biomedicine and folk healing, though in different ways.

17 As outlined in Chapter One, I use the term indigenous medicine to speak about therapeutic practices in India that exist outside biomedicine. As I have noted, there are recognized ‘folk’ and ‘codified’ streams of indigenous medicine. My own observation was that there were overlaps in ‘folk’ and ‘codified’ traditions. While I use ‘folk’ to highlight the strength of the oral tradition and the informal, non-commercial or low key commercial nature of the practices I documented, there are overlaps with the ‘codified’ traditions and the diversity within the folk traditions itself.
In the literature on folk medicine and medical anthropology, patients and folk healing practitioner’s use of multiple health systems are often used to highlight the popularity and resilience of vernacular health systems (see O’Connor especially). An important nuance to this debate involves the fact that the practices of all the health systems are themselves constantly changing, and furthermore influence each other. Underlying these analyses is the important idea that health systems are “intrinsically dynamic” (Leslie, Paths 6). Charles Leslie notes that there has been a tendency to see “permeability” between systems as part of “an irresistible encroachment of Western Medicine” or, from the point of view that romanticizes indigenous traditions, as a kind of contamination, whereas in fact all systems are constantly changing and can borrow from each other (Paths 5).

In this chapter, I will highlight the flexibility Bai exhibits as a healer in dealing with a variety of illnesses, and her uses and understanding of both biomedicine and folk healing within a framework of “self-help”- that is, “self-help” is the larger framework under which the resources of all health systems are integrated. Focusing on social relationships, the question I begin with is whether in this process of integration, the differences in the value systems associated with biomedicine and folk healing are indeed irrelevant. I would argue that this is hardly the case- the process of integration involves choices that are not without ambiguities and tensions and are influenced by the underlying power relations in social relationships related to different systems.

Furthermore, at the local/village level, the presence of the various health systems and people’s access to them are highly variable. I will highlight the politics of circulation
of information about health and its connection to local networks that informs choices in integrating resources of multiple health systems and what it says about Bai’s positionality within those networks. Several studies such as Healing Logics and Healing Traditions highlight the politics of circulation in health modalities, such as unequal access to multiple health systems (as with the case of minority gay groups in O’Connor’s study of HIV/AIDS related therapeutics) and conflicts over meaning and economic control of folk health rituals (as in the case of Clements’ study of Lakota sweat lodge ceremonies within the New Age movement), with a focus on the coherence of the evaluation strategies of participants. I am in agreement with this understanding, but would argue the notion of choice (or lack of it) and its basis in “logic” (based on experience-centered approaches to folk medicine) dominates many of these studies, and that they fail to highlight more adequately that these negotiations are sometimes acts of resistance by social groups to prevailing health conditions. In general, notions of resistance and the politics of culture in general are under theorized.

My own interests are also in the embodied presence of the institutions of the health systems, at the local level, which is where negotiations of health are made at the everyday level. This is based on the idea that all health systems are embedded in cultural practices and social networks, and involve high levels of organization. Bonnie Blair O’Connor’s work Healing Traditions, posits the claim that “all [health] systems, to a greater or lesser degree, include acceptance of information on recognized and legitimized authority as a valid means of knowledge” (22). She is especially keen to establish how vernacular health traditions involve “systematic and coherent organization” not just
biomedical systems which have historically claimed exclusivity in this matter. Furthermore, she argues (building on the work of Arthur Kleinman and others) “its protestations to the contrary withstanding, modern biomedicine is, like vernacular health belief systems, profoundly culturally shaped” (O’Connor 22).

So what about the differences between different systems? As O’Connor argues “there are innumerable differences between systems with respect to specific content (23)” so that “what is acceptable as evidence in one systems may be thrown out by another as insufficiently authoritative, not germane to the argument, or even as not granted actually to exist” (12-23). Linda Connor offers nuances that are particularly useful for this chapter that follows from this theme, which is that health systems are based on certain notions of relationships and social identities within the politics of the nation-state. She argues: “Biomedical hierarchies of knowledge sever the biological from the social, and biomedical institutions construct the social relations of healing through bureaucratic practices” (Connor 11). More specifically, “in post-colonial states, citizen’s affiliation to the state is cultivated through new forms of social association—in formal institutions such as schools and clinics, as well as in the public culture of the nation (anniversaries, commentaries, orations, and celebrations)”(Connor 11). More specifically, biomedicine “has been placed there by national governments intent on their own modernist projects of ‘development’ implying notion of social progress and economic development for the nation’s citizens” (Connor 7). This is to say that biomedicine’s underlying cultural and ideological principles have to do with notions of “development.” Connor notes that, on the other hand, “indigenous healing is both sustained by and sustains forms of social
relationship that bring into question the primacy of people’s identity as citizens” (11).
The argument is that social relationships are conceived differently in each system, and that they are linked to social categories about the recipient communities, such as that of “citizen.” For me, as mentioned earlier, this establishes the reliance of biomedicine on particular social and culturally framed categories with relation to the Indian nation state (though by no means is this the only argument that can be made about biomedicine), a theme I will examine. But it also makes the provocative observation that folk healing and patients’ perspectives occupy an alternative space not just a complementary space vis-à-vis biomedicine. In integrating both systems, practitioners and patients are able to access alternative social relationships even while they engage with biomedicine, in its form as government health care in this case, and the relationships associated with it. Do the practices of Bai suggest this, I ask. In terms of her use of the local embodied presence of these health systems, and framed by notions of self-help, what notions of social relationships do emerge? I argue that notions of gender that emerge in these negotiations are particularly important and also that Bai’s commentary reveals that the asymmetrical relationship of power within health networks and with the recipient communities their serve influences the nature of her work, but also all relationships are forged on an ongoing basis and are open to renegotiation at any given moment. The process of integration is embedded in the everyday, ongoing, highly nuanced politics of local culture, in other words.

Another underlying debate here pertains to arguments about the “medicalization” of society which highlights biomedicine use in social control, as discussed in Chapter
One. I want to make note of two themes here. Linda Connor notes, speaking of a Tibetan practitioner’s use of multiple resources, that a patient using the healer’s services “does not necessarily experience herself as medicalized, even when biomedical equipment is used” because a Tibetan healing epistemological framework is operational here and so “appropriations of modernity should not be taken as a capitulation to its terms” (Connor 17). This remark highlights, at one level, the anxiety of “capitulation” that follows from a critical view of biomedicine as a dominating force though it also alerts us to the underlying logic or epistemological framework that patients use which may indeed be different from the actual procedures in use. While this is useful, I want to interrogate in this chapter the presumed all-pervasiveness of biomedicine at the village level but also how medicine registers, following Mark Nichter, at “the site of the body.” He takes a more critical view of the notion of “medicalization,” highlighting the heterogeneous nature of health systems and also the spaces for resistance. Commenting on the idea that “biomedicine is out there serving the interest of ‘capitalism’ through processes such as commodification and medicalization,” he argues in *Anthropological Approaches to Ethnobotany*:

Underappreciated are coexisting ideologies embedded in medical practices and discourse, the role of medico-religious institutions in the mediation of conflicts between competing ideologies, and the heterodox and dynamic nature of medical traditions...[so the] researcher must take stock of the ‘discipline’ of medicine as well as the means by which medical systems provide space for emergent, negotiated forms of resistance at the site of the body (xiii).

Nichter also highlights, reiterating Charles Leslie comment earlier in this chapter, that these viewpoints about “medicalization” are often based on nostalgia. Because sometimes
such nostalgia is “engaged in by those who have a need to create a non-Western, traditional medicine as a means of calling attention to the alienating, dehumanizing practices of biomedicine” the result is “attention has been drawn away from power relations underscoring [all] health practices” (Anthropological Approaches to Ethnobotany xiv).

I would argue the communities/individuals are part of multiple networks of these systems at various local levels and their experience captures the fissure and the overlaps between the systems and thereby reveals how the multiple health systems influence one another. As articulated in Chapter Two on the People Health Assembly movement, the inadequacies of the governmental structure and methods are core to MALAR’s impetus towards self-help, while at the same time building better links (or mobilizing for better links) with the government are part of the vision for change. Bai’s practices too reflect negotiations with a wide rage of networks involved in health and call for a nuanced understanding of all social relations involved.

As I have noted in Chapter One, indigenous practices, both codified and folk, are varied, differing in form and content regionally and locally, and within local communities, where each practitioner and patient offers different interpretations, based on a larger body of knowledge. All the practitioners I worked with used herbs and dairy products, such as yogurt and milk in their practices. Bai’s practices involved other kinds of animal products as well and were one of a kind in that. Familiar in her practices from my work with other healers were the organization of medicines according to the “genres,” including the decoctions or kashaayams for internal use, hair and body oils for external
use, as were the similarities in techniques in making oils and kashaayams. The excerpts from the interview I use here focus on particular sets of practices: cures for children’s illnesses, dealing with social problems, and women’s health issues, including child birth and post natal care.

**Of Pathiyam and Pakuvam: Reciprocal responsibility in Folk Healing in Child Care.**

Notions of social relationships operate within folk healing traditions at various levels. Of them the relation to concepts of pakuvam and pathiyam are particularly interesting. Bai’s rendition of cures for various children’s illnesses stressed the importance of accurate knowledge—knowledge of herbs, method of preparation and dosage, on the part of the practitioner and proper usage by the patient, who must follow the exact procedures of the cure, which sometimes involved special diets. This is based on a common theme in indigenous healing which every healer I worked with highlighted—making medicine with pakuvam or accuracy and particular kinds of diets and regimens required of patients, that is, the need to follow pathiyam. I highlight here the rendering of this theme by Bai in the context of explaining cures for children’s illnesses to illustrate an important nuance within folk healing about the responsibilities assumed by the healer and those of the patient, that is “reciprocal responsibility,” which is tied to the making and use of medicine (O Connor 22). While pathiyam is not used for every cure, underlining the concept is a holistic healing model that treats the whole body particularly through diet in which the patient is expected to take an active role.
From a conversation about where Bai learnt folk healing, we moved to the specificities of the medicines involved, and she begins by talking about children’s illnesses.

Bai: We have given medicines to lots of patients and many have been cured.

I notice the use of the word “we” highlighting folk healing as a family practice, though she could be called the primary bearer in her generation.

Shobana: Ok, for what diseases and what types of medicine have you administered?

Bai: [We have medicines for rashes caused by worms] when it comes for small children after birth on the hands, legs and sometimes the whole body…we use herbal medicines.

Shobana: What kind of herbal medicine?

Bai explains in detail, in the following chronology. One cure is a kashaayam or decoction which uses a number of fresh herbs, including krishNa thuLasi (cimum sanctum/ holy basil ), aadathodai (adhatoda vasica/vasak), ciRuciNdai (solanum indicum/ indian night shade), pida viLa (feronia elephantum), nettu (sesbania bispinosa),vetRillai (piper betle /betel leaf), kuRu miLaku thandu (piper nigrum /black pepper-stem) and naRunaNdi kizhangku (hemidesmus indicus/ indian sara saperilla). The herbs are pounded together to extract their juices and mixed together, which is the basic kashaayam. It is then mixed with koracanam (purified ox gall/ ox bile) a product derived from the cow’s stomach, in powdered form, usually available at herb shops. The resulting mix is applied externally on the child. As for the dosage, it is given for six, nine or twelve days, based on the practitioner’s assessment, then stopped for one or two days and then the baby is given a bath, after which the procedure is repeated.
The mother must follow *pathiyam*, Bai notes. This is important and she repeats this several ways. For this cure, this means: “Mothers should not take fish with lot of fat on them, *kanthari miLaku* (*capsicum* /guinea pepper), *karuppatti* (*borassus flabellifer*/ palmyra sugar), and *akkaNi* (*terminalia chebula*). This is because the mother is feeding the child so the mother should be careful about *pathiyam*. When you have to give the medicine to children…[the mother has] to follow the prescribed diet...Then after some time you have to give [the medicine] again.”

Another remedy involves: Two measures each of *munthrika pazham* (*Vitis vinifera*/ grapes), *elam* (*elettaria cardamomum*/cardamom), *nal jiirakam* (*cuminum cyminum*/ cumin seed) and *ayamothakam* (*ajowan*/ bishops weed) in powdered form from the herb shop. The process: Take five measures of *padathaLi kizhangku* (*cissampelos pareira*/ false parcira brava), *catavlLi kizhangku* (*asparagus race morsus*/asparagus) which is often found in people’s gardens and make a *kashaayam*, along with a ripe coconut’s water. Mix the powders from the shop, and place the mix on slow heat with two to three liters of water. Heat well till it reduces in quality and the powdered medicine thickens. When that is done filter and squeeze out the residue completely. Then add [about 1 kg] of ghee\(^{18}\) from cow’s milk and coconut milk and boil again. It will become thick and when [the residue or scum] reaches sand like consistency remove from the fire. After filtering, the medicine is ready to be given to children.

We conclude our discussion about cures for worms:

Shobana: You have done this many times…this is a common illness?

Bai: Yes, this is a common illness…we have made this medicine for many people.

\(^{18}\) Clarified butter.
Shobana: People come to your house and you give them the medicines?

Bai: Yes.

As we move on to other cures, she emphasizes how she carefully sorts out and processes herbs and how many of her cures involve pathiyam and pakkuvam so I ask her for greater elaboration.

Bai: Pakkuvam is about the method of preparation. [In the case of oil] when we boil it first [the mix of ingredients] will turn into a mucus form. We should make the oil on low fire only. Then [the residue or scum] will change to a coal form, that is, broken coal. If you keep on boiling, [the residue or scum] will become like sand in the end. That is the time to remove the oil from the fire. It should not be overdone. At the correct consistency, we should [said with stress] remove from the fire. When the oil becomes clear [that is, the residue settles at the bottom], filter it and preserve carefully in bottles or jars.

Pathiyam is a dietary regimen that has to be followed while the herbal cures are being taken, as per the specifications of the healer. Bai recalls an incident where she failed to follow the practice.

Bai: At the Edaikodu hospital, I was given herbal medicine once. They asked me to observe pathiyam and take only raw rice porridge. But I ate fish. I made kari\(^1\) and kootu\(^2\) and ate it with rice... and I collapsed. My husband had to run to the doctor to get another medicine for my recovery. I had a severe headache too. So we have to observe pathiyam very carefully.

\(^1\) Sautéed, semi-dry side dish  
\(^2\) Gravy side dish
Through personal experience, she discovered that the cures would misfire without her following through on the diet regimen required. Clearly, there were medicines that rebalance the effects she had to encounter, but essentially the cure is now more complicated. Furthermore, when used improperly or inaccurately, folk medicines can cause harm. Therefore the patient’s cooperation is very important.

Bai explains *pathiyam* applies only to some cures and is always very specific: “If you are not supposed to drink water, you should not drink it and if fish should not be eaten, you should not eat it.”

In her more general comments about herbal medicines, the idea of frugality is also linked to that of accuracy: We buy medicines depending on the number of children or people who come here to be treated, she says. You need money if you want to make oils for long-term use and so things were always made on an as needs basis, she adds. She explains the storage process: “If it [the oil] is in good condition we can keep it for one, two or five years. Nothing will happen to it. But the jars and bottles should be dry and kept clean. Then [the medicines] won’t get spoilt. In the big *vaidya salai* \(^{21}\), they keep it for years. A *kashaayam* will not last because we prepare them with water. That has to be made fresh. But the oil will stay for many years.” She did not have many oils on hand. In fact, since her involvement with MALAR, she had less time to prepare oils, though she continued to treat people and make medicines as required. But the use and making of medicines within the context of poverty is a key factor in her as-needs-basis system of cure.

\(^{21}\) Big pharmacies/hospitals selling indigenous medicine.
Bai clearly has had a great deal of success with her work, pointing to the value her community sees in her work. It is also the case community members must first opt to come to the folk healer. In my conversations with community members, mostly MALAR participants, in different parts of the village, the need to follow pathiyam was cited as an inconvenience as it was more time consuming and people sometimes chose biomedicine because of this. Patients, in other words, may resist the terms of reciprocal responsibility and prefer the treatment that in their perception required less effort at their end, at least in the short run. Conversely, biomedicine is also acknowledged as more expensive, especially since many of them started to go to private clinics, which posed more responsibilities that were financial. Women often cited how they would go to any lengths for their children’s health, so irrespective of choice of treatment, they sense of responsibility was higher with children than it was for treating adults. Bai is very successful with children’s medicine. The sense of responsibility that children’s illnesses draw is certainly also connected to her success.

Curing wounds and community: Dealing with alcoholism and medical negligence.

MALAR’s members often spoke to me about one theme when I visited their groups and asked them questions about health issues and resources in their community which was also highlighted in their newsletters and the literature of the People Health Assembly: Health did not just involve different kinds of diseases but included social and economic issues as well, that is the idea of health as wellness, or health as connected to social and economic empowerment in general. The ills that were recurring within a
community or those that infected neighbors, not just those that effected individual families was important, especially given the importance perceived in the efforts of the group in the microcredit and other activities of MALAR. In Bai’s account, what was striking to me was the kinds of “social health” issues that came up but also the kinds of cures involved. In her cures for alcoholics who were in trouble with the law, the cure was entirely physiological. A cure for a child maimed by medical negligence was, on the other hand, “social” (including “bureaucratic” interventions).

As we finish the lists of cures for children’s diseases, she continued to review her notes and moved to the next set of cures, the first of which were for wounds caused by police beatings. This was the first time I had heard of cures for wounds which were specific to an incident.

Bai begins: Take *aadathoda* (*adhatoda vasica* /vasak) leaves, clean them well and take the juice out of them. After filtering the juice, add *carayam* (alcohol) every one hour. Then take a small domestic chicken and cut its head and take the blood and add that and mix well…

The question of alcohol was an important issue so I interrupted Bai to ask for clarifications.

Shobana: What type of *carayam*? Brandy?

Bai: No, this is different. It is specially prepared. It is country arrack. It is prepared by local healers, by adding *karuppatti* (borassus flabellifer/ palmyra sugar) and other ingredients.

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22 This is not the only report I heard about medical negligence based on interviews- the PHA surveys also detailed several.
Many herbal brews, due to the degrees of concentration and specific property of herbs, especially *aristham* which is a syrup, could have the same effect on the body as alcohol and therefore is in demand as a substitute for commercial liquor, which was also more expensive than *arishtam*. A local Siddha healer in the village was in fact selling *arishtam* in small sealed plastic packets at reasonable prices that was much in demand among the men, which angered many of the women. The women were unable to shut his business down as they had local liquor shops in the past because he was a licensed practitioner of Siddha medicine and could sell medicines, even though the *arishtam* might be not used as medicine. Indeed, the contention of the women in the village was that he was only making *arishtam* and not practicing any other kind of healing. I paid a visit to this healer as I was surveying the village healers and caught him in a defensive mood. He explained the range of medicines he made very reluctantly and then asked me outright whether the local people had been talking to me about his *arishtam*. I said I had heard that *arishtam* was sold as liquor. Sometimes men are consuming this as alcohol but I am running a legitimate business, he averred. He had his son fetch a little bit of an *arishtam* for me and had me taste it. It tasted like a cough syrup though, essentially, I could not evaluate its value as medicine and thought the whole episode only served to highlight he had something to hide.

From another folk healer, in an informal conversation, I was informed about the nexus between the police and some folk healers, which involves sharing the profits of the sale of *arishtam*—in fact, this healer claimed that he himself has been approached by the police but he has turned down the offer. So there was no doubt about the prevalence of
these businesses. Bai alerted me to another form of alcohol though, made by folk healers and was sold as alcohol, and her interest in alcohol was precisely in its properties as a stimulant.

Bai [returning to details of the cure]: You should take either half or one ounce, depending on the age of the person. The pain and heaviness will vanish, but the patient has to run after drinking this.

Shobana: After drinking this you have to run?

She explained later that this was for the purposes of blood circulation which is important for the cure.

Bai: Yes. This is good medicine.

Shobana: Have you given this to many people?

Bai: I have given to many people with my own hands, preparing this for those who have been hit by the police.

She proceeds to give me one another cure for similar wounds, after which I was able to ask her more questions about police beatings.

Shobana: Are police beating very prevalent here?

Bai: Yes, police beat those who steal [generally commit crimes] and drink illicitly sold liquor.

The connection of the police to various alcohol uses was double-edged, clearly. My sense of Bai’s own attitude was that it was non-judgmental with regard to patients’ drunkenness. This was interestingly to me given that alcoholism was such a point of
contention in households. I do not mean to say she condones the practice but rather it points to her capacity to engage with various groups in her community with ease.

Another episode she narrated involved a disabled young man, whose condition was beyond medical cure in the community that highlights again her multi-faceted role as a community healer. This is the story of a young boy who became lame after polio shots were administered wrongly and whose family was not able to help him cope very effectively. The context of talking about the incident was initiated by my questions about why people don’t bring their children to get vaccination and polio shots and other services the government offers, which she had noted was a problem in the community. She enlists the lack of knowledge about how to treat the fever children get after taking injections as one important reason but also that the wariness was based on experiences of medical malpractice. She recounts: “This happened to a boy near by. When he was given the injection, both his legs became weak and he became lame. Now he is around 24 or 25 [years old]. His health is not good and he does not have parents. They bring him here in a cart.”

Shobana: How did this happen?

Bai: The injection was given in the nerves. Suddenly the legs weakened. When he reached the walking age, his mother died…The grand mother was looking after the child, but when she went to work, like basket weaving…no one took care of the child. If they had taken care of him well at that time he would have become strong again in his legs…Because of lack of attention and exercise, he became permanently disabled.
Bai and other community members wrote many letters to various officials. The boy gets Rs.100-150 from the government monthly now, she informed me. Commenting on the boy’s current situation and that of his family’s, she notes: “The boy does not have any life skills. There is one unmarried aunt in the house. Another married someone and ran away. The father left the boy when the mother died. But in spite of these circumstances, the grand mother has taken care of the child, but they are very poor. This incident and similar cases in other places has made people in the community scared [of biomedicine and of participating in the government health system].”

The breakdown of the family support system signals the need and the value for it, but Bai also highlights the fragility of the family and the community in general whose poverty exacerbates injury and illness. The reaction in the community is enormous, moving to “inaction” one might say, because people have begun to doubt the efficacies of participating in the government health system, which can obviously disable not strengthen. The cure, though only partially resolving the issues, is social and involves engaging with bureaucratic procedures. Bai’s resourcefulness in engaging with the government bureaucratic process reveals the primacy of particular social relationships in the community in dealing with health and her sense of responsibility as a community leader who sees the individual family’s well being as being connected to the well being of the whole community. Both episodes also highlight how the range of interventions of the government in the life of the community, in direct or indirect ways, in “health” issues, is also unpredictable.
In both the child care practices and the ones outlined in this section, the underlying theme is also that of self-help, which I would argue emerges in this context as a community-oriented health care network (in that, it is not about individual self-care alone), involving community healers like Bai, who have particular areas of expertise in healing but are also engaged in addressing health issues that otherwise might not be addressed at all. Just at the most practical level, these community health care social networks play a vital role. Bai’s services are essentially a form of community service. It is common practice with many healers that community members would pay for the cost of herbs by their own accord but in the case of her midwife practices alone did Bai mention any money being offered to her, though it is possible that her patients did reimburse the costs of ingredients for other cures. Her work also relies upon the larger folk healing network of pharmacies, herbs shops and other folk healers. That is another level in which reciprocal relationships work.

Bai’s personal practices of health and for her own family include preventive care that involves the use the medicines of other folk healers. One included different kinds of fish oils that her family has used for generations, which she notes has been especially good for clearing and preventing white discharge in women, which she notes is often associated with low immunity [meaning, the fish oils that she and her family consumed helped to build long term immunity]. She ended that anecdote by noting: “The old man who used to make those oils is now dead, so we can’t use that anymore.” This highlights the sometimes exclusive role these specialists in the folk healing systems play.
In the light of that, Bai’s practices indeed occupy an important niche in the overall health care scenario.

**Body Registers: Facilitating Women’s Health Programs**

As our conversation began to move away from folk healing and social problems, two community members who had business to conduct with Bai’s husband who was away, dropped in. They decided to wait for him and joined our conversation. Bai had just begun to say she worked with the local Village Health Nurse (VHN) also. The men then began to discuss the role of the nurse. Her job has been limited to administering polio drops, one said. That may be the case, the other argued, but she is also expected to document child and mother health in general also. He continued: “Why, we organized that event here in Bai’s house, making announcements to everyone that the documentation of births and mothers’ and children’ health condition, in addition to giving drops and vaccines, was taking place.” The two men appeared at first to be arguing, but it was clear in the end that they agreed that the VHN did a better job in some areas than in others and that she could complete all her tasks better, and also that she could not complete those tasks without the community’s involvement. What was interesting to me was their strong sense of involvement in her work and their role in organizing the community around her visit.

Bai, interestingly, just waited till they had completed their conversation. I began to wonder for a moment if their presence would cut our conversation short, but she continued on with the same enthusiasm as I proceeded to ask more questions afterwards.
and the two men listened. I became clear through the course of my three visits Bai’s
house was regarded as a community center. Within about half an hour, more specifically,
a government health worker associated with a program to provide mid-day meals to local
children and special whole grain nutritional balls to pregnant women, stopped by, asked
for a drink of water, spoke to us for a few minutes (mostly articulating for me what her
work involved) and then left. Clearly, there was an informal element in the relationship
between governmental officials and local community members. These levels of
hospitality are not unusual even with strangers, but what was noteworthy for me was the
fact that every detail of the work of the government workers was community knowledge.

As this worker left, the two men were still around and made their own evaluations
about her work, though this time to inform me about her work. “She too had become
healthier doing this work,” one noted. It was a personal remark, and implied that she
might be taking some of the nutritional balls to her home, and though that did not seem
verifiable to me since she was not from this village, it was acknowledged by the others as
a fact. The evaluation was not presented as a complaint, and in fact rather as a joke about
“business as usual” in government work that was not to be taken seriously. I laughed
spontaneously with them, though also felt bad for the woman, walking for miles in the
sun. She looked pretty thin to me, and was likely from a poor family herself and I noted
this. Oh yes, Bai said sympathetically, “but you know she was even thinner before.” I
laughed again along with every one else—clearly, this was about seeing humor in upward
mobility associated with government jobs, which are often long term and secure
positions, and in fact are coveted jobs. In other words, government officials are not just
part of the bureaucracy but also community members, and their social status is defined by
their work among other things; government work is much sought after and associated
with security and upward mobility. I would argue this was another reason why the work
of officials was closely observed.

In her work with MALAR, Bai has held discussions in the self-help groups (she
co-ordinates five, where each group comprises of approximately 20 women) on herbal
medicines but also AIDS and TB. She has taught women how “AIDS, T.B and other
diseases spread…through blood, the husband wife relationship…through needles.” She
stresses prevention with AIDS: “ If you live as a monogamous couple it will not
spread...If you want to save a person from death, you have to give blood, which we get
from blood bank or from other people…When the blood is contaminated [she seems to
suggest it often is], it takes six months to find out, and nothing can be done about it…So
we tell people that if this disease comes, there is no cure so it is a killer disease.” She says
about TB: “If there is T.B in the house, I tell them that they [family members] should not
sleep together. They should be separated. The patient should be clean and the water and
the food used by them should not be taken by other person.” Bai had not dealt directly
with TB or AIDS patients and the nature of her work was chiefly informational.

Bai also aids the Village Health Nurse (VHN), another village-level
government employee, in her duties. Her work with the VHN has enabled her to acquire
more training as a nurse, including in emergency medicine. Further, when women
complete three months of pregnancy, she takes them to the hospital for registering their
names and for checkup. After four to five years, she helps them get them vitamins. She
notes: “We also apply on behalf of women who are eligible for money, for Rs. 500, after
the birth of two girls, if they go in for family planning,” referring to a government
incentive for people adopting permanent pregnancy prevention measures\textsuperscript{23}, a little known
scheme, which Bai found out about during a workshop held by MALAR.

Bai sees her work explicitly in terms of filling gaps in addressing health issues
that the Village Health Nurse deals with. She continues about her work: “I prepare a file
about the number of pregnant women, and how many have given birth. This is the job of
the nurse, but they don’t come to every house…and after I have taken on the job, they
just come [to my house]” and collect the information. She told me a VHN had told her
she might receive compensation but she has not received anything so far and it bothered
her that she gets no recognition. To me, her faith in the act of documentation of health
was important—it clearly gives her access to information about what people need to know
and have in terms of resources. She continues her work because “people in the
community did not know any thing about all this” while she herself “came to know about
these things only after attending [MALAR] workshops.” The stress is on information and
access to it; the self-help involved in acting on the information is not in doubt. But she is
frustrated that her ability to use resources is not that good because getting information
about government schemes is a hurdle. It is also significant that Bai extends the
government health system where it would otherwise struggle to go, through extending the
services of the Village Health Nurse. These sections of the interview are rife with images
of containment and control: images of the cause, effect and modes of prevention of
infectious diseases like AIDS and TB, control of population and the detailed

\textsuperscript{23} Such measures address the practice of having many children till a boy is born, among other things.
documentation of the women and their children’s bodies, as part of creating indices of health for the government health care system. Bai sees her work in participating in this health education process as part of gaining rights for community women-by accessing the benefits of governmental schemes and any information that could contribute to their well being. The question of personal recognition, not from within the community itself but from within the government health system, is also very important to her; there is a desire for compensation and reciprocity that has to do with her services. It is my sense that within the folk healing network, her place as an expert is clear whereas within the hierarchical system of the government health system her role is nebulous. There are also indications of promises made to her about compensation that were not kept. I will return to these issues and their connection to issues of social identity, but will first examine the nuances that her work as a midwife adds to these issues.

**Internal and External Intersections: Midwife practice.**

In Bai’s work as midwife, the reliance on the intricate social networks and how they informed her work is particularly important. The people she treats are all known to her and in delivering babies her knowledge of the terrain of women’s bodies extends to their insides, therefore connecting her to the women in the community at one more level.

Describing her entry into the field, she says: “One day a mother had labor pains… she wanted me to come. Till then, I had not gone anywhere. Initially I was shy. Then I prayed to God and saw her through the delivery…She got the labor pains before going to her mother's place…[before the] date of delivery. I did not have any one to help
me. I removed the child, cut the umbilical cord and bound it, and then bathed the baby. I did this with what I knew and it was a success. Then after that I have seen many deliveries.”

Bai remains in touch with this family as with the many others in the community whose childbirths she has overseen. The woman (from the episode I just recounted) has another child also, for whose delivery the family asked Bai to conduct but she could not go: “I told them that it is not possible for me to stay on with her, so I advised them to take her to the hospital. The delivery was normal and I went and saw her in the hospital.”

Bai uses both herbal medicines and biomedicine as a midwife, the former in the form of internal medicine and dietary practices, some of which she makes and some other she acquires from other healers, but she also aids the patient’s family in more personal ways, acting like a member of the family. Not all her deliveries were successful. She recalls: “One day I had to take care of a woman whose child died in the womb. She had gone to the hospital to see the doctors but since they were not available she came back and she had bleeding…Since I had treated her sister-in-law, they called me immediately. After washing my hands I went there with my gloves… she had heavy bleeding. I asked her whether there was movement to which she said yes, but I knew there was not. Then I prayed to God and removed the child. It was dead…The child was 7 months old. The body was spread out like pancake and the head was coming loose. The cord had shrunk and also the child's skin… She [the mother] had told her mother that there was no movement for five days. Anyhow, by God's grace [the mother Bai had helped survived]. Her mother's place is Kollangodu. And we had to inform her about the death…I washed
the cord with the hot water. This they have taught us in the training [with the VHN] because otherwise the stomach will bloat. I checked up every thing in her...Her husband asked me whether we needed to take her to hospital...I told him that I could guarantee that there is no problem, but for more medicines you can take her to the hospital. Otherwise you can do one thing. Make a kashaayam of karuppatti (borassus flabellifer/palmyra sugar), chukku (zingibar officinalis/dried ginger) and miLaku (piper nigrum/black pepper) and give her. I stayed there and gave her a bath and buried the child and cleaned the house and then only they took her to her mother’s place...they gave me Rs.150 but since the child died, I did not accept it.”

Bai has been asking for the government’s midwife kit from both the VHN and MALAR’s Executive Committee and has heard many promises, but has not received anything. She spent a long time talking to me about this: explaining the details of the kit, including the gloves (which she bought herself) and the stethoscope (which she really wants), “props” this healer thinks she will benefit from, stressing as she has elsewhere, that the more tools you have to know your body, in this case, biomedical equipment, the more you can prevent health problems and empower a local resource such as herself and therefore the community. Bai was hoping I might be able to help.

Bai’s frustrations further highlight her ambiguous status within the government health care system. As Kalpana Ram, in her study of the role of midwives in India (her fieldwork area included the district of Kanyakumari) notes that: “They come to their vocation in response to the needs of women in their communities, and learn through ‘immersion’ in the birth milieu by watching, talking, doing. Their practicing may include
negotiating relationships with biomedical authorities on behalf of their patients, despite their frequent rejection by staff in hospitals and clinics” (“Modernity” 14). Ram concludes that the midwife is “located at the intersection of diverse relations of power” including “the relations of the home where most rural births still take space, as well as the clinic” (“Modernity” 14).

Bai’s appeal to me as a potential resource comes out of our roles within a non-governmental activist network, but it was my impression of Bai and many other MALAR healers that the possibility of networking with government officials and being able to be active participants in the government health care system remained a priority. Their sense is this is part of their “rights” as citizens. As I have noted earlier, the government health care system would have less reach if it were not for the active participation of women like Bai. Bai’s underlying logic in this work is that of providing information to her community and where possible accessing governmental schemes for the poor. However, Bai’s argument relates not just to the right to information but also to the right to participation that values her expertise and community service. Her resilience suggests that indeed “institutional power relations shape healing in local contexts but never totally define it” but also her work does raise questions about the boundaries of “people’s identity as citizens,” especially in terms of notions of reciprocity (or the lack of it) (Connor 7).
**Gendered and Embedded**

I want to return to the theme of the “medicalization” of society with relation to the government health schemes Bai helps to promote, that is, predominantly in family planning. The primary focus of the Village Health Nurse in terms of family planning was an issue that the MALAR health coordinator and coordinators of other local non-governmental groups I met through the People Health Assembly movement raised with me, noting their frustrations in not having other aspects of women’s health be addressed. This is wider than a local issue, however. The history of development in India in *gendered* terms has been noted in the scholarship on Women in Development. I will highlight some key points made by Rachel Kumar based on her recent study of current Reproductive and Child Health Policy (RCH) in India, policies that were developed in the wake of the 1994 international conference for Population and Development, which was significant in the recent trends of the “engendering” of development (that is, gender-sensitive development) (75).

In her overview, Kumar notes that while there are varying viewpoints about the patriarchal nature of the Indian state, it is well recognized that women’s inclusion into “the development process is a precursory step to emancipation and recognition with society and polity” so that their “development identities” (or the identities that development initiatives construct) are important to study as those identities “both facilitate and forestall political status,” that is, influences women’s capacities to be empowered (74). She elaborates: “The official channels of the state promote the image of a woman of a self-sacrificing wife and mother assuming her ‘natural’ place in the home
for the upbringing of India’s greatest asset—her children.” Within the national agenda of economic development, on the other hand “citizenship [of women] is affirmed in their capacity as producers and laborers” (Kumar 77-78).

With the adoption of the New Economic Policies (NEP) in the early 1990s, women being “seen as efficient producers and managers of the household and community…has greatly enhanced interest in them as a target group through which to foster development initiatives locally and internationally” (Kumar 84). The earlier “mother-worker binary to women as economic actors” are all constructions that are however “mutually reinforcing” (Kumar 84). There have also been shifts in policy which are the results of the efforts of women’s organizations. Unlike older models of family planning, the current RCP programs are more “gender sensitive” and non-coercive. However, what stays the same is that it is “women who are targeted for contraceptives and beneficiaries of the state’s pre-natal programmes.” These programs “especially centers around the notion of ‘a healthy mother’” which has bearing on the “national system” in which the “state defines its obligations to women’s health…[in its efforts to] reduce infant and maternal mortality…[while] women’s responsibility to the state…[is] to contribute to the stabilization of the population” (Kumar 84). Kumar argues the underlying assumption is “that women have a ‘natural’ willingness to undertake health responsibilities and work in the interests of family and community” (84).

In Kumar’s reading, these norms “used to construct women’s identities within the development state influence the kind of emancipatory processes open to them” and that a “mere positioning [of women] as productive agents within development…cannot really

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Based on neo-liberal policies of the Structural Development Programs of the World Bank, IMF et al.
challenge power relations.” Kumar argues, in conclusion, that “women have to also
deliberately stake political claims independent of the development process” (85).

In an overall sense, Bai’s own work does signify a “willingness to undertake
health responsibilities in the interests of family and community” both in her own work as
well in her work educating women in her community, and in that she helps to promote
the notion of “healthy mother” that might indeed have a bearing on the “national system”
of obligations and responsibilities outlined by Kumar. None of her practices involve any
form of coercion; indeed her work relies on persuasion that will influence her community
positively not alienate them. Further, she is also placed in the position to speak on behalf
on biomedicine, in the light of distrust in the community due to medical negligence. The
framework of self-help, I would argue informs her work, and complicates notions of
reciprocity, obligations, and “participation” in the government’s development process.

While Kumar’s analysis does very usefully articulate how notions of “mother” or
“worker” are not “natural” categories but ideological positions, it is not clear what the
alternative categories and positions outside of the development process might look like,
for implicit in her argument is that only outside of the development structures might
women gain more power. In the case of Bai, her networks of folk healing are independent
of her role within the government health care system and to some degree she has access to
resources through non-governmental networks. But her work within each network is not
exclusive to that network but rather all flow into one and another, under a broad
understanding of self-help. Furthermore, she herself is invested in the process of gaining
more rights as a citizen and seeks a better position within the governmental system not
just the folk medical system. I would argue that Bai is both complicit with the process of
development while she is also trying to resist and redefine its terms, both from within and
outside governmental and civil society networks. What is interesting to note is that the
self-help groups that make up MALAR are very much part of the national agenda of
development. As I have noted in Chapter Two, the concept of micro-credit through self-
help groups is widely accepted across the political spectrum. My own sense is those
public policies do define women’s roles in ways that suggest the women as seen to be
more manageable. The promotion of self-help group among women is based on the
perception that women are more responsible and cooperative. Other the other hand, as
activists like K.Kalpana have also noted [see Chapter Three for detailed discussion], the
self-help groups does offer the opportunity to mobilize women to seek greater systemic
change and in those contexts define their own identities. My conclusion is that there is
unevenness in the levels of participation by rural women in government supported
community interventions, but I would not suggest that participation in those networks is
necessarily detrimental. On one hand, Bai’s reach of work is extended through the
microcredit schemes, but on the other, her work’s potential in terms of social
mobilization and greater participation in the government in the context of health care
meets its limits faster.

I find also more useful Sangeeta Kamat’s critique of the development process, in
highlighting the singular focus in development discourse on individual recipients
(including who they are and how they are to be characterized) rather than also the social
relationships that underlie their lives. Following Foucault, she is interested in the
complex nature of individuals’ negotiations in relation to “power as practices that constitute subjectivities, rather than simply as practices of denial and suppression; as practices that cultivate desire and motivations that both empower as well as regulate and discipline individuals” (Kamat 36). This reiterates my point that Bai is both complicit in extending what could be seen as modes of surveillance though her registers of community women and children but she also seeks to transform levels of participation that moves away from viewing poor rural community members as being passive recipients of health services.

Kamat notes, speaking of risk-based categories as the basis for community intervention, that development discourse operates through “diving and labeling individuals and groups on the basis on certain definitive characteristics” (that is, “the poor”) so that one is “compelled to speak mainly in terms of ‘needs’ and ‘absences’ in individuals, with no reference to the social relations that give rise to them” (65) (my emphasis). She argues this lack of systemic approach to development leads to inconsistencies within different sectors—the legal, the economic, the political etc. In fact, the divisions of sectors itself is problematic to her. As an illustration, she observes: In the political sphere, marginalized groups may make some gains, but their limited access in the economic sphere counterbalances those gains. Taking the case of the relationships between tribal communities and landlords in the state of Maharashtra, she notes that “within a discourse of equal rights and equal protection under the law” the tribal communities initially “gain ‘freedom’ from debt bondage but simultaneously it also binds them to the ‘unfreedom’ of wage labor” as they enter the marketplace that is not set up to
address social inequalities (67). These sector-level differences are applicable in the case of Bai’s community. There are clearly contradictions within the varying wings of the government development network—though health and other forms of community development might be seen to be interrelated for “citizens” like Bai, there are varying agendas in play within those sectors (or as Nichter has noted there are several “co-existing ideologies” even within each health system), so that in dealing with multiple and mutli-layered health systems, Bai and her community will necessarily engage with varying degrees of “freedom” and “unfreedom” (Kamat 67).

Where the resolutions or processes for social change will come from, through individual negotiations (that have the potential to become larger community wide movements) and/or systemic changes such as at the national governmental level remains an open question, though it is clear the dynamic between them is constantly shifting.
CHAPTER 5

ON BEING AT HOME: DIETETICS AND HEALTH

Food is Brahman; for from food, verily, are these being born; by food, when born, do they live; into food [at the time of dissolution] do they enter, do they emerge.


This chapter looks at the “home” or the “household” as core components of the circulation of knowledge about health and its relationship to gender. This involves some paradoxes. The MALAR village level meetings are held in people’s homes. This usually means the front room of the house or in the courtyard in front or the back of the house. In the Literacy programs, women participated in large numbers. The use of homes to conduct these programs are cited as a key reason for their success. This has to do with the “home” and the “domestic” as being associated with women’s place in society and so their participation from home is not seen as disruptive to patriarchal norms. Furthermore, the home as a site for the programs aids the process of peer encouragement and accountability (as this is something one can expect from a “neighbor”) in the micro-credit schemes. The third reason has to do with practicality- being at home reduces the need for travel as planning can take place in a more impromptu fashion as neighbors have a good sense of each other’s routines.
This scenario seems ironic on the face of it. MALAR envisions for their communities not the maintenance of status quo where women remain in their assigned place, but to transform their roles to support women’s entry into new economic sectors, create awareness through informal education about a wide range of local and international issues, promote leadership roles outside the home, explicitly take up and tackle as a group instances of violence against women and restrictive social customs etc. But curiously, as I have noted, the movement does so by building on the sphere where women do not have to explain their presence—the home. Now it is the case that while women find it difficult to work outside of the home and enter spheres that are customarily men’s domains, they do so. Thus, women have been forging new directions outside the domestic sphere. The MALAR movement itself is an example. But something larger is being indicated here, which is that the domestic sphere is being envisioned differently. Women are not being taught to be good wives, mothers and daughters of the kind that will accept social norms at face value but rather the aim is to view that position critically and also see the home and the responsibilities associated with the domestic as assets. I begin with this question: What does happen at home, given such a centrality assigned to it?

One place where the centrality of the home and its relationship to gender is especially significant is in MALAR’s health initiatives which stress home-made medicines and dietetics. I will look at the interconnections between dietetics and medicine in family or household practices. I will argue that it is important to note these negotiations engage with what R.S. Khare had called “multiplex classificatory schemes” (“The Indian Meal” 177).
Multiplex classificatory scheme

The Indian meal engages with “moral, humoral, physiological, and symbolic criteria together,” R.S. Khare notes (“The Indian Meal” 177). He stresses the centrality of the household in food practices in the Indian context: “Indian feeding most often goes on around the household, a chief locus of safety, subsistence, prudence and social responsibility;...all major issues of feeding and eating normatively involve the householder” (“The Indian Meal” 177). Therefore “the household...mirrors the moral and material of the larger society” especially the Indic (Hindu, Buddhist and Jain) systems of a moral economy (“The Indian Meal” 160). In more recent history, a host of secular and practical considerations also play a part, as do criteria for sufficiency and distribution that mirrors that of state policies. He observes:

The domestic food economy is itself now as concerned with issues of food ethics as question of estimation, calculation, and the management of food availability. Domestic decision making has also begun to reflect the impact of the Indian economic development. The same economy guides initiatives to manage conditions of food scarcity (of sufficiency) in the household. A household does not only follow: it also discovers better choices and decides on them for daily survival (“The Indian Meal” 173).

R.S Khare elaborates that all of these forces constitute “multiplex classificatory schemes” (“The Indian Meal” 177) that a householder has to negotiate. He comments on the challenging nature of the domestic food economy:

Though much is changing socially and economically at the domestic hearth, most of the daily meal distribution and use occurs at this locus. A domestic hearth usually has to face a whole range of strains that fluctuations in income, family size, interpersonal relationships, personal health, and moral choices produce, and has to find it way through them to provide feasible and acceptable meals to the household everyday. It is at the domestic hearth, for example, that a factor like scarcity of cooking fuel has to
be handled alongside the feeding of the sick and the feasting of those assembled for a ceremony— all on the same day (“The Indian Meal” 171).

The key issue here, I will note, is that the householder is responsible for making meals that are “feasible and acceptable” so a high degree of adaptability and evaluation capacities are required. In the case of the householders presented in this chapter, this involves developing meals made up of “healthy” foods which fits in with practitioners perceptions of balanced eating within constraining budgets among other things.

Furthermore, the practitioners have to negotiate various “classificatory schemes” which are co-present, and which therefore may be brought to bear by the householder in their everyday choices simultaneously. A key issue here is the underlying values on which choices are based, whether it is the “moral economy” of Indic systems, other forms of belief or pragmatic, secular considerations.

In the Indic moral economy, “both medicine and food are considered together and in the larger context of the ecological, climactic, physiological, moral and cosmological criteria indigenously differentiated and ordered…[so that] one diet is considered to be part of one’s medicine” (Khare, “The Indian Meal” 162), a pattern observable in Indian food practices across regions. A.K. Ramanujan elaborates traditions like Ayurveda and folk practices are based on “a medical view of food” where “food is often described as the elixir, herb of herbs.” He notes: “The medical texts (as well as mothers and hypochondriacs) take characterization of food seriously and literally [and that]…all foods have medical properties and [are] part of the Ayurvedic regimen …and its pharmacopia” (“Food for Thought” 229). Food and medicine are classified together in four ways: as “three gunas, or strands or constituents, of all things” of sattva, rajas and tamas, in
heating or cooling properties, the three *doshas* or humors of bile, wind and phlegm (*vata, pitta and kapha*), and finally the six *rasas* or tastes of “sweet, sour, pungent (or savory), astringent, bitter, and salty” (Ramanujan, “Food for Thought” 228).  

B.K.S. Iyengar, renowed yoga teacher, interprets the *gunas* as “consciousness [which] manifests itself in three different qualities” (Iyengar 46). There is “*sattva* (the illuminating, pure or good quality), which leads to clarity and mental serenity,…*rajas* (the quality of mobility or activity), which makes a person active and energetic, tense and willful,…and *tamas* (the dark and restraining quality), which obstructs and counteracts the tendency of *rajas* to work and of *sattva* to reveal.” He notes: “the quality of *sattva* leads towards the divine and *tamas* towards the demonic, while in between these two stands *rajas.*” Food contain these qualities as do people themselves: “The faith held, the food consumed, the austerities undergone and the gifts given by each individual vary in accordance with his predominating *guna*” (Iyengar 46-47). Further, popular food practices involve other finer differentiations which also relate to temperament and social status:

In popular perception, there is a general correspondence maintained between rich meals and rich people. Diary products and meat are associated with ‘rich’ foods …An indigenous dietary formulation is that ‘light’…easily digestible foods are eaten daily…while the ‘heavy’…ones only occasionally. This notion of ‘weight’ rests on the digestibility of foods- an Ayurvedic notion…[but] also the after meal feeling of ‘heaviness’…Though the categories of ‘good’, ‘rich’, and ‘healthy’ goods may overlap, they are not coterminous. ‘Good foods’ are those eaten daily for maintaining one’s health, efficiency, and happiness. Under this definition, ‘good foods’ are also by inference nutritious foods…Each regional cuisine in India

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25 I have used the Sanskrit words based on Ayurveda and various Vedic texts here, as I am speaking of the Indic system in general terms here. I note the variations in descriptions in Tamil and in Siddha traditions later in the chapter. A.K Ramanujan’s essay, I should note, uses Sanskrit and also Kannada where the material comes from ethnographic fieldwork.
identifies such a meal and expands on its merits by age, personal health, and season (Khare, “The Indian Meal” 175).

My grandmother conflated “light” foods with the qualities of sattva (sathveekam in Tamil) specifically, while “heavy” foods leaned towards rajas (and in some cases tamas) though not in those exact words or equivalents, but these are differentiations also seen in many other accounts. The notion of heavy and light foods occurs in my fieldwork and I have seen them as related to the gunas, which themselves not explicitly mentioned. These distinctions operate at different levels, at any rate. A.K Ramanujan notes: The rasas are “sensory,” the hot and cold qualities and doshas are “physiological (and causes of certain effects)” and the gunas are “characterological” where food relates to temperament, that is “you are what you eat, and your taste expresses your character” (“Food for Thought” 228). So “heavy” and “light” foods are identified in physiological terms, though also based on sensory perception, but may also be seen an indicative of temperament of the person making those choices.

I will not explore the foundations of Indic philosophies. Instead I will demonstrate how those philosophies play out in everyday practice of food and its relationship to medicine. Essentially, these notions of food are based on a dualistic (and non-dualistic) view of the world (Khare, “The Indian Meal” 162), in which the four ways that A.K. Ramanujan has outlined about the relationship between food and medicine, define the interconnections between the individual and the cosmos (in ideas of “Food is Brahman,” where Brahman is consciousness). Khare notes: “Such a comprehensive classification of meals is inevitable since the same ‘five subtle elements’ (ether, air, fire, water and earth)
that compose food and body also constitute the cosmology...[and] similarly, at the personal level, the same foods which the Ayurvedic system classifies for the primary humours also get classified by the three-fold guna (sattva, rajasa, and tamasa) scheme to yield overlapping messages about the eater’s innate dispositions” (“The Indian Meal” 176). The Indian meal involves harmony at the individual and cosmic level simultaneously. Khare concludes: “Such multiple classifications make the Indian meal a finely-tuned ‘total’ communicator; the meal begins to reflect faithfully the larger social issues of coherence and conflict [and]...meals also show how they are ‘totalized’ by the Indian, beginning with self and ending with cosmology” (“The Indian Meal” 176-178).

Given this, the meals involve care in cooking methods. In earlier chapters, I have referred to the notion of pakkuvam which involves preparation methods, but I will emphasize in this chapter that care also involves selections and evaluations based on the qualities of food/medicine outlined earlier in this chapter which are expressed in complex and varied ways. Khare notes because “a delicate configuration of the three body humors determines one’s health...[and] since this configuration is always regulated as complex and fragile, there is a great concern in Indian dietetics for proper cooking, eating and digestion of food” (“The Indian Meal” 176).

Further, these classifications pertain to different aspects of food: “The daily meals are orchestrated around the rasa: textures, temperatures, smells etc” while “heating and cooling components do not usually [get] reflected in the daily meal but they are a big part of the regimens of the sick” (Ramanujan, “Food for Thought” 229). It is important to note the regional variations in making these distinctions: “These four characteristics do not
seem to be related to each other in any precise fashion, through correlations are clearly made…there is much disagreement from community to community regarding what might account as hot or cold foods” (Ramanujan, “Food for Thought” 229).

Another underlying principle, according to R.S. Khare, involves moderation. He notes:

The Indian meal draws on the indigenous criteria of good and sufficient eating. But eating must proceed under self-control. Hunger as a state of helpless deprivation does not receive support in any Indian norm, though purposeful fasting certainly does…A status-related notion of sufficient and satisfying meal existed in India from early times [such as what is appropriate to a monk versus what is appropriate to a householder]…In the popular Indian culture, two notions of moderation work side by side, one pursued under the established notions of austerity, renunciation and self-control, one pursued to control physical ailments. The first situation demands voluntary control under normal health and the second enforces regimen to regain health; the first assumes normal diet and food availability while the second calls for diet selection and simplification (“The Indian Meal” 168-169).

As I will demonstrate, notions of a balanced meal or what appears to be appropriate to “healthy” living reflect ideas of moderation as self-control, while regimens for the sick (pathiyam) are an intrinsic part of healing based on herbal medicines. I will argue the idea of moderation also involves filtering out, in the case of the practitioners discussed in this chapter, “instant cure” medicine (that is biomedicine) and readymade nutritional foods so that the stress is on the “home-made” and the “home-grown.” In other words, traditional practices that speak to the question of moderation outlined by Khare above are interconnected to more recently available choices. A significant detail here is that the householder is working with available resources. Khare notes: “moderation is rendered less significant for the poor” (“The Indian Meal” 169). In fact, Khare’s own research among the poor suggests that the “self image of deprivation” often
reflected on the evaluation of food people ate—that even when poor are well fed, “they perceived shadows of insufficiency and dissatisfaction” so that for the poor, “moderation was a value of luxury” (“The Indian Meal” 170). As I have noted in Chapter Three, food scarcity but also the self-perception based on poverty can lead to the view that herbal medicine is a luxury (or more generally self-help which can imply choices between different set of resources that may not exist or appear to exist).

Under these circumstances, it becomes evident that all “classificatory schemes” are fragile in the face of the realities of malnutrition. My own research deals with how these issues are accounted for in varied ways by practitioners. Where I argue in Chapter Six, that belief practices offer both a critique and a “resolution” to the question of starvation (or goes beyond choices available in terms of food itself), I suggest in this chapter the notion of moderation is highly flexible and is adapted to accommodate food scarcity. As Khare notes, accounting for both these positions: “the fragility and insufficiency of the Indian moral economy of food becomes evident, especially as population increases,” and there is increased food scarcity and the “indigenous moral economy of food is now increasingly heterogeneous and insufficient” (“The Indian Meal” 178). Under these circumstances, “people usually have to direct themselves to such an indigenous cultivated value as moderation to contain their dissatisfaction, and to make the best use of what they have” so that “moderation becomes a practical value for survival” (“The Indian Meal” 179). On the other hand:

After a stage, moderation is left behind to let dissatisfaction and helplessness take over to yield resentment. The old as well as new orders of social justice and security get immediately questioned once a household has to skip a daily meal (“The Indian Meal” 179).
Food, the Elixir, Herb of Herbs, on a Budget.

R.S. Khare notes that for an Indian household “the ‘good’ routine meal carries standardized parts” and they “incorporate the critical cultural principle of moderation” as the parts stand for elements of a “balanced” meal. There is “a basic gastronomic grid” which includes “bread and/or rice, lentils, and vegetables (alongside fish or specified meat in appropriate social groups and ecological regions)” (“The Indian Meal” 175). In Kanyakumari, this grid translates into rice, fish, a gravy or semi-solid dish (or kuzhampu) typically with a coconut base (sometime including lentils, like in rasam [or racam] which is one version of a kuzhampu) and when available vegetables (which tends to have a more dry base, sautéed raw in oil). Tapioca either supplements the meal or is consumed in lieu of rice. In many cases, the vegetables and gravies were combined, such as in the popular dish of aviyal, a vegetable dish with a coconut gravy base.

In the case of Uma, householder and MALAR member who also helps to coordinate one group in Mangaalimoodu (as noted in Chapter Three), the notion of a balanced meal or a nutritious meal operates at multiple levels. I present here excerpts from three formal interviews conducted on the porch of her neighbor’s house where she spent a lot of her spare time. Her neighbor’s daughter, Viji, was also part of the conversations while Uma’s children also listened in. The excerpts demonstrate how for Uma food and medicine are intertwined. At one level, many ingredients used in food have medicinal properties (while some don’t—they are foods that add flavor but are not medicinal per se). On the other hand, she adds certain ingredients which her neighbors
rarely do explicitly on the basis of their medicinal properties, seeing their value as preventive medicine through food. She often makes herbal medicine as sweet dishes or integrates them into daily meals, though I discovered the outcomes are not seen as “tasty” to her neighbors. More foundationally, her choices reveal a worldview about the intricate connection of the body and food to larger social issues, and with regard to these choices moderation is an important principle. In other words, for her, rasas, doshas, gunas and the heating and cooling properties of food cannot be separated, and further, these criteria are connected to the family’s budget and the realities of living in a busy world..

She notes that the imbalance of piththam (or pitta in Sanskrit) or bile/phlegm in the body can cause wounds to erupt more easily.

Uma: For wound and itching...
Shobana: For wounds and itching.

Uma: For piththam, musu musukku (mukia scavrilla/morus alba) is good.
Shobana: Right, for piththam [which causes wounds and itching].

She notes that her children don’t get many sores because she has administered herbal medicine for them since they were very young.

Uma: With good herbal medicine...children grow healthy like a rock. Take vallarai (cantella asiatica/indian penny wort), dry it in the shade and give it with milk to children. It is good for the growth of the brain.
Shobana: Have you used vallarai regularly?
Uma: For a while I was giving them [the children]. After joining work at the [cashew] company I have not done that.
Shobana: No time?

Uma nods

Shobana: When you fall ill, you use these herbs.

Uma: Then I always do but people don’t do that around here. They go only to the hospital. You should have faith that you will be cured with these medicines. No one has faith. That is why no one is trying these medicines. But I have given them to my children since they were very young. I have given them the vallarai tonic. [This is] with karuppatti (borassus flabellifer/palmyra sugar) or jaggery (unrefined cane sugar) and is like a tonic. It is very sweet. Then in cooking I use vallarai.

Shobana: You use vallarai in cooking.

Uma: I put vallarai and other medicinal herbs in the cooking. [Also] different spinach [kiirai] varieties, like agathi kiirai (sesbania grandiflora/spinach), aria kiirai (amaranthus indicus/ spinach), ponangkaNNi kiirai (alternanthera indica/ spinach).

Noteworthy is her conviction that “children will grow like a rock” by regularly consuming herbal medicine but also that people don’t not practice what she does, a refrain in her interview. Her practices involves adding items like greens to the basic foods itself but also making tonics that are like sweet foods.

Shobana: Where do you buy the herbs?

Uma: We don’t buy. We collect them from the fields.

Shobana: Even for kaayathirumeni oil?

Uma: Yes, everything is available there.
Uman: The spinach, everything is here, near the road and pond. When there is rain, they will come out.

Since I had become aware in my observations of MALAR initiatives, that with more complicated medicines like *kaayathirumeni* oil which uses many herbs people are less inclined to make them at home in their families, I ask about her use of local resources. It turns out these choices are about economics but involves a high degree of belief and effort, which involves children in the preparation. Further, it is also connected to theories of herbal medicine as harmless and therefore worth the effort.

Uma: I do it for my family without spending much money. The children run around to get the herbs- that is their job. And I, with salt and garlic, just with simple things, I prepare the medicines immediately. I prepare the *kashaayam* [decoction] from the medicines from the [herbal] shop too, for two to three rupees. In the same way we have good medicines for infections. If you have fever and if you take the hospital medicines you will get relief from the fever in one hour. But if you take the *kashaayam* [decoction] the fever will be relieved after three hours. But you must know the after-effects of the hospital medicines and harmless nature of herbal medicine. People don’t believe this and understand that difference. They look for quick relief.

Uma’s neighbor Viji adds her view here, highlighting that these choices are not just about economics but about the nature of the body itself which is transformed by the choices made. Other way to put this would be to say *gunas* and *doshas* can be transformed; they are not innate unchanging capacities but rather ones that can be transformed with practice.
Viji: For some people the medicines won’t be effective; for their body it won’t work.

Shobana: It depends on the body.

Viji: For these young children [pointing to Uma’s children], since they have taken [these medicines] from the young age, the herbal medicines is effective But if I catch a cold, even if my mother gives me kashaayam it won’t be effective. I get relief only with injection and medicine. So the medicines should be suitable to our body [that is, the body operates based on what it has been used to].

Uma: It will be difficult for two or three days. But you will get cured soon. Even if you are not cured with the hospital medicine in two days, definitely you will be cured with the herbal medicine in four days.

As a practitioner of preventive medicine through dietetics myself, with Uma I was especially comfortable sharing my knowledge and eliciting responses by sharing my ideas. I will note some basics about Indian cooking that is part of our shared knowledge that we assumed throughout our conversation, though much of it also emerged in the conversation. There are certain processes that is not particular to Tamil cooking alone, but also found elsewhere in India. There are some important steps involved in Tamil cooking: toasting dry spices in a small amount of oil or ghee\textsuperscript{26}, which either starts the dish or is added to the dish, as the final step; making a semi-solid paste with ground up spices with vegetables, such as with onion and tomatoes or coconut which comes a base for other dishes; specific steps to bring the components of vegetables, lentils/meat and spices together. These were some shared assumptions which means I was paying attention to Uma own methods rather than asking for why these steps were being

\textsuperscript{26} Clarified butter.
followed. It became clear through my conversations with Uma and Viji that the demarcations between food and medicine and preparation differ with individuals not just between regions, and is based on experience and “lay theories” about health that are individualistic as well. Uma’s refrain about her neighbors’ lack of belief and interest pertains to her critical view of a culture of “instant cure” and commercialized health culture, which seems to her, ironically, to involve more expensive options compared to the ones she opts for. She also suggests that biomedicine “heats” up the body- as a medicine, it imbalances the body, in other words. I move the conversation to foods with medicinal properties to get a better sense of these distinctions.

Shobana: Other than these herbs [you have mentioned so far], there is jiirakam (cuminum cyminum/cumin seed), manjal (curcuma longa/turmeric), garlic, miLaku (piper nigrum/black pepper) which are added in the cooking. They are also forms of medicine.

Uma: In cooking, they are used. They do not come under medicines. Jiirakam (cuminum cyminum/cumin seed), manjal (curcuma longa/turmeric), omam (carum kopticum/the bishops weed), uluva\(^{27}\) (menthiyam/triogonella foanum gracum/fenugreek), vaal miLaku (cubeb/tail pepper), chukku (zingiber officinala/dried ginger), malli (coriandrum sativam/coriander seed). These are also like medicine. Vattal (red chili) won’t come under medicinal preparation.

Shobana: What about karukappilai (murraya keonigili/curry leaf).

Uma: You can use it both in medicine and cooking.

Shobana: You can use it both in medicine and cooking

\(^{27}\) Uluva and menthiyam are the same- Uma uses both names at different times.
Uma: Then *narakai elai* (*citrusacida*/acid lime-the leaf), can be used both in cooking and medicines.

[A little later]

Shobana: Other than these, what do you do for general health, for healthy living.

Uma: If you want do live healthily, you should take good nutritious food. Potato is good but full of heat…But meat, milk, and eggs are fatty, heavy.

Uma agrees certain foods have medicinal properties but they are not medicine per se, where medicine usually involves some treatment in mind even if it is preventive medicine. Further, Uma connects the idea of heat (or body heating) to certain foods like potato. Dairy and eggs and are referred to as “heavy” foods. “Heavy” foods are also the more expensive foods consistent with the idea that “heavy” foods are consumed by wealthier people, as R.S. Khare has noted (“The Indian Meal” 175). She goes on to elaborate that her sense of “good, nutritious” foods are plant-based proteins and greens and also eating foods as whole grains, which, incidentally, is accessible to everyone (though as she also keeps highlighting these foods require more time and effort to gather and prepare).

Uma: I practice healthy cooking…like adding *kiirai* (*spinacia oleracea*/ spinach) in a cooking. Egg and milk are heavy foods…Other wise healthy food is only sprouted items. Take *ulundu* (*phaseoksdiatus*/black gram). Also *kodumai* (*triticum vulgare*/wheat)…In the same way, peanuts have more nutrition. And then in *chiRu payaru* (*phaseolus mungo*/green gram), you have lots of nutrition

Shobana: Yes, you have lots in that.
Uma: We plant ulundu (*phaseoksdiatus*/black gram) in the field, as it contains lots of protein. You know which we put for dosai?\(^{28}\) [I nod]. Not in the husked form but as whole grain. Cook the *ulundu* with *menthiyam* [*uluva/triogonella foanum gracum*/fenugreek*] and garlic and keep it covered overnight and give it to children next morning after brushing the teeth. It is good nutritious food.

Shobana: Should we add salt?

Uma: Without salt also it will be tasty. If you buy hundred grams of *ulundu* (*phaseoksdiatus*/black gram), one rupee *menthiyam* [*uluva/triogonella foanum gracum*/fenugreek*] and one rupee garlic that is enough. Cook it in the night and give it in next morning. In the same way, some fresh peanuts is enough. Soak it in water over night and take it raw next morning. It is very good and nutritious. Also *raagi* (*eleusine coracana*) grain is very good. It looks like mustard seeds which is red in color…This is very nutritious food. One kg [kilogram] of *raagi* is equivalent to one bottle of Horlicks or Boost\(^{29}\) [popular powdered energy drinks] which costs a hundred rupees but one kg of *raagi* costs only five rupees. Nowadays, mothers feel lazy and buy Horlicks and Boost [popular powdered energy drinks]. I have three children for whom I never got Horlicks or Boost or Complan. I see them [the advertisements for the energy powders] only on TV or in the cinema. I soak the *raagi* and grind it then filter it, using a clean cloth then I make a syrup of *karupatti* (*borassus flabellifer*/palmyra sugar) and then mix that with the filtered

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\(^{28}\) A crepe made with rice and black gram.

\(^{29}\) They contain, in my view, nutritious ingredients like barley and vitamins but also harmful preservatives. However, at a time before my family’s own awareness of these issues, these drinks were very part of my childhood’s “healthy” regimens.
grain. Heat this well till it becomes like halva. And cut it into pieces. For small children we give raagi in the form of porridge. This is high protein food. Like that, kambam (pennisetum typhoides/pearl millet) is good and it is given to hens also. It will be like a small pearls. Fry them and make into a powder. Then mix with sugar and give it to children. But nowadays people don’t do such difficult work at home…The problem is this injection medicine adds heat to the body and that prevents wounds from healing faster too. It is not good. It adds heat to the body.

She is highlighting the commercial nutrition products which she does not use because of its prize but she is also connecting its use by others as part of a “lazy” temperament or guna. Further, she again connect the notion of heating to biomedicine. She does not suggests cures to “cool” the body after it has been through biomedical care, but rather her practice is to try to avoid it altogether. Interestingly, chicken pox is also seen as excess of heat in the body, one caused by Amman, a goddess, who takes possession of the body. Almost everybody I met saw chicken pox are something that does not need hospital care but something that would disappear on a regimen of cooling foods, like fruits, and would go away in a few weeks on its own. So the question of heating and cooling is not based on modern/western and indigenous dichotomies in healing. Uma also prepares several tonics to treat chicken pox, in addition to offering prayers at temples.

Uma: We have to take more porridge [observe pathiyam]. We should take nongu (borassus flabelliformis/ the fruit of palmyra) and fruits which will reduce the heat. I also make kashaayam [decoction] with the herbs like tuLasi (ocimum tenuiflorum/holy basil), kanam (dolichos biflorus/ horse gram), and jiirakam (cuminum cyminum/cumin seed) and

30 Sweet dish with a semi-solid, viscous quality.
then we have to smear the mix with *kasturi* (*moschus moschiferus/musk*) tablets.

Otherwise, [I use] elephant tooth.

Shobana: You smear with elephant tooth?\(^{31}\)

Uma: I have one half broken tooth. I use that only. Otherwise we make *kashaayam* [decoction] with *veppam elai pattai* (*azadirachta indica/the bark of the neem tree*). Only my daughter got chicken pox.

Shobana: The other children did not get it.

Uma: No, only sometimes if one gets it others will also get it. I gave my money to the temple as *kaanikkai* (offering).

Shobana: You prayed in the temple.

Uma: I give two rupees for firecrackers as *kaanikkai*.

Shobana: On the way, I see a temple from the bus, where they burst crackers all the time.

Uma: Yes, it is an Aiyappan\(^{32}\) temple. They burst crackers. One should have belief. Only then, that will work.

Her concerns about health, it turns out, do not always coincide with some others’ local sense of taste and smell (*rasas*), including the value of bitterness.

Uma: Around here, ninety-nine percent of women don’t prepare *masala* [spice mix] much. Most women don’t even put *malli* (*coriandrum sativam/coriander seed*) and *jiirakam* (*cuminum cyminum/cumin seed*) in the fish preparation. They add only *manjal*  

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\(^{31}\) Bai, the subject of Chapter Four used fresh animal products in a way that was more unique, but small amount of animal parts as dry herbs are clearly used in many medicines and at the same time plant or herb based medicines also are used in veterinary care, so comes to be referred to as “herbal” medicine is not strictly plant-based.

\(^{32}\) Hindu God.
(curcuma longa/turmeric), little coconut and puli (tamarindus indica/tamarind). They don’t add menthiyam (uluva/triogonella foanum gracum/fenugreek) and omam (carum kopticum/the bishops weed).

Viji: It has bad smell, menthiyam and omam.

Shobana: So they don’t use them?

Uma: They [others] don’t put but I add a little.

Viji: Still, it is smells in the fish.

Uma: I use menthiyam (uluva/triogonella foanum gracum/fenugreek) and omam (carum kopticum/the bishops weed), jiirakam (cuminum cyminum/cumin seed), miLaku (piper nigrum/black pepper) and chukku (zingiber officinala/dried ginger). I fry them slightly then add a little bit of fried coconut and grind well with puli (tamarindus indica/tamarind) and salt. I give one spoon of this to children in the early morning without adding to the fish. This is very good for the stomach of children.

Shobana: Did you make this now [recently]?

Uma: I don’t do it daily but do so once in fifteen days. When I prepare this it will hold for three or four days. And my children take this. But some people don’t eat this saying that omam and menthiyam smell. If you start giving at a young age, that is good. It is very good for the stomach. These days the girls suffer due to severe stomach ache and they don’t understand the value of this masala. If they take this once in fifteen days they will not get the stomach pain. They get severe stomach pain and spend money for hospital medicine…Next, bitterness is good for health. But no one accepts it.

Shobana: I like bitterness.
Uma: You know *pavakkai (momordica charantia)/bitter gourd*?

Shobana: Yes, I do. It is bitter. My mother puts a little sugar when she cooks it.

Uma: If you want the bitterness to go, boil well with water. And remove the water. And filter well. You need not put any sugar.

She shares some of her recipes, in telling me about what her typical week might look like, highlighting about three days of food—a Friday, Saturday and Sunday. R. S Khare notes that typically meals in India are broken up along the times of morning, afternoon and evenings, but this is highly variable, and also it is an ideal to afford three (or four) meals. Two, negotiations involve mixing small with large meals, which differs for each family member in some cases, and also pertains to the seasons (Khare, “The Indian Meal” 164-168). In Kanyakumari, in the families’ practices I observed, lighter meals, or *tiffin* usually make up breakfast and the fourth meal in the late afternoon, but the primary meals of lunch and dinner involve rice and fish, and along the gastronomic grid described earlier, of rice/bread, lentils and vegetables. I interviewed Uma in the weekend of Easter and I observed a distinction between daily meals and festive foods—her diet included chicken on this weekend which she later told me was something she could afford only once a year. The question of local taste and its to connection individual/familial sense of medicinal properties came up again in this discussion.

Uma: The day before I prepared *kiirai (spinacia oleracea)/spinach*- generic word for spinach)

Shobana: Which kind of *kiirai*?

Uma: Red one (*chikappu kiirai*).
Shobana: How did you prepare.

Uma: Cut the *kiirai*. Smash up a small amount of coconut. To this, add onion, *jiirakam* (*cuminum cyminum*/cumin seed) and a little garlic and salt. Lightly fry the *kiirai* in oil and mix the paste in. Then I prepared *rasam*. For [*rasam*], we have to grind on the *ammi*, *miLaku* (*piper nigrum*/black pepper), ginger, garlic and *karukappilai* (*murraya keonigili*/ curry leaf)and also tomato. Then boil this well in a small vessel after seasoning with *kaduku* (*brassico juncea*/black mustard seed) [which is first toasted in oil]. After that add a little *puli* (*tamarindus indica*/ tamarind) and boil well with some vegetables.

Shobana: You have to put water at this stage.

Uma: Yes, you have to put water. It will stay for three days.

Shobana: This is due to…?

Uma: Because we fry in oil [which helps to preserve it better]. We will finish the rest of it today. The other day I prepared fish *kuzhampu*.35

Shobana: When did you buy it? You gone to office early, right?

Uma: I did not go for three days because it is Easter.36 So I had time to buy fish after returning from the company [cashew factory]. That morning, Friday, I prepared *aviyal*.

Then I prepared rice. After returning from the company I took a bath and made fish *kuzhampu*. …Yesterday, Saturday, I made *aviyal*.

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33 Typically, a light/watery lentil-based gravy like a clear soup, but sometimes it is made without lentils, as in this case..

34 Flat stone grinding stone with a heavy stone rolling pin.

35 Semi-solid gravy

36 Uma identified as Hindu but she also celebrates some Christian festivals, like one or two other coordinators I spoke to.
Shobana: Do you have porridge in the morning?

Uma: In the morning I have coffee. Then I either make *uppuma*\(^{37}\) or buy *dosai*\(^{38}\) from the shop. If nothing is available in the house, then tea.

Shobana: So mostly *tiffin*.

Uma: Yes. Morning *tiffin*. Some times at ten [AM] we take cold rice. If it is there, otherwise we take rice in the afternoon.

Shobana: At night you take rice mostly.

Uma: Yes, only rice. Some times, in between, I have tea.

Shobana: So you made *aviyal* on Saturday.

Uma: I make *aviyal* with *vazhai kai* (*musa paradisiaca/raw banana*), *kathirikai* (*solanum melongena/egg plant*), *miLakai* (*capsicum frutescens/pod pepper*), *aamerika* (*terminalia chebula*), *veNdakkai* (*hibiscus asclentas/okra*), *veLLarikkai* (*cucumis sativus/cucumber*). I ground up coconut, garlic, onion, *karukappilai* (*murraya keonigili/curry leaf*), *jiirakam* (*cuminum cyminum/cumin seed*) and *manjal* (*curcuma longa/turmeric*).

Shobana: You have to grind nicely.

Uma: You have to grind more than for *kiirai*. In the afternoon, I bought fish.

Shobana: What fish?\(^{39}\)

Uma: *Natholi* fish, which is small.

\(^{37}\) A grain-based mush, like a polenta.

\(^{38}\) Crepe of rice and lentil.

\(^{39}\) Vimala, the health coordinator, explained how the poor essentially were able to access only the smaller fish which is the miscellaneous catch. Several of them have lots of nutrients like *natholi*, which has soft bones which can be eaten, and thus is a good source for calcium. People always attempted to get the bigger fish though as they were tastier and better for fried fish dishes, she noted.
Shobana: You can eat that as it is, right [does not require too much preparation I had noticed when other families had cooked them].

Uma: You can eat it without taking the bones out. But you have to cut off head, stomach, and tail. I made *aviyal* with *natholi* fish… I cook the fish with salt. And mix the ground mixture of coconut and other things like *jiirakam* (*cuminum cyminum/cumin seed*) with the fish after removing from the fire. And mix like *aviyal*. Then I made *kuzhampu* with *cura*\(^{40}\) fish.

Shobana: You made *cura* fish in the night again?

Uma: Again I bought *cura* fish and made *kuzhampu*.

Shobana: How did you prepare?

[A little later]

Viji [addressing me]: You cook?

Shobana: Yes, I do.

Viji: Then why are you asking?

Shobana: I want to know your methods, how you cook in this region.

Viji: How do you make *kiirai*?

Shobana: We made *kiirai* in many ways. Mostly I make a mashed *kiirai*. We toast red chili, *ulundu* (*phaseoksdiatus/black gram*) and *kaduku* (*brassico juncea/black mustard seed*) in a little oil, then add *perungkayam* (*ferula asafoetida/asafetida*) and add to the mashed *kiirai*. We put lot of *perungkayam* in our cooking.

I stress the use of *perungkayam* as it is one ingredient that my family considers to have many medicinal properties, especially useful for ailments related to the stomach.

\(^{40}\) Slightly larger and a little more expensive fish compared to *natholi*.
Uma nor her neighbors have much use for it, on the other hand, based on local sense of taste.

Uma: We don’t put *perungkayam*…people don’t like it cooked that way here.

Shobana: We prepare like that…that is why I say that methods are different. That is why I am asking [speaking to Viji].

Uma: We put *perungkayam* in *sambar* [or *sampar*], *rasam*\(^{41}\) and pickles. Otherwise we don’t put *perungkayam*.

Shobana: What have you planned for today?

Uma: I have *rasam* that I prepared three days back. Then I got chicken today. Today being Easter I prepared chicken…Today I prepared *thuvaran*. That means boiling the meat well with *manjal* (*curcuma longa/turmeric*), red chili powder and *malli* (*coriandrum sativam/coriander seed*). Then we have to add coconut milk and cook well, with salt. And then after cooking it, remove it from fire. Toast *miLaku* (*piper nigrum/black pepper*), ginger, garlic and *karukappilai* (*murraya keonigili/kari leaf*) in oil and mix this into the cooked meat. This will stay for two days.

Shobana: In the morning you ate *tiffen* only?

Uma: Today I prepared morning *chappati*\(^{42}\)…yesterday I prepared *uppuma*.

Shobana: You try to eat healthy food.

Uma: We try to eat healthy food but whatever possible since I am going to work.

Sometimes I powder the raw rice and prepare the *uppuma*\(^{43}\) with the powder and then

\(^{41}\) Kinds of lentils gravy.

\(^{42}\) Wheat flat bread.
take bread and two bananas. If I have one kg [kilogram] of powder it will come for three or four days…I am not very particular about anything. Whatever things are available we eat that. If we have this powder in the morning you take two teaspoons of this with tea….Otherwise, I have cold rice [rice soaked in water overnight].

When I ask people about their every day meals, it often became evident that while these “healthy” schemes and classifications were important, it was a struggle to make sure the family was feed. Uma spoke to me on many occasions about her work at the cashew factory, work she started after having children to supplement her husband’s income as a day laborer. Through MALAR, she has participated in several workshops about labor conditions and learnt about the impact of the working in a factory on her health, including fumes coping with fumes at the cashew factory, that are part of the processing. Uma recounted at length about a workshop in which she learned that she must eat eggs to keep healthy (since the fumes in the cashew factory are likely to make her lungs weak). But eggs are expense, she notes. As she has suggested earlier, eggs are also “heavy foods,” so they are not on her preference list. Ultimately, she notes, I am working to save for my children and I have to be careful about what we eat. She looks fondly at her kids and says: They will eat anything, they are not fussy at all.

For women, moving out the sphere of the home and into work places like factories comes with its own challenges. It was my observation that many MALAR women were able to find employment in the cashew industry; in fact, Uma reiterated that it was women who composed the bulk of the labor force in the factories she had worked in. I also learned that young women especially worked in the factories and that it was

Grain-based mush, like a polenta.
predominantly to held parents raise their dowries\textsuperscript{44} for their marriage. While MALAR’s programs decry the practice, it is still widely practiced and it is indeed ironic that increased opportunity for women aids the practice (although the alternative is life long debt for the parents which makes these choices rather complex).

For Uma, the added income is useful and adds to her sense of worth, she says, despite the challenges. In recognizing the impact of the work on her health, Uma saw a value in the informational workshops she attended. But eggs are both “heavy” and “expensive” to her, so she interprets what is useful for her household based on her notions about healthy eating which employs another criteria. This demonstrates how MALAR’s initiatives are used by its members using a wide set of evaluative criteria that involves many contradictions. In other words, MALAR’s initiatives essentially come in the middle of things and add new layers of meaning to ongoing negotiations about health. How it influences the work already being done or attitudes that are prevalent are not predictable by any means. On the contrary, looking at the programs through myriad interpretations allows us to see the choices involved for women are rather complex and that they are negotiating various kinds of moral and pragmatic worldviews that overlap but also produce contradictory effects.

**Household’s Thresholds**

In the case of Savita and her family, they offer similar ideas about food as Uma but add some other dimensions related to the growing of herbs in their garden. MALAR’s initiatives validate this family’s own conviction about the value of herbal medicines,

\textsuperscript{44} Financial and material contributions to the bridegroom’s family, from the bride’s family.
which they already use extensively in their household. They also routinely offer their family knowledge in the group discussions. Savita lives with her son and daughter-in-law Suma. One of the MALAR groups meet in their home. In informal conversations, I made an instant connection with them. Savita and Suma are well versed in herbal medicinal practices and in fact are related to the local Siddha healer who has found mention in several places in this project as the seller of arishtam, a herbal brew with the potency of liquor.\textsuperscript{45} They don’t support his practice and in fact don’t have regular contact with his family although they live within a mile of each other but highlighted for me that he was well-trained in Siddha medicine, having gone through government supported courses and certification processes which added to his family knowledge.

Savita’s own childhood involved helping out the healers uncles they share in common. The choice available to the cousin as a man for further training are different from hers, which highlights the hierarchies within the indigenous healing network. In several MALAR meetings, Savita often added to the discussion her own suggestions. On one occasion when I was there Suma went out in the middle of a meeting to get samples of herb from her garden to share at the meeting and to discuss its importance. Like Uma, they held the view that their neighbors did not believe in the practices and were wasting their resources by going to hospitals for everything without making attempts at self-help at home. Savita’s stress, like Uma, was that people did not want to make the effort and wanted instant cure, so she too connected use of herbal medicine with the temperament of the user. She recognized that indeed nattuvaidhiyam or indigenous medicines demanded a

\textsuperscript{45} Many people claimed that the mix included ingredients other than herbs but no one could tell me what. Essentially, there was a lot of ambiguity about his practice.
bigger role from patients, especially in observing pathiyam and in involving the patient in making part of the remedy at home, a practice which made people reluctant to use the medicines. She, like Uma, saw the medicine as worth the effort. Of course, as I have demonstrated, people have many complaints about biomedicine and government health care as well. I see MALAR’s role as making self-help more accessible as well as demonstrating that this involves both herbal medicine and being pro-active with government health care- both requires more effort from the patient.

Uma and Savita argue that belief in herbal medicine is an important part of those shifts in choices. Another claim that both MALAR’s programs and Uma, Savita and many others make is that herbal medicine has few side effects. I also heard from almost every healer I spoke at length with the rubber trees did not permit undergrowth and herbs are therefore more difficult to find. Furthermore, the chemicals used in agriculture, which people often referred to as “poison” (vesham) was rendering the herbs available less effective as well as contributing to their decrease. Food itself was less nutritious (although yields were very high). Many of the MALAR members’ families owned small patches of land, but those were not extensive. One family explained to me at length how the holdings, because they were divided within families, were scattered and farming practices were haphazard as a result. In other words, the people in the local communities appeared to have little sense of control over the land with everyone following their neighbors’ practices.

Typically, the use of fertilizers were learned by observing the neighbor who might have asked the owner of the pesticide shop for instructions. In that, the pesticide shop
owner is not different from the people manning the small pharmacies in villages who often act as doctors. In this scenario, while the experience that chemical farming might be detrimental is articulated, I got no sense that people felt they could do anything about it, especially since they were tied to the economy that stemmed from the rubber plantations especially. At the household level, Savita and her family, it turned out make an attempt to retain control. They grow their own herbs. While taking a tour of their garden, I observed the use of manure based fertilizers but was also shocked to note uses of DDT although only for a few plants that were “sick,” since I had assumed DDT was banned by now. So even in the instances where more local control seems possible, given that information can come from anywhere with people relying on whatever resources they have to make evaluations, it does not always translate to an a more effective choice.

Mark Nichter, in his work with Ayurvedic healers, is interested in the recurring diagnosis of “indigestion” in how it becomes a “central trope for modernization as well a bodily response to environmental (physical as well as social) degradation and change” (“Political Ecology” 102). Imbalances in the digestive systems of the body and the food taken in are connected to “defective modernization” (Nichter, “Political Ecology” 102) in the practices of chemical farming but also various aspects of modern life like urban living are indicted. He also outlines how indigenous medicine is marketed as a cure for modern life, especially to urban people, pointing to the commercialized aspects of these perspectives. My argument is these claims about indigenous medicine as a corrective to the ill effects of modern life assume a clear separation between modern and indigenous system where one is an alternative to the other, whereas in practice they often overlap.
Two, the claims of indigenous systems have to be seen as strategic themselves. But the experience of people who have direct contact and are in a place to observe change in their communities to note the effects of practices like chemical farming, for example, are very valuable, including in throwing light on the misuse of chemicals. Their experiences also point to the challenges involved from moving from kind of practice to the other because of factors like patterns of land ownership. Suma and Savita do not claim that indigenous medicine is a cure for modern ills; they simply contrast the two systems and point to the difficulties of practicing herbal medicine.

The question of conservation and its connection to indigenous knowledge has been recognized as a contentious issue in the Indian context. Scholars evaluating Indian folk ecological knowledge, such as Vijaya Nagarajan have articulated it is important to pay attention to the contradictions between belief and the way it is applied in everyday life. Her interest is in highlighting that “‘embedded’ ecologies” in cultural lore, such as the worship of an herb, must not be taken to signify a conservation consciousness, as activists such as Vandana Shiva have argued (Nagarajan 269-295). In my view, Vandana Shiva, in all her work, makes an excellent case for farmer’s rights, especially in relation to the protection and exchange of seeds which insures a kind of commons and also validates farmers’ own experiences. But she makes some generalizations about indigenous knowledge as ecological/conservation wisdom that are problematic in her work such as Staying Alive and Stolen Harvest. Also, as Nagarajan has noted, in Shiva’s work, Hindu customs come to stand for all of India’s inclinations where as in fact there is a diversity of viewpoints about conservation. The notion of conservation itself is
problematic because it has come to mean one thing in the West and those models are not applicable elsewhere, but an existent indigenous knowledge that seeks to protect the environment cannot be assumed. In fact, I would suggest it can be cultivated and that process could and ought to involve knowledgeable community members. I will not review these debates about ecological “consciousness” at length.\textsuperscript{46} Instead, I present women’s knowledge of herbs in this project. In this chapter, I also address some meanings related to the practice of the expressive art of \textit{kolam} and its relationship to food. I also focus on women’s challenges in small scale stewardship and its relation to the political economy of natural resources, such as the influence of land ownership patterns, as well as the transmission of community knowledge over generations within families, and through mediated discourses like the media and a variety of local level sources of information which I submit are sites in which authorship and communities’ responses are harder to track. I also submit that the household is part of a larger set of public and private natural resources, and is deeply influenced by the larger network of food production, even while it forges its own particular negotiations.

Indeed, I am interested in how the household becomes a site where these challenges are played out. I have this image of Savita sitting near the entrance of her house, on the ritual art of \textit{kolam}\textsuperscript{47} on the floor, cutting vegetables. As the evening comes around, that same place becomes the site for MALAR meetings. \textit{Kolam} is made from rice

\textsuperscript{46} I will not attempt a review here but will note these viewpoints are represented in several debates between eco-feminists and their critics who highlight similar essentailizing moves articulated in this chapter, and eco-feminists’ response about the lack of attention to women’s role in nature stewardship and other related nature-based practices. See Escobar and Mellor.

\textsuperscript{47} Designs made on the floor with rice flour. See Nagarajan for an extensive study.
flour and typically adorns the place right in front of the house and marks the threshold and defines the boundary between outside and inside (Nagarajan 269-295). It is interesting to me how these threshold points embody the multiplicity of worldviews, so that Savita’s own traditional practices interact with the new ones that MALAR proposes. In other words, with relation to the household, the negotiation of outside and inside are always changing and emerging. Indeed, what lies underneath might be ephemeral though powerful. As Nagarajan notes in her study of kolam:

[As a form of Goddess worship kolam] is packed, dense with knowledge both implicit and explicit, embodied and aesthetic. The irony is that the kolam itself is very light, ephemeral, almost weightless…locally physically on the spatial periphery on the threshold of the household, the kolam quickly disappears under people’s feet into the soil (272).

Some more permanent versions of kolam which involves mixing the rice with water are also placed elsewhere in the house where sacred events are held, like worship at weddings or festivals, though those too slowly fade away. Savita is sitting in one such place, witnessing all the contradictory (and complementary) forces in her community, evaluating what seems appropriate to “let in.” Vandana Shiva has noted kolam is an expressive art where women are the bearers, but in cultural lore kolam is also seen as laying out food for ants (“Gift of Food” http://www.resurgence.org/2005/shiva228.htm). Nagarajan has noted that while this is one aspect to it, other peculiar paradoxes are involved with relation to connections to the natural world. Concerns for the natural world exists side by side a disregard for it. She notes (which I would testify from my observations in both cities in India and everywhere in Kanyakumari) how the insides of Indian households are kept very clean and just beyond the threshold where the outer
world intersects with the inner, all the garbage is thrown.\footnote{For a excellent study of trash, which also flows through channels with similar clear demarcations based on purity and pollution, see Korom.} This includes all sorts of inorganic matter like plastic. The edges between the front of the house and the rubber trees beyond are littered with plastic covers. These thresholds embody the contradictory practices of care and pollution, in other words.

**Multiple Uses for Plants**

In speaking about how their food and medicine are interrelated, Savita and Suma often stressed they used many parts of a single plant, each of which have different value, so that “with the leaves we can make *koottu* [a gravy dish, an everyday food] and with the root *kashaayam* [a decoction made for specific ailments].” Savita stresses the importance of family practice and lay knowledge, and the value of herbal medicine in terms of preventive medicine and laments that her neighbors don’t see it as such.

Suma: When we make rice *puttu*\footnote{Steamed dish of broken rice} we put various leaves.

Shobana: What leaves?

Suma: We put *karukappilai* (*murrayakoenigii* / curry leaf). We pound the *thenkai poo* (*cocosnucifera* /flower of the coconut) and mix with rice and make *puttu*. Then, there are other leaves like *punni elai* (*calophyllum inophyllum* /alexandrian laurel) and *isangku* [or *icangku*] *elai* (*azima tectracantha*). We pluck them, pound them into the rice flour when

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\footnote{For a excellent study of trash, which also flows through channels with similar clear demarcations based on purity and pollution, see Korom.}

\footnote{Steamed dish of broken rice}
we make puttu. Then we fry the rice flour and the leaves and mix them together to make a dish.

Shobana: So you put every thing in the cooking. That is very good for health.

Savita: It is good.

Suma: It [what Savita has just explained] is good for itching and also wounds on the skin.

Shobana: I see.

Suma: For wounds and itching the leaves of puvarasu kilanthe elai (thespesia populnea) is good. There are many medicines like this. There is another good medicine for those who are unwell due to dysentery. If we take the water of kodangkai elai (sesbania aegyptiaca) for about 60 days it is very good. If you take with a little milk or porridge, it is good. But if I talk about these medicines no one cares. They go to the hospital and get an operation. If this fashion, we tell [people] many times. Those who don’t have the brain to understand don’t care much about it.

Shobana: Mostly people run to the hospital.

Suma is connecting uses of medicine to temperament or guna, as Uma often does.

Then Savita and Suma highlight the use of the same plant for various purposes.

Savita: Take a bit of murunkai elai (moringa oleifera/ drumstick leaf) and smash and grind and apply that. If the leg is bent and the water [retention] in the leg is not reduced, grind the murunkai elai (moringa oleifera/ drumstick leaf) with a little salt and apply it over the affected part of the leg. The water in the leg will come down…This is useful for pregnant women with leg problems…For pregnant woman, there are other medicines in which we have to make the kashaayam [decoction] and give them. If they [the neighbors]
listen then we tell. Take root of kuRunthotti (pavonia zeylanica/ country mallow), root of veLLai amanakku (ricinus communis/caster bean) and make kashaayam [decoction] with it.

Suma: With the plant we can make koottu [gravy dish] and with the root kashaayam [decoction].

Shobana: We can make kashaayam with the root.

Savita: Take one measure of the roots [that she just listed] with half a cup of malli (coriandrum sativum/ coriander). Grind it and add to five hundred ml [milliliter] of water and allow it to boil till it is reduced to one or two glasses. If a pregnant woman takes this twice a day she need not go to doctor at all. In the seventh, eighth and ninth month of pregnancy take this three times a day. If she drinks this kashaayam [decoction], she need not go to doctor and safe delivery will take place in the house itself. I have given birth to seven children. I have not gone to the doctor

Shobana: Every thing in the house with the help of mother.

Savita: With or without the mother the delivery will take place in the house. When I was resting in the house after delivery then they would call a doctor [with basic training] to tie the umbilical card of the child. I have given birth like that. There were lots of medicines those days. If there is discomfort in the eyes, take the honey from the vazhai poo (musa paradisiacal/ flower of banana tree) which stands at the corner here and apply it to the eye, on your own.

Shobana: How often does it flower?
Savita: When the bunch of banana comes out the flowers will also come. When you break
the flower, inside the flower, the honey will stand out, which can be applied to the eyes.
This will give a great relief.

Shobana: You can apply this when you get the burning sensation in the eyes due to heat?
Savita: This is good for that too and will give good relief…When I talk about all these
good medicines no one cares.

Again, there is the refrain about other people not using these medicine, given their
effectiveness, based on personal experience. Next, Savita highlights, along with notions
of preventive medicine and pro-active care through food she has elaborated on, a related
idea of moderation in diet which R.S. Khare has noted, through regimens for the sick, or
pathiyam.

Savita: When the skin becomes thick and swollen like after an insect bite, take a handful
of tender *murunkai elai* (moringa oleifera/ drumstick leaf) and grind well and mix with
the coconut milk nicely and drink three times a day.

Suma: We should take that on an empty stomach only.

Savita: We should take that on an empty stomach and should not take salt when you take
the medicine.

Shobana: We should observe *pathiyam*.

Savita: *Pathiyam* includes going without salt for three days and you should not take bath
if possible. You can take porridge without adding salt. You can take *eethan pazham* [a
local variety of banana] and cow’s milk. When you stay without salt for three days there
will be improvement and also by avoiding bathing… Some girls have come here with
wounds and sores near the hip [from wearing a sari too tight] and I prepare this medicine…People run to the hospital as they don’t have faith…but you should at least try these things, should you not, before going there?

Shobana: Yes, I think people could make an attempt.

Savita: You have to at least try.

That is her conclusion: people should at least try, echoing Uma’s idea that effort is involved using herbal medicine. Later I asked about her own practices and that of the Siddha healer, the cousin. She says based on her conversations with his family, she thinks he now knows a wider variety of medicines and practices full time but fundamentally she sees little differences. I learnt from observation, she says. It is my sense that she recognizes that the cousin has more privileges as a man but she sees her own practice in the family as valuable and effective. Preventive medicine is best, she says and concludes, getting a little quiet “it is a pleasure to be without diseases.”

**Small-scale Land Stewardship: “All from the garden.”**

Suma and Savita stress to me how important herbal medicine is for their family and say every time: “the herbs are all here in our garden.” So when I come to observe an herbal oil making session, it begins with a tour of the garden.
Suma’s garden tour:

Suma takes me on a tour of the garden as soon as I arrive to observe their oil making. We plant many of these things we cook in the garden itself, she says. She strolls through the garden identifying various trees and plants, pointing them out. The garden is well-tended, with many trees standing in neat rows suggested these are all trees that have been planted. Mostly, the area is clear of large trees, all of which are at the edge of the garden. The garden is all around the house, so our tour takes us around the house. The family is middle-class by standards of the village though not by much. Their house is large but the kitchen roof is not made of concrete like the rest of the house, but open with a temporary cover made of large dried plantain leaves. But they have a well of their own in the front of the house and the area around the garden is sizable. Suma’s son who is twelve, and two of the cousins, a girl of ten and a toddler of about two years accompany us, running ahead of us playing with each other and stopping and joining us occasionally when Suma speaks. Below is a record of the conversation between Suma and me, with the occasional comment from the children that was clearly recorded in my video camera. I acknowledged Suma when she identified each plant with “hmm” but did not speak much, trying to capture the plant as closely as possible with my camera.

Suma: There is pineapple… kaithoni (Eclipta alba/ Trailing eclipta)

Son: That we have used.

Suma: Chempu (arum colocasia/cocco)…aadathodai (adhatoda vasica/vasak)…piraNdai (vitis quadrangularis/ cissus quadrangularis). That is good for stomach gas. I brought a piece to the group the other day, do you remember? [referring to
a MALAR meeting which was held in her house where she shared details about this herb]…Here is something. It is puli (tamarindus indica/tamarind) [referring to a tree]. Right now it is not bearing fruit…[That is] miLakai (capsicum frutescens/pod pepper).

Little Girl/Cousin: MiLakai.

Suma: There are new leaves on this. We plant all the trees…Here, this is manjal (curcuma longa/turmeric). The rhizome is the important part…There is jackfruit [said in English] and coconut [said in English]…[There is] vazhai (musa paradisica/plantain tree). Many have fallen down now…This is Papaya [said in English], do you know? [I nod. I notice a ladder perched on the trunk of the tree to help get the fruit out]…This, it is kurunthu (murraya paniculata)...[This is] kaithoni (eclipta alba/trailing eclipta). That is coffee [said in English]…and that is pakk (areca katechu/betel nut)...[This is] veli paruththi (pergularia daemia/asclepiadaace)...We are growing radish [said in English] and strawberry [said in English]. We brought it back from Ooty [a town in the Nilgiris district in Tamilnadu where they have relatives]51…That is chiRu payaru (phaseolus mungo/green gram)...[This is] narangkai elai (citrusacida/acid lime)

Shobana: What kind of manure do you use?

Suma: We use cow manure. But we also use DDT. [Then pointing to a host of plants sitting in pots:] That is vallarai (cantella asiatica/indian penny wort). We have yet to plant these. And that is garlic from Ooty also.

Little Girl/ Cousin: This is kodangkai elai (sesbania aegyptiaca).

51 Where I was raised, incidentally. My family knew their family it turned out so our sense of connection strengthened during my stay.
As we enter the house, I talked to her about DDT and its effects and why she should avoid it. She nodded in understanding but I did not return to the issue and do not know what her final decision on that was.

The spatial connections between food and medicine or health in general is evident in the house connected to the garden, connected to the fields beyond and the other way around—fields/garden to house and to the body itself. In this sense, Savita and Suma mark the household’s connection to larger moral and social forces in terms of space, in specific ways. Within the household itself, food and medicine are handled in a similar fashion with a few small distinctions that I will note in my descriptive account of the performance of oil making and the cooking of a feast below. Food and medicine are similar in the use of utensils, methods of grinding, use of base oils and also many ingredients overlap. Below is an example of the making of herbal oil made specifically for certain ailments, medicine rather than food, in other words. It is also applied externally only, unlike food.

Suma’s Oilmaking:

Suma’s large stone mortar and pestle is outside, just near a corridor that leads to the two kitchens in the house. One kitchen, the smaller one, has a wood stove, used to make rice in a mud pot. The rest of the cooking takes place in the other kitchen which has a gas range which like all ranges in India runs on propane. The oil making process involves pounding the dry herbs into a rough powder and then the fresh green herbs to extract their juices, and then boiling the two in three kinds of oil, castor, coconut and
sesame in equal proportion. Suma does the boiling in the larger kitchen on the gas stove. Suma starts by tackling the dry herbs.

Suma: We are going to use candhanam (santalum album/yellow sandalwood), ok? Then this is kottam (apaotscs antcut/costus root), jiiarakam (cuminum cyminum/cumin seed), karung jiiarakam (nigella sativa/black cumin). Let it dry out in the sun just now.

She places the dry herbs on a newspaper and leaves it out in the sun. After she organizes some of her other work in the house, she returns and pounds them. This takes a full twenty minutes and while she is doing this she has brief conversations with her mother-in-law, her children and their cousins and her husband’s sister who has just dropped by. She then mixes the three oils. The fresh green herbs that she has picked today from her garden are adaathodai (adhatoda vasica/vasak), kurunthu (murraya paniculata) and kaithoni (eclipta alba/trailing eclipta). She asks her daughter who has just come back home to get a brass pot ready to heat the oil.

Suma [directs a question at me]: Do you use hair oil?

Shobana: The oil with herbs, I get from the Ayurvedic pharmacy when I am in Chennai. Without the herbs, I make one with just sesame oil, and I add jiiarakam (cuminum cyminum/cumin seed), miLaku (piper nigrum/black pepper) and ginger to it. It really cools the body.

Suma nods. The oil she is making today also has a similar effect. While there are heating and cooling foods, home made medicines also are made to tackle heating and cooling of the body, again one more level at which the food and medicine are related. Suma’s son goes to the garden and gets a leaf from the miLaku (piper nigrum/black
pepper) plant for me since I have just mentioned it. He asks his mother, looking at the stack of green herbs: Should I remove the leaves?

Suma replies: No, that is ok, we need the essence from all of it [that is, the stalks as well].

She first pounds the fresh herbs. A neighbor drops by and watches. There is a cacophony of voices. Suma tells me: I have used 600 grams of oil. About a cup of essence comes from the herbs.

She removes the juice and then pounds them a second time. She adds a few drops of water, pounds and squeezes out the juices from the herbs with her hand. One of the little cousins comes out with a new shirt as it is her birthday today, and shows it off to everyone. Much is made of her. Cooking and making medicines are interwoven into social life. Suma pounds the herbs one more time and squeezes out the juices one more time. A total of about two cups comes out. She then takes the dry herbs and adds water and mashes it for ten minutes.

Suma: This oil will cool the body. Overall, good for the health too.

She removes the mashed dry herbs and washes the mortar and pestle out. She adds the mashed dry herbs and them adds to the juice, then adds the oil and goes into the kitchen. She mixes the ingredients thoroughly, and puts the mix on stove on high flame in a brass pot. Suma’s son tells me this process will take about one hour. Suma stirs.

Suma: It will go through several stages. It has to mix. We keep stirring otherwise it will catch at the bottom…Since the rubber plants came, we have less herbs.

She offers small observations like these, “since the rubber plants came, we have less herbs,” which is about the available resources, that is meta commentaries related to
the larger scope of the practice, while describing the process of making the medicines themselves. She is suggesting here that while her own family’s own practices of herbal medicine continue, it is getting more challenging since the herbs are not easy to find since the coming of rubber. Suma carefully watches the medicine, stirring more often. Their father [referring to her husband] uses a lot of this. The rest of us use less otherwise we catch a cold. She is suggesting that the cooling effects of the medicine may suit some better than others—so that her husband benefits from using it more, whereas the rest of the family has to be more cautious.

Suma: See the color change a little? It is more dark green? Okay, this is really good for the summer.

Shobana: Yes.

Again, she has highlighted the cooling aspects of the medicine.

Suma [refers to the brass pot in which oil is being made]: This is from my mother’s. It holds heat very well.

This brass pot is used for cooking and for medicine. Suma’s son inspects the oil now and then. I try to capture the kitchen in my camera. Suma notices and comments.

Suma: We are trying to build another kitchen that side and move all this there, and hoping to get a second stove also.

Shobana: I see.

A small boy, another cousin, comes into the kitchen but is sent away as he might get too close to the fire. The oil is now itself green; the oils have become infused with the herbs.
Suma: When raw rice disintegrates in here then it is done.

The rice is dropped in and it falls apart slowly

Suma’s son: That is the signal.

Suma: That is enough.

The children are learning by observing, offering their own commentary, something I noticed with almost every family. Suma removes the oil from the fire and lets it cool on a bench near the window, still continuing to stir occasionally. It is now clear on the top. As Suma stirs again, this time more gently. Her son says my mother is writing sri rama in the oil. Sri Rama is the name of a Hindu God, so this is the religious/spiritual aspect of oil-making in this family. Suma nods. She had not told me about this. She just does it in a matter-of-fact manner and moves to the next step. She tilts the pot and scoops out, with a ladle, the top section with the clear oil, and pours it into another vessel. She takes her time, removing as much debris-free oil as possible. This itself takes another five minutes. Get the plastic bottle from the shelf in other room, she tells her daughter, who has been standing near the kitchen.

Suma [to me again]: You can also include nellikai (emblica officinalis / gooseberry) in this. I did not find enough of it in the garden today. That cools the head also.

Suma’s Feast:

Suma invited me to come for lunch with her family, where, she said, we will only cook with whatever comes from the garden so you can enjoy what we grow here and see some of our recipes. When I arrive, Savita is sitting in the front room of the house near
the door, where the floor is adorned by a large kolam. She chats with people who drop by while watching the over the many grandchildren who have also dropped by today, while simultaneously cutting various varieties of spinach. She is cutting them into long shreds. Suma is cutting vazhai thandu (musa paradisica/ stem of banana/plantain tree) into uniform small cubes. In the case of food that are part of everyday meals (rather than medicine made for particular ailments like the oil) the manner of cutting and shapes which are related to aesthetics (or rasas) are stressed. While watching Suma take her time over cutting the thandu into cubes, I am reminded of Vimala painstakingly cutting mango into long slim slices to match the long slim shape of the natholi fish. That is part of our fashion, Vimala joked to me.

To cut the vegetables, Suma and Savita are both using the arumamanai, which involves a blade attached to a wooded plank. The hand moves downward into the blade, while a leg placed on the wooded plank keeps it steady—the person cutting sits on the floor. Suma next cuts the outside of a pineapple. It cannot be too ripe, she notes. It has to be a little tart. She cuts the insides into small cubes as well. The recipes themselves are very similar. All of them involve a paste made from coconut with various spices. Suma makes a paste for each of them separately even though some are exactly the same. This way she can make an assessment of how much to make based on how the dish is progressing. Like with oil making, in food each session is different and assessments and adjustments are made as the food cooks, that is, in performance emerges one version of the preparation. Suma uses a modern blender to make her paste. When it is Savita’s turn to grind for another dish, she goes into the smaller kitchen and instead uses the ammi, the
stone grinder with a rolling pin. The rice is done in the smaller kitchen too in a mud pot on a wood fire, while all the rest of the cooking is done on the propane gas stove in the larger kitchen. The same brass pot used for making the hair oil comes out, this time for a surprise dish—a sweet dish of rice and raw sugar, *payasam* [or *payacam*], made in my honor.

Each dish uses pastes that are quite similar though the final products all have very different textures and, of course, tastes. The *chiRu payaru* (*phaseolus mungo*/green gram) is cooked in a pressure cooker. When it is done, Suma adds a paste of onion, *manjal* (*curcuma longa*/turmeric), red chili, and coconut to the gram and then equal amounts of water to match the cooked green gram. She returns this back to the fire, brings it to a boil and then removes from the fire. This is the main gravy side that will be placed on the rice itself. All the rest of the vegetable and fruit based dishes are side dishes. In a pan, *jiirakam* (*cuminum cyminum*/cumin seed), onions, and the *vazha thandu* cubes are sautéed. To this she adds a paste of *manjal* (*curcuma longa*/turmeric) onion, coconut, salt and red chili. The third dish is made predominantly with ginger. Ginger is mashed in small mortar and pestle in the kitchen. In a pan, *kaduku* (*brassico juncea*/ brown mustard seed) and *karukappilai* (*murraya keonigilli*/ curry leaf) is toasted and then the ginger is added to it. Next, a paste with red chili, *manjal* (*curcuma longa*/turmeric), *jiirakam* (*cuminum cyminum*/cumin seed) and coconut are added to it. Water is then added to make it a semi-solid gravy dish. Next is the pineapple. The pineapple cubes are put on boil for a full twenty minutes after which a paste of *milaku* (*piper nigrum*/black pepper), *jiirakam* (*cuminum cyminum*/cumin seed) and coconut are added. It is then quickly removed from
the fire. Suma lightly toasts *malli* (*coriandrum sativum*/*coriander seed*) without oil in a pan and adds it to the pineapple as a final touch with salt.

She then heats oil, adds *karukappilai* (*murraya keonigilli*/*curry leaf*) and adds this to a mango pickle, which has been cooked previously. This is one more optional item which she decides to take care of today since it is a feast. That a simple everyday meal is becoming a feast in my honor becomes more clear as she brings out *papadam*[s], lentil crisps. They are bought dried and then deep fried at home. Next comes the *payasam*, the sweet dish made with coconut, *elam* (*elettaria cardamomum*/*cardamom*) raw cane sugar and rice, in Suma’s favorite large brass pot in which she also makes her medicinal oils. The ingredients are boiled together in water on a slow flame till it acquires a slightly viscous quality but there is no particular point at which it must be removed. Unlike the medicinal oils, method of making foods has to do with texture and taste rather than health specifications, though as I have noted, there are many points of similarity between preparations of food and medicine. The children who have been running around playing in the garden have found a mango, so Suma decides to add this to the meal as well. She cooks this like she does the pineapple, by boiling first and then adding a paste. The paste includes *jiirakam* (*cuminum cyminum/cumin seed*), *miLaku* (*piper nigrum/black pepper*) garlic and onion. Later, she toasts *kaduku* (*brassico juncea/brown mustard seed*) in oil and small green chilies and adds them to the boiled mango. The feast is complete. The children and the guest, that is, me eat first. Suma and Savita eat next. The husband comes in late for lunch on most days. He comes in later and eats last. Everyone eats heartily. All from our garden, Suma notes.
In terms of issues of gender, Savita and Suma exemplify the role of responsible householders expected of women. In participating in MALAR’s programs, especially in discussions about herbal medicine, their informal education of their neighbor continues though they are not convinced that their neighbors care enough. Their home is also the site of a small scale stewardship of natural resources. Through this, it is felt the ill effects of food grown poorly may be provisionally tackled. I say provisionally tackled since Suma and Savita are suggesting these are part of their trials with healthy living and they are also very conscious of the challenges – so that while their garden exits, it is the case that herbs are getting harder to find. Their stress is on trying and attempting to maintain some semblance of local control and self-help with regard to access to natural resources. It is also provisional since it is clear their practices are not necessarily healthy since they still sometimes use harmful chemicals. At any rate, the rubber trees lie just beyond the garden. While women mark the thresholds and assign them particular value as with kolam, all those worlds (household, garden, fields and beyond) are very much connected in a broader physical environmental sense so that the trash and the farming practices beyond the house eventually make their effects known in the household. However, it is the case that the home as a spatial and conceptual space is very central in bringing to bear, in everyday practices, the various complex multi-classificatory schemes of food and medicine for families. Indeed, the household is the site where the challenges of the multiple schemes are played out.
CHAPTER 6

BETWEEN CONTEXT-SPECIFIC AND CONTEXT-FREE: ROLE OF BELIEF IN HEALTH PRACTICES

In 'traditional' cultures like India, where context-sensitivity rules and binds, the dream is to be free of context.

-A.K. Ramanujan, “Is There An Indian Way of Thinking.”

In this chapter, I will focus on how women within the MALAR network negotiate belief in their healing practices. As noted in Chapter One, belief speaks to the question of faith that a practice will work and also an understanding of being connected to a universe governed by supernatural/divine forces. Interestingly, a common word in Tamil, nambikkai (a noun like belief) was used to describe both kinds of belief, in the context of my fieldwork. I want to begin with the following observation: within the MALAR programs and meetings, religious or belief based instruction of any kind, that is, one that be perceived as being Hindu or Christian custom, is strictly exempt. People talk about having faith in the belief as very important to the practice of herbal medicine. Through the course of interviews, I discovered this idea would be raised in the groups. But anything that resembled formal religion was not included in the health initiatives.
MALAR coordinators stressed to me how much religion can be a divisive force in their communities—that is, it gets easily politicized and battles are evoked on the basis of religious affinities, especially between Christians and Hindus.\(^\text{52}\) MALAR’s goal is quite the opposite: to get people to work together irrespective of class, caste or religious backgrounds. Therefore, because religion could be intermingled with politics (the collusion of religion and politics is brought to them explicitly by politicians especially in election time) it makes the coordinators of MALAR wary about discussing certain aspects of folk medicine that are belief-based such as those involving religious rituals associated with Christianity and Hinduism. In my interviews with individual healers and MALAR members themselves, expressions of religion and the value of belief in folk healing would come up. MALAR coordinators readily acknowledged that in practicing any kind of healing at home, people do evoke their belief in many forms. In other words, as personal practices, they were acknowledged and accepted, as practices for MALAR to validate would be walking a far more dangerous line. In this scenario, particular forms of belief are taboo within the public sphere of MALAR meetings. A few coordinators also stressed to me that talking about rituals like praying to deities, evoking special mantras in medicine or healing through temple or church rituals like group singing etc are to them examples of “blind faith” or “superstition.”

I will look at all these claims within the MALAR network related to the permissibility of certain practices over others in tandem with interviews with individual practitioners, and argue that the practices of belief is a contentious site, engendered by

\(^\text{52}\) There is some history of communal clashes in the district, including one in 1982 (Ram 29, Mukuvvar Women).
class and gender differences, including in the relationship of practitioners to institutionalized religion, even while the great value of belief in the process of healing is acknowledged. Pat Mullen notes:

Folklorists study everyday experience with a focus on knowledge, behaviors, and cultural expressions that are traditional in the sense that they exist in the present as an interpretation of the past. Belief is part of those cultural processes, but it is not one that should be used to hierarchically distinguish one group from another (139).

While in our own ethnographic representational practice we have to be vigilant about reinforcing stereotypes, we also have to continue to pay attention to how such viewpoints are pervasive in culture at large, and what kinds of (new and old) forms the evaluations take and what purposes they serve. In the scenario I have described in MALAR, belief is associated with backwardness of some kind, of individuals (and the community by implication) consistent with a pattern of “pathologizing” of folk medicine and its practitioners (Mullen 121). Religion is also seen as a marker of difference between women that cannot be easily overcome.

Looking at interviews with healing practitioners and other conversations with MALAR members I explore the range of practices and responses to belief within the personal sphere, that is, in individual practices and ask what role beliefs plays in dealing with health issues. I draw predominantly from two interviews- both with healers (Maria and Vasudha) I was directed to talk to by MALAR coordinators and members as they were acknowledged to be experts- that is, their range and knowledge of medicine was extensive and they treated many people outside their families.
I suggest the larger social world and its dilemmas are very much connected to healing through belief. The excerpts from my interviews are records of the practices themselves but interwoven are stories about the practitioners’ lives and what becomes evident is the way experience of belief shapes life history and vice versa. Also, I will demonstrate, because belief practices can so broad, they are to be found in everyday expression nonetheless, and as such are not “containable.”

In addition, I will look at how belief can also become powerful sites of empowerment especially where all other options for healing have failed. In presenting Maria’s beliefs, I will highlight evidences of social critique her belief narrative, including critiques of local religions institutions, and also how the body becomes a site for such an evocation, as Maria “performs” her belief. Evoking A.K. Ramanujan’s notions of the desire for the “context-free” and the “anti-contextual” in a world of “context-specific,” I will argue such idiosyncratic, highly personal notions of belief involve a dance between deep rooted culturally situated sense of self and the intricate web of defined social relationships on one hand and the desire for transcendence on the other (Ramanujan, “Is There an Indian Way of Thinking”). I will also look briefly at how declining belief in herbal medicine is understood as being related to agricultural practices.

This scenario leaves us with some interesting paradoxes with relation to MALAR: to not speak about religion and (supernatural/spiritual) belief aids the need not to evoke divisive politics within the group (and helps to preserve a sense of solidarity). But to not speak forestalls the capacity to dialogue about how people’s everyday lives are affected by religion. Belief is then a site of contestation about the boundaries of the personal and
the public (public represented through MALAR). As I have demonstrated in earlier chapters, MALAR initiatives reconstitute the boundaries of women’s space and alter sense of self. MALAR deftly negotiates its growing status within national and international campaigns but it is clear within the arena of belief the personal practices do not get articulated and thereby reworked explicitly in a public, more communal fashion as other issues do. In MALAR, by extension, herbal medicine is seen as effecting the body at the physiological level alone, not providing “social” solutions directly, that is. In other words, while illness may be caused by social factors, herbal medicine in particular is seen as a physiological cure.

David Hufford has outlined there are certain “core experiences” of belief that occurs cross-culturally. They are: the experience is real, that is, it not all in the mind, it is qualitatively different from the everyday material world, that supernatural beings interacts with this world in certain ways, that beings do not require a physical body in order to live. The beings “are variously called ‘the spirit world,’ ‘the supernatural,’ ‘land of the ancestors,’ and so on…[and] how this spiritual order is different, when and how it interacts with the mundane world, and who the persons in it are, constitute major differences in cultural and religious traditions, and frequently between institutional religious tradition and folk belief” (“Beings Without” 15). Based on direct personal experience of the narrator, what belief narratives essentially “offer is an account of the nature of spirits and their relationship to humans” (“Beings Without” 30). My own work tracks some of the features of experiences involved in terms of performance. For one, I look at how practices of belief come to the fore in the interactive process of the interview.
Essentially, I follow Pat Mullen’s call to understand how the experience can be enhanced in performance, including in looking at belief in the context of life histories in terms of form, in the “breakthrough into performance” moments (Hymes 79-141). As Bauman has noted:

[Performance] is marked as available for the enhancement of experience, through the present enjoyment of the intrinsic qualities of the act of expression itself. Performance calls forth special attention to and heightened awareness of the act of expression and gives license to the audience to regard the act of expression and the performer with special intensity (44).

Following from the idea of “core experiences,” as expounded by Hufford, I do assume the narrators have had experience with the spiritual world, and that it is their experience that strengthens their belief. I will also look at culture-specific notions of the experience with the supernatural, that is, specific to the Indian context, in looking at the belief practices of Maria as bhakti (or devotion- based) expression, which are traditions that celebrate a direct, unmediated experience with the supernatural/divine, even while those expressions involve features that overlap with that of institutional religion, (Roman Catholic) Christianity in this case. Further, in articulating the transmission of knowledge about belief, I will also argue belief practices involve secrecy which are tied to lineage and temperament of the bearer of knowledge, such as in the use of mantrams (prayers) in healing by Vasudha.

**Interviewing María and Vasudha**

Maria and Vasudha are both older women, with grandchildren in their late teens and early twenties. In the course of both their interviews, they would not always
remember all the herbs involved in various medicines. In the case of Vasudha, I discovered that she did not know the names of all the herbs but relied on her visual memory of them. I stopped by her house one day to see her grinding a herb for skin infections whose name she did not know but knew where to find it near her house. In my interviews with all healers I got a good sense of the range of their work. Each of them allotted time for me and carefully explained what they knew and so I did feel what was offered in interviews was thorough. But as Vasudha’s example demonstrates not all the knowledge can be verbalized. I would say, in her case, there is somatic memory involved in the collecting and making of herbal medicines that is particularly active. In all cases, I was conscious the practitioners’ accounts of their work were responses to my questions, though I would also get many accounts of medicines that I did not explicitly ask for. In all cases I was also interacting informally with the women I interviewed, and wherever possible I have tried to record details of those interactions, and how they influenced the formal interviews. The information recorded here is based on the means of communication that presented themselves to me and the particular frameworks I was interested in.

Informal conversations with women involved small conversations while meeting in public by chance, dropping by to say hello at their homes that would lead to chats, walking or taking buses with coordinators from group meeting to group meeting etc. I would record many such conversations in field notes later but did not have a visual record on my camera to review. The formal interviews involved set times and my camera was on continuously. I would request a pause in conversations when my tape ran out and then
continue. I could do this pretty fast so rarely did this interrupt the rhythm. But people accepted the presence of the camera as if it were part of my body. Indeed, I learnt to do camera work with minimal use of a tripod, often crossing my arms with the camera cradled in them so it was part of my body in one sense. Two, I was never without it or my bag with water and food, so I was more or less associated with these “appendages.” In the course of the interview with Maria, I became aware of her discomfort with photographs which was the first time I heard that from anyone and it was significant. She showed me several photographs of her family but also of herself which were clearly taken recently and in a church (the local Roman Catholic it turned out), rather than in a photo studio like the others. The fathers and sisters [priests and nuns] who come from abroad took the pictures, she told me, and they gave me a copy. Earlier in an formal interview, as I will demonstrate, she had been very critical of the Church, for whom she had worked for many years. She was not comfortable with the photographs as she believed that her images were being used to help bring money to the Church. That was her suspicion, she clarified for me, but she was not sure at all.

I had first heard from another coordinator and her family, that many of the poor people in the village (and elsewhere in the district) believed that their photographs were being taken in order to get money from charitable organizations abroad. People were bothered by the fact that that money was not reaching them since presumably that was what it was being sent for—for the Church to do charity and service. But, the coordinator told me, you should know these are all rumors so I can’t really confirm, but it is a feeling many of us have. I heard from another coordinator that MALAR itself was very
concerned with all the Churches’ extensive land ownership. This included include farms in which bonded labor was being practiced, MALAR women aver. The MALAR women has questioned the Church involved and were told that the allegations were not true, but the coordinator said the people working there were known to MALAR members and therefore they were going to continue to work to end the bonded labor practices and engage further with that Church. Studies like Kalpana Ram’s work *Mukkuvar Women* (an ethnographic account of women in the fishing villages in Kanyakumari) catalogue very well the history of the Roman Catholic Church in the district and I will not go into that history here but look at some local perceptions that I was able to record. I will note all the Churches are very influential in the district since half the population is Christian but also as they own a great deal of land.

From a historical standpoint, there are some circumstances peculiar to Churches in the Indian context that are noteworthy. Most Indian Churches, take what Kalpana Ram calls a ‘accommodationist’ view of the caste system, meaning Christians continue to follow the caste system (*Mukuvvar* 32). In other words, there is a history of discrimination within the Church and the case of Maria who is of the so-called “outcast” groups with her difficult history with the Church would not be an exception. I will note here I guessed which caste category Maria belonged from the way the subtle hints that Maria threw out when she spoke about herself as having nothing and being at the bottom of the pecking order, so to speak. I confirmed with Vimala, the health coordinator. Vimala just said *dalit* and that she did not know which particular local caste group (of the many that fall under the banner of *dalit*). *Dalit* which means ‘oppressed’ is a self-
identified umbrella phrase of people who within the caste system are considered “outcasts.”

On a self-reflexive note, in the whole project, I record the instances where caste as a marker was pointed out to me explicitly rather than enquire of everybody what caste they were. More importantly, I was interested in how the question of caste, when raised, played a constitutive role in questions related to health. But I took a long look at the questions in my fieldwork dairies that said: “Ask participant’s name, place of residence, caste etc” and decided that I would not ask the “caste” question till it felt comfortable for me, if it did not emerge in conversations. In part, this came from my own discomfort with the caste system and my worry that my (so-called) upper-caste status would make people uncomfortable. No one appeared uncomfortable when the question of my caste did come up in conversation. I will admit that my reluctance to pose questions related to caste may have limited my ability to catch some nuances and that indeed I was being reluctant to engage with my social privileges. I enquired about Maria with Vimala since by that point we knew each other well and she was aware that this was an uncomfortable topic for me.

I would not say I “blended” in, in my travels. I did not wear a pottu (a temporary mark, customarily round, using vermilion, made on the forehead between the eyebrows) which would have marked me as a Hindu and it was indeed rare that I was asked what caste I was (though of course people could have also guessed) or religion I belonged to for that matter. I was clearly an urbanite from a big city, as people would ask

53 Interestingly, dalit was also meant as a corrective to Mahatma’s Gandhi’s own reframing of “outcasts” as harijans or “god’s special children.”

54 Bindi in Hindi. It is now widely used as a fashion statement in the West.
whether I was from Chennai or Mumbai. I always wore a salwar kameez, which is a north Indian garb which has become very popular everywhere, which the young women in the district also wore but their styles were completely different from mine. I could have been either Hindu or Christian, but it was my urban-ness that I felt caught the most attention. But I was a researcher-guest of MALAR and that meant people in the villages I spent time in were comfortable talking to me.

Having said this, after my conversation with Maria about photographs, it occurred to me that a person who was visibly non-Indian, a foreigner, in my place may have been distrusted because of the associations of Christian Missionary work with foreign funding and its relation to photographs. I want to note there are several Churches in the area involved in charitable work which MALAR coordinators themselves noted and also commended (and I met some of the Church’s activist-priests in the PHA whose politics I observed are close to that of MALAR’s). These Churches and groups within a Church also offer strong internal critiques, Kalpana Ram has noted (Mukuvvar 43). With regard to institutional religion, the issue I am highlighting is the ambiguous relationship between Christians and the Church itself, which involves constant rumblings about who is benefiting from whom and forms a useful backdrop to my interest in belief in healing.

Family Histories and Belief

In interviewing Vasudha, I discovered one key factor in the process of healing was the temperament of the healer. Her daughter said my mother has kairasi, which refers to the hand as lucky in a literal sense and indicates that she has special skills to
cure people. In Tamil culture, this term is used for anybody- from building contractors to astrologers, so it is not particular to a healer. It highlights the body (the kai, or the hand) as a site that contains the luck and is seen as being inherent (that is, it cannot be acquired). But the notions of healing associated with the hand are recurrent. As noted, home-based healing practices are referred to as kaiviadhiyam (literally healing by hand), which again evokes the hand as a source of power. Interestingly though, the details of the healing practice of Vasudha were accompanied by stories of difficulties and sorrow in her family, unfortunate unlucky circumstances, one could say.

I had met Vasudha at a group near her house and during the discussion where I asked the women there about herbal medicine, she told me about several medicines she made. The group members all told me she was a very good healer and that I should go spend time with her. She agreed to have me visit her for a longer conversation. In the first meeting at her house a few days later, I provided details about my research, met her oldest daughter and then came back a few days later when she said she would have time to conduct the first interview, which is recorded below.

Vasudha and I sat in the front room of her house. Her oldest daughter walked in and out of the room through the course of the interview. The second daughter’s husband joined us a little later. Towards the end of the interview, her second daughter too returned home and sat down with us. Their contributions to the conversation are also included. This conversation was the first of two formal interviews. One or two small sections of the full interview were edited so I do consider these excerpts, but I have attempted to keep

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55 In my family practice, a concept out of Indian food traditions that is valued is the notion of kaimanam, which literally means “the aroma of the hand” and indicates an inherent skill in making tasteful food that goes beyond knowledge and experience of cooking.
the breaks to a minimal amount and to stay with the chronology to demonstrate the interweaving of healing with family history, and how the issues of belief specifically came to the fore.

Shobana: How long have you lived in Manjaalimoodu?

Vasudha: At 17, I got married and from the age of 18 I have lived here [she is in her late sixties now].

Shobana: So you practice *kaivaidhiyam*.

Vasudha: People come here and bring small children, I prepare *basmam* [powders] and *kashaayam* [decoction].

[A pause]

Shobana: What was your husband doing?

Vasudha: Wood business

Shobana: Wood business.

Vasudha: He is not doing well for the past ten months

Shobana: You told me that. You did take him to the hospital? What did they say?

Vasudha: We took him to the hospital, they say that the bone is dislocated at the hip and he cannot walk.

[A pause]

She is listening keenly to my questions and answering them, but I was directing the flow of the discussions. Vasudha’s husband is in an adjoining room. He is resting. She leans over a little while talking to me to check on him and she looks troubled by his state. In the little time I have spent with her, I get this sense that Vasudha feels helpless.
Her family has faced many challenges and there does not seem to be any respite. Given that context, I wondered about the role of herbal medicine and belief in her life in dealing with these dilemmas.

Shobana: Do you prepare herbal medicine for this [her husband’s problems]?
Vasudha: I do
Shobana: Any relief?
Vasudha: There is improvement. There is some relief and it is getting cured but he is not able to walk.
Shobana: So there is some improvement. You have belief in herbal medicine.

I acknowledge the limited effects of herbal medicine. I move quickly to the question of belief, as that had come up in an earlier informal conversation. So I say “you have belief…” as a statement rather than as a question. She nods and responds with details of her practice.

Vasudha: For jaundice I prepare effective [good] medicines and people get cured.
Shobana: With kiizha Nelli (phylanthus urinaria)?

This is an herb popular in the cure of jaundice, which my mother gave me as a child as well.

Vasudha: This is a different medicine, an herbal one.

She indicates the cure involves many fresh herbs. This includes kiizha Nelli (phylanthus urinaria), so she is probably referring to its use in powder form, stressing she uses the fresh version.

Shobana: What herbs?
Vasudha: Apart from *kiizha Nelli* (*phylanthus urinaria*), I add others. Grind *kilanthi pazham* (*thespesia populne*), *pattai* (*cinnamomum tamala/ cinnamon bark*), *jiirakam* (*cuminum cyminum/cumin seed*). Grind them all well and make an oil with them which can be applied over the head. This can be used for internal application also. Ground them into a paste with the rain water and use that.

Shobana: Really? [surprised by the addition of rain water since I have not heard that before. I don’t ask for details about the oil, assuming it is made like other oils are, a process recorded elsewhere in this project] How many days should this be given?

I always ask her for dosage which she offered precisely for most cures though she rarely offered that information up front.

Vasudha: For twelve days, for six times each. The oil should be applied for three months.

Shobana: What are the other things to be observed? [rules of *pathiyam/dietary regimen*]. I asked this question with relation to jaundice because of my own memory of being kept away from various kinds of foods when I had jaundice, though otherwise, I would have waited to be offered that information and perhaps Vasudha would have offered it anyway].

[A little later]

Vasudha: No *manjal* (*curcuma longa/ turmeric*).

Shobana: We should cook without *manjal*. This is for jaundice. What other kinds of healing do you do?

Vasudha: I make oils for ear ache, eye ache and headache.

Shobana: For ear ache, what are the herbal medicines you put in the oil?
Vasudha: There are many medicines. [There is] kaithoni (eclipta alba /trailing eclipta), kiizha Nelli (phylanthus urinaria), koottupa (alternathe sessilis), maruthontRi (lawsonia alba/henna plant), karukappilai (murraya keonigili / curry leaf), kuRuNthotti ver (pavonia zeylanica/country mallow), paRpadakapullu (mollugo cerviana), niillakam (indigofera tinctoria/true indigo), nalla miLaku (piper nigrum/black pepper), chukku (Zingiber officinala/dried ginger), and alam vizhuthu (ficus bengalensis/the bark of the banyan tree). Pound these and squeeze out the juices and grind them and then mix them in one litre of sesame oil and coconut oil each together and mix the paste in the oil and boil it. Towards the end, add a little rice which will puff up [indicating the oil is done]. This has a very good smell.

Shobana: You have to apply on the head.

Vasudha: You have to apply on the head and the hair grows well [as well] when you use this. For ear, eye and head aches, you have to add murunkai kodi (moringa pterygosperma/drumstick).

In seeking to understand use of the local resources, I turn our conversation to sources.

Shobana: Do you prepare every thing at home?

Vasudha: Yes I make every thing at home.

Shobana: The herbs are available all around here.

Vasudha: Some times we buy them also.

Shobana: So you buy from the shop also.

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56 One liter equals .265 Gallon (i.e., One Gallon equals 3.78 litres).
Vasudha: If you give about twenty rupees to someone, they will find the herbs and bring it. Then we buy from the shop also.

Shobana: The heating [of the oils] and the preparation you do at home.

Shobana: Do you give it free or do you charge something?

Vasudha: I give away per bottle.

Shobana: How much is a bottle?

Vasudha: Fifty rupees

Bai (from Chapter Four) and Vasudha are the only two healers I spoke to who indicated that they receive any payment for their medicines. Vasudha, like Bai, traverses the blurred boundary between codified/professional and folk forms of indigenous healing. These details emerge later in this interview—what her training involved and her sense of her role within the larger indigenous healing community. This is important to the question of belief, where belief is part of a lineage.

The heat has been intense in the area for a few weeks now and I realize I could use some oil for my hair as it might cool my body.

Shobana: Do you have any hair oil now? I would like to get some to take home.

Vasudha: Yes I have.

Shobana: Then I will buy from you today.

I shift the conversation to her son because in my first interview she mentioned him more than once and she talked about how he was neglecting her. I sensed a general anxiety about her family from the beginning of the interview and want to provide an opportunity for her to express her thoughts.
Shobana: In Madras\(^{57}\) does your son own a company?

Vasudha: My first son, he has his own company. He has a phone.

Vasudha’s daughter [interrupting]: One day you can go and see him.

Shobana: He does not care about you. Would he acknowledge me [a friend of yours]?

Vasudha’s daughter: He will talk to you. He always flies to America for free [my status is then connected to being American rather as her friend and I am seen more as an advocate of them, one who has social standing]…And the son is studying in London, earning one lakh\(^{58}\) a month and they live in so much comfort in Madras, visits Jayalalitha’s [The then Chief Minister of Tamilnadu] house also.

Vasudha: But in spite of being so comfortable he does not give money to the mother.

I accept as facts what they present me about their family, and acknowledge with them the son appears neglectful of his responsibilities. The details are important as they are establishing markers of class. The core issue, in terms of the emotional flow of these conversations, is the sense of abandonment that Vasudha and her daughters feel.

Vasudha’s daughter: We asked for money, saying that Amma [mother] is unwell and even opened an account in the bank but he did not help.

Shobana: What about the daughter-in-law? She does not do anything?

Vasudha: The daughter-in-law never responds in spite of our phone calls and letters and she always goes with my son to America but she never tells us.

\(^{57}\) Now, Chennai, Tamilnadu, where my parents now live.

\(^{58}\) 100, 000 Dollars
Vasudha’s daughter: If you go in person you can see her after getting the appointment on the phone. You can see a minister [politician] but not her as she is a very busy person [she is being sarcastic].

I was being asked to advocate for them. This is in part rhetorical- they are saying “if you call the son, then you yourself will know what he is like.” Further, they would like some news. Three, they would like assistance from him. Although it appears they are insistent, I did not feel the pressure to follow through, though it did not seem unreasonable to request that I call the son when I was in Chennai next. Incidentally, I called the son’s house when in Chennai two times and was told he was not there and that no one knew when he was getting back. Essentially, I was going to have to keep trying till I found him at home, something I did not get around to on my busy schedule. I understood his family’s frustrations with him.

Vasudha’s second daughter’s husband [who had joined us a few minutes earlier, speaking for the first time]: He works for the Small Scale Industry Special Bureau.

So the oldest son was a government official, a political appointee, which clarifies why he goes abroad, possibly for free, and knows the Chief Minister. The son-in-law leaves shortly. He does not seem interested in the conversation.

Shobana: What products is he making?

Vasudha’s daughter: He making railway engines and spare parts in Guindy. Every one knows about them.

[A pause]

59 Area within city of Chennai
I am not sure what to say about this at this stage. I nod, pause and I return to questions about herbal medicines.

Shobana: For dysentery, what medicine do you make?

Vasudha: If they bring the children with dysentery, then I make the medicine.

Shobana: What do you do for that?

Vasudha: Grind garlic, veppam pattai (azadirachta indica / bark of margosa), karukappilai (murraya keonigili / curry leaf), murunkai ellai (moringa pterygosperma / leaf of drum stick) and murunkai pattai (moringa pterygosperma / bark of drumstick) together.

Shobana: You have to give that. How many times do you have to take that?

Vasudha: Mix an amount with water [meaning a spoonful] and give once.

Shobana: So that is enough. Is it for small children or you can give to adults?

Vasudha: You can give for adults also.

[A little later in the conversation]

Vasudha: This is meant for jaundice, for small children

Vasudha: Take the peruvilai thazhai (feronia elephantum) which stands near our house and grind with garlic, ginger, chukku (zingiber officinala/ dried ginger), perungkayam (feralu asafeotida/ asafetida) and mix with manjal (curcuma longa/ turmeric) water.

Shobana: After mixing with the manjal water if you give once, that is enough?

Vasudha: Give two or three times with water

Shobana: You will get relief.
Vasudha: Then take the leaves of chili, the one that is very big and grind with the turmeric and give that.

Shobana: Is it for tooth ache?

We are now going through one medicine after the other, and I have a hard time connecting the cure with disease, age group or, as it turns out, whether it is meant for human or animals.

Vasudha: No, for the cows if you give this is enough [for general aches].

Shobana: So this is for cows. People around here say they get leg pain [vadham] a lot.

I use the word vadham based on local description. It refers to leg pain, but is described as a “humor” which has to do the balance of air in the body, which is now in imbalance. The theory of disease based on humors found in Siddha and Ayurvedic traditions are expressed in the folk traditions as well. The humors are seen as physiological but reflect and influence larger imbalances in the universe, because they are connected to the ideas of gunas or qualities which are present in all things, as A.K. Ramanujan has noted (in “Food for Thought,” discussed at length in Chapter five). So this is another level in which a “cosmic” sensibility is drawn into the healing processes.

Vasudha: For that [vadham], grind the tender leaf of veppilai (azadirachta indica / neem) and boil in the veppilai oil.

Shobana: Boil with coconut oil?

Vasudha: No, only veppilai oil.

Shobana: Around here, people also seem to suffer from asthma a lot. Do you have any treatment for that?

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60 doshas in Ayurveda and naadigal in Siddha traditions.
Vasudha: For that, if you grind veppilai (azadirachta indica / neem) and give that, that is enough.

Shobana: It will it stop that completely? People seem to suffer a lot here.

Vasudha: You have to show to the doctor in the hospital

Shobana: So with kaivaithiyam you can treat only to certain extent.

Vasudha takes several cues from my framing. We both refer to the medicines she makes as herbal medicines [muulikai marindhu]. But I have just described her practices as kaivaaidhiyam and so now it is now being described as first aid, or as complementary care to other healing modalities.

Vasudha: I give for certain disease [confirming indirectly what I have just said].

Shobana: Mostly what diseases have you observed around here?

Vasudha: Around here, stomach aches, ear ache, asthma and vadham.

Shobana [suddenly feeling very tired]: For fatigue do you have any medicine?

Vasudha: Take lime juice with a little salt

Shobana: Like glucose [powder].

[A little later in the conversation]

Shobana: For woman's problems like excessive bleeding do you have any medicine?

I am listing the problems that I know are recurring problems in the community as articulated by MALAR members.

Vasudha: There is one herb called thiNda nazhi (aristolochia bractiata /Indian birth worth). Grind the herb nicely and mix with the cow's milk and give that.

Shobana: How many times?
Vasudha: For two weeks.

Shobana: Two or Three weeks? [I am fatigued by the heat and I know I have heard wrong so ask again]

Vasudha: You have to give for two weeks [She clarifies].

[I now turn to Vasudha’s daughter]

Shobana: Has your mother done lots of naattuvaidhiyam for you. Do you go to your mother or do you go to the hospital?

I use a third term here, naattuvaidhiyam [indigenous healing] without thinking about it, but I have automatically then set up the question as “do you use biomedicine only or indigenous medicine.”

Vasudha’s daughter: I go the hospital but when I get a headache.

Shobana: For what type of disease you get [medicines] from your mother? Which hospital do you go to, the government hospital?

Vasudha’s daughter: I go to the private hospital only.

[She then goes inside and gets a set of tablets]

Vasudha: What is that?

Vasudha’s daughter: This is a medicine for my asthma. Herbal medicine was not effective. It stops only when I take this.

Shobana: It stops immediately. Do you have any thing to prevent that before the attack?

Vasudha’s daughter: If I use this, that is enough. But if you go to the bigger folk healers, you can get treatment for preventive care…My neighbor's daughter did that. I am looking into it.
Shobana: An Ayurvedic healer?

Vasudha’s daughter: A Siddha healer. You get a powder and you have to make ]

kashaayam [decoction] and drink it.

Although I asked the people about which kind of healing modalities they picked for different diseases, I see them as records of what treatments were perceived to be useful overall. The actual “order of resort” as Bonnie O’ Connor has noted, is highly changeable (27). This emerges slowly in the conversations, as above. The daughter is switching back and forth between various kinds of treatments, although she may be using biomedicine primarily. This is a recurring pattern of use for many people I talked to. The idea of “first aid” implies that people are attempting to make their own medicines. It could be used as the first option but really it could be included at any point in the treatment.

I know I wanted to buy something that would help with the heat. I have nambikkai that in using herbal oils on my hair my body cools down, having had the experience of it since I was a child. The key is to place a significant amount of the oil on the crown of the head. The effect of the cooling is best reflected in the eyes which burns less and I have the heavy feeling in my eyes from the feeling the oils from the hair have sunk into the eyes. My feet and palms also burn less when combined with body oils and because both applications involve at least a basic massage, either a self-massage or one administered by a family member, I have a sense of well being. Vasudha lists several oils for the hair. I then move the conversation to her clients and her history as a healer. 

[ A little later in the conversation]
Vasudha’s daughter: People come here. Because they don’t get good sleep they come here to apply some oil.

Shobana: Where did you learn healing?

Vasudha: My father’s brother taught me.

Shobana: He was practicing at home and at young age you saw that and learnt from him. He taught you everything?

Vasudha: He told about the medicines and I prepared the medicine by squeezing, powdering. I learnt this way.

She is articulating that she learnt through experience, displaying independence.

Shobana: You tried all this on your own.

Vasudha: I started after marriage

Shobana: When you started this, who was coming for treatment?

Vasudha: For medicine people come from Arumanai [larger town close by, that is people from further away are also coming].

Shobana: From Arumanai, people are coming. People say that faith is very important. What do you think about that? [ It seemed a good time to broach this topic since she is indicating when people find relief in certain treatments, they will journey to find the resources]

Vasudha: They have absolute faith, the people who come from Arumanai in the medicine I make.

Shobana: They have the experience of whether the medicine works alright or not [ I am offering this as a explanation, essentially as a note to myself as I don’t follow up with
her]. You said that the other day you recite a *mantram*[^61] [formal prayer] when you grind the medicine.

This is something she mentioned in our first conversation so I decide to ask for more details.

Vasudha: When we pluck the herb, I tell the *mantram*, and the after grinding and mixing when we keep it on boil I tell the *mantram*.

Shobana: You say that to yourself. Not aloud?

Vasudha: I have not said to others.

Shobana: You should not tell others? Who taught you this? What type of *mantram* is it?

Vasudha: We say one pertaining to the *guru*[^62].

Shobana: It is like worshipping a god [indicating it is like a temple ritual]?

Vasudha: Agasthya *guru*. [legendary sage from whom Ayurveda and Siddha is said to have come]…When you take the medicine you should pray to the *guru* with devotion[^63] and also when we prepare the medicine.

Shobana: You give the medicine only after worshipping. Then there will be cure.

Vasudha: When they bring the children, you should give the medicine reciting the *mantram*

Shobana: Is it so? When you give the medicine?

[^61]: *Mantra* in other Indian languages, a word which has entered everyday language in the English speaking world.

[^62]: Sage/ teacher.

[^63]: *Bhakti* is used generally to mean devotion. The Bhakti movements or traditions involve many saints with great following. Essentially is based on paths to divinity/god through devotion.
These sections form the crux of Vasudha’s unique belief practices. She uses *mantram*[s] that is part of her family’s method of healing in her work which comes with very specific instructions about when they should be recited. Based on informal conversations, where I pursued these issues more, Vasudha told me that the *mantrams* would not work if she revealed it to anybody which is why they have to be kept a secret. One can presume her family members could be told if they had an interest in healing. She stressed to me that the person doing the healing should be of good temperament, so in the family a person who is sincere about the healing only would likely be told the mantra.

There is belief in the *mantrams* themselves as aiding the cure. But its power lies in its non-vocalized recitation (except when Vasudha learnt it from her family members).

Further, it is associated with a talisman in some cases of curing children.

Vasudha: When they [children] are sick I say the *mantram* with a thread and then tie it on the hand.

Shobana: Is that so? What type of thread?

Vasudha: A black thread

Kalpana Ram, in her work in the fishing villages, has noted among the Mukuvvar community the use of a talisman and icons including a “mental cylinder, with a special mantra (in this case a Christian mantra) inscribed on it” ([Mukuvvar Women](#) 56). She comments: “It is worn tied around the waist and derives it full efficacy not merely from the prayer, but from actually being worn on the body to ward off evil spirits” ([Mukuvvar Women](#) 56). So in the use of talismans, the body is a site where an interaction with the divine takes place.
[A little later]

Shobana: How do you know that is what you should do? Do you check the pulse?

This is part of the diagnostic procedures that professional healers in the indigenous healing network in the area mentioned to me [and it is systemized in the texts of the codified practices]. Vimala, the health coordinator, says she took workshops where this was taught but she does not know fully how to do this and does not teach this in the groups. Vasudha has a lot of experience, having learnt her practice from professional healers in her family. I want to know more about the range of her skills and also how they are connected to belief.

Vasudha: When I see the pulse, I will find out the type of disease.

Vasudha’s daughter: You can find out from the sound of the pulse

Vasudha [who does not provide any further details on this and continues with accounts of where she says a mantra with the cure, but it is to be assumed that listening to the sound of the pulse is her method]: When I give the basmam (powder), I worship and pray to god and then give.

Shobana: They [patients] become all right. So they have belief [nambikkai] in that.

Vasudha: They have.

Shobana: So that is very important.

In other words, the belief of both healer and patient is important. At this point, a neighbor comes in for a few minutes and Vasudha mentions she cured the women of jaundice. When we resume talking by ourselves with her daughter listening, I ask her about MALAR and whether she has benefited from the loans. Yes, she said. I took a loan
out for my daughters but also to make more medicines but then my husband fell ill and I used that loan for treating him. Again, she mentions how he cannot walk and that is difficult. She thoughts again return to her oldest son. Her daughter asks: How far Guindy [where the son lives in Chennai] is from Mylapore [where I live in Chennai]? You must tell him what is happening here and ask him whether you can come to see his company. Vasudha adds: Tell him you have the photo of his mother and tell him that I am unwell. It is interesting that my camera could come to be used in this way. I say: I will try to call. Vasudha is now very quiet. So I ask her daughter about her life. She reveals that her husband had a mistress who he brought home when she became pregnant. Her children and her were starved, “treated like dogs” so she came to live with her mother after first trying to tolerate the situation for a year. She then went to Muscat [in the Middle East, a popular destination for workers especially from the state of Kerala, which borders Kanyakumari], and worked as a English tutor for a wealthy Arab family, which involved getting young children familiar with alphabets and basic words. From there she went to Kuwait [again in the Middle East], doing similar work, but returned home after a year and a half when her father fell ill. The pay supported her children but it was not exceptional. She was reluctant to go again but felt she had no choice. I don’t have any other way to make a living, she said. She remembers again the only sibling she has who has financial security. He [the rich brother in Chennai] could give my son a job, she says. Vasudha joins our conversation again.
Vasudha: My son has eight cars. And many companies. Once he sold iron scrap which got him a lot of money which can support ten families like us. But he does not care about and his wife never allows us there.

Vasudha’s daughter: We have to go and talk in person. The problem is he does not understand the problems of the house, since we go neatly dressed when we go out.

Shobana: Yes, I know. Most people have two or three sarees. When they go out, they dress in the best clothes…There are many problems that come from poverty around here. When you talk about health here what are the problems that you see? You are a healer. What do you see, what is happening around here?

I understand the problems about the son to be about a sense of abandonment but also relates to poverty as a source of illness, grief at the very least. Talking to people in the village, I heard self-descriptions of being poor often. Kalpana Ram makes a similar observation about the Mukkuvars. She notes that the Mukkuvars’s common self-description is as “a place of suffering (‘Idu paavankal udiya uuru’),” She notes: “The suffering is that of sinners- paavam in Tamil refers simultaneously to the objects of pity, and to sin itself.” I often heard a phrase with the same meaning in conversations I was observing: paavam patta makkal (people who have suffered/people touched by paavam).

In everyday language, descriptions of poverty is imbued with language that comes from religion, both Christian (in ideas such as the Original sin and redemption from sin through faith in God) and Hindu (especially in its idea of re-birth, where to be born poor or lower-care or generally to be unfortunate are results of sins committed in past births). In that sense, social identity and the question of belief are intricately linked and I would
argue that belief underlies many negotiations and is not contained in certain practices alone. I asked Vasudha earlier in the conversation what diseases are common in the area and get an answer about specific diseases. Now I have asked a general question about health, just after we have finished talking about financial stress and social injustices. Vasudha answers my question thus: [There are] many problems. Particularly drinking. People starve at home and men [drink] and create problems in the house.

I notice the son-in-law, the husband of the second daughter in the next room. I direct my next question at him,

Shobana: What do you say to that? Women say there are lots of problem due to men drinking?

Vasudha’s son-in-law: Men drink brandy arrack for fatigue

Shobana: They say that the Siddha healer [in the village] is selling arishtam like liquor.

Vasudha’s son-in-law: It is called madhukashaayam…They mix herbs [with other things]. Since it gives drowsiness they drink that and go to sleep. And go for work in morning.

Shobana: They [the women] say that there are too many problems because of that…The other day I saw police catching people.

Vasudha’s son-in-law: In this area only there are some problems because that person [Siddha healer] sells it here. But they [the healer and his family] prepare Siddha medicines so when they [the police] come to conduct tests they escape…In rural areas people work hard. They go to work at six in the morning and come back at six in the evening. In the evening, for fatigue, they feel the need to drink heavily and come back
home and eat and take rest, to cure the body pain. And again they go for work in the morning. They take cheap brandy and madhukashaayam.

Through the corner of my eye, I see Vasudha’s daughter shaking her head unconvinced by his arguments. On another occasion, the second daughter told me her husband was drunk too, so this was really a habitual drunk’s justification. His eyes were bloodshot and I guessed that in this interview too. I tried engage him in future discussion.

Shobana: But you lose money.

Vasudha’s son-in-law: The rate is very low. For 500 ml (milliliter) you have to pay 15 rupees. Brandy costs 50 to 60 rupees.

Shobana: Yes, but when you try to put money into savings [in MALAR] you can do only ten rupees. Even that is difficult.

Vasudha’s son-in-law: Men are not able to save much due to drinking. They spend half money there. The rest the use for the house and for the hotel expenses when they go for work.

Shobana: They say that they are beating the women.

Vasudha’s son-in-law: Mostly men and women go for work.

I am not sure what he means. I think his suggestion is women work too and so have the money to feed the family, which, in fact, is what typically happens.

Vasudha’s daughter: Apart from beating they abuse verbally also.

Shobana [looking at the son-in-law]: What do you say to that?

Vasudha’s son-in-law: Those who drink do that.

Shobana: They do that. It is difficult. Women also work hard but they don’t drink.
The son-in-law falls silent. He admits to the problems but seems to think there is no solution. Vasudha and I then talk about MALAR. She tells me she is in Kavita’s group and talks about the conversations about herbal medicine in the group. She says she is familiar with most of the medicines. She says she does not bring up her own knowledge very much in the group. She sees them as classes, in which she either has something to learn and to incorporate in her own practice or not, rather than dialogues where people share information. I will add here this is not true for all healers. Savita, discussed in Chapter five, shares her knowledge in the MALAR meetings. Vasudha notes that she herself learnt healing from her uncle who was a professional healer, a fact we have discussed before. I am trying to teach that grandchild, she says. I notice a small girl of about ten in the other room. The girl says: I had written that [the medicines] in a book but my brother sold off the books by the kilogram [to make quick money]. It seems to me the legacies of the healing will continue, despite this hiccup, since the girl seems keen. Vasudha then clarifies that what is done at home and by professional healers is not different.

Vasudha: Those healers make on a big scale and store it. But in our practice, we prepare the medicines fresh by making an assessment of what is needed [for the patient]. We [only] store the oils for head ache, ear ache, and eye ache.

Shobana: Other than that, you make every thing fresh based on your assessment of what is needed.

Vasudha: The [professional] healers make spending lots of money and make large amounts. We make little by little with less money.
So *kaivaidhiyam* for her is related to frugal use of resources that operates on an as-needs-basis. We are reaching the end of this conversation and I buy hair oil. The second daughter is now present and she adds one more angle, in fact another aspect to belief.

She says: My mother has a lucky hand [has *kairasi*].

Vasudha adds: *Kairasi* is important. What ever you give you should first dedicate it to God and then give.

I wondered though if Vasudha was not also telling me that for her broken heart, they are no solutions except that her son may acknowledge her and support her. The interviews became an occasion for venting out frustrations and for many sides to speak their point of view in the family, except of course the son in Chennai, the subject of a good part of the conversation.

**Breakthrough through belief**

In Dell Hymes’ view, performance involves “the authoritative assumption of responsibility for presentation” where practitioner is not only knowledgeable and able to provide information but in performance demonstrates what the values and meaning of the traditions are. In performance we get records of the histories of peoples etc, but the significant issue is that it is about people demonstrating how and why their traditions are important for them (Hymes 82). In interviews could emerge the reports about traditions
but it also a demonstration of traditional forms of communications (Hymes 83). I will look here at Maria’s interview with me, which shifted from being a conversations between us based on my questions to a “breakthrough” into an authoritative performance of the kind that Hymes describes, into a mode of prayer or direct conversation with God. This “breakthrough into performance” which involves “style-switching” (from reporting information to prayer) reflected on “the situation of its telling,” that is, our interview (Hymes 130). I will demonstrate how my questions about food preparation and schedule set up the occasion for Maria to take up the question of poverty and connect it to belief, in an eloquent way.

Like Vasudha, Maria’s descriptions of medicines are also interlaced with stories about her life. She spoke about being driven out of her house by her mother when she was young. Her husband died young and she supported four children on her own. She worked for close to thirty years as a maid and nurse at the local Roman Catholic Church, who she feels did not pay her adequately but more importantly asked her to leave when she grew old offering little financial help. She herself has tried to be very fair, she notes. During her mother’s prolonged illness before her death, she worked to support the family but also paid her own sister to take care of the mother. Her knowledge of herbal medicine is extensive which I will not record in detail here. My interest in presenting her work here is to draw attention to the contexts in which issues of belief were articulated and to draw out highlights in the interview that helped to build up to the moments where belief is expressed as a foundational principle in her life. In addition to being a midwife, she

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64 Used here in the sense of a customary practice that has been practiced over time which in the case of Dell Hymes’s work meant performances unique to Chinook communities, acknowledged as a expressions vital to their cultural identity.
practices herbal medicines at home as well as in nursing others. As a herb collector for professional herb shops and healers, she is also a crucial link in the local economic base of herbal medicine. Her work with the Roman Catholic Church was the longest tenure. Below is an example of her work with the Church.

Maria: For the Convent [Church] sister I cured her of leg pain. One sister did not get cured at all using hospital injection.

Shoabana: She did not get cured.

Maria: I boiled the pattai in water and gave her. She got completely cured.

Shobana: What is this for?

Maria: This is for water in the leg [sic]. It is called neer [refers to leg pain caused by water retention]. That sister had severe accumulation of water in the leg. I gave this medicines and she got cured…I gave this medicine for twenty days and also ground up the kodangkai elai (sesbania aegyptiaca) and mixed with water and gave that. And then after another ten days again I gave this in hot water and she got cured.

Shobana: You made this yourself.

Maria: That is best tonic. They have belief [nambikkai] in that.

The nuns she has treated have belief in the cure, though through the course of the interview, she would stress how she did everything herself and notes they were her cures, so it is probably the case the nuns had belief also in her ability to cure them. She is also establishing the amount of work her has put into the Church, an issue that gains importance as the interview progresses.
When our conversation shifts to drinking problems in the community, we start to talk about the strain it puts on the women. This begins our conversation about food. Since food and medicine are intricately related, I ask her about her consumption for the week and method of preparation. My purpose was to get records of actual practices where the interrelationship between food and medicine would be established.

Shobana: When we speak of medicines, we use in the cooking ginger, *omam* (*carum kopticum/the bishops weed*), *jiirakam* (*cuminum cyminum/cumin seed*), which have medicinal value though we don’t say it is medicine

Maria: We add them in cooking fish…Will you take rice [lunch] here?

Shobana: No, I am carrying food…Could you give me an idea of what you have cooked in the last few days. Mornings, what do you eat?

Maria: I take a cup of tea in the morning.

Shobana: You take tea, in the morning daily.

Maria: Morning one cup of tea and at ten [AM], I take cold rice porridge.

Shobana: Porridge.

Maria: I drink porridge.

Shobana: How do you make that?

Maria: It is yesterday’s rice soaked in water.

Shobana: Water with the rice.

Maria: Then for the afternoon, I bought tapioca and then I will make *koottu*.65

Shobana: How to you make *koottu*?

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65 Gravy vegetable/meat side dish.
Maria: Like *aviyal*. Then, I will make fish *kari*. If there is nothing, I just manage.

Shobana: You brought fish today? And for how much for today?

Maria: For two rupees.

Shobana: For two rupees.

Maria: Some times for five rupees.

Shobana: How do you cook it?

Maria: We make *kari*.

Shobana: What *kari*. With coconut and other spices?

Maria: We put little coconut then *malli* (*coriandrum sativam/coriander seed*), *menthiyam* (*uluva/trigonella foanum gracum/fenugreek*) and *omam* (*carum kopticum/the bishops weed*), *miLaku* (*piper nigrum/black pepper*) which we have to fry and grind and mix with the fish.

Shobana: That is for the afternoon. To prepare fish. If it is *aviyal*…

Maria: For *aviyal* we grind coconut, *miLaku* (*piper nigrum/black pepper*) and garlic.

Shobana: Garlic? [which my own family does not use in *aviyal* so I ask]. You use *karukappilai* (*murraya keonigili/curry leaf*) also [which my family recipe calls for]?

Maria: Yes.

Shobana: Boil the vegetables in water and mix the ground up spices [confirming the rest of the recipe].

Maria: Mix well like in *kari*.

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66 A vegetable side dish with coconut gravy base. *Kuttu* is a generic word for a gravy side dish where *aviyal* is a specific version of it.

67 Fried fish. *Kari* is any side dish that is sautéed in oil, and is usually dry.
In this fashion, Maria and I discuss her regimen. But it becomes obvious that the items mentioned so far are available only on good days. In the absence of the above, she cooks dishes like *rasam* [or *racam*], with spices like *milaku* (*piper nigrum*/black pepper) and *perungkayam* (*ferula asafoetida*/asafetida), which has curative properties. But when that is not available, rice porridge is the only option. Three meals are desirable to her but it becomes evident that sometimes she did not even have one meal.

Maria says finally: Some times I drink water only.

In these circumstances, she notes, it is her *nambikkai* that keeps her going. As we started to get to the intricacies of her diet, the issue of poverty becomes the overwhelming issue in front of us and she begins to outline how she came to this state.

Maria: I cried to God to give me a house then I got a small land with God’s blessing from an Father [priest] from Kunthankuzhi [a town in the district] who gave me six hundred rupees to build the house and the compound wall [fence]. Then I earned same money and put in a savings account. Then I built a house for two thousand six hundred rupees. My two sons say that I have lots of money in hand and I have kept it with my daughters. To whom I have given! [suggesting she has not]. I have to live my life, I have to take a cup of tea and [I need some money for] oil for my hair, clothes, my for needs. How do they know about it! They say I have lots of money.

S hobana: They say that.

Maria: I am sixty-six years old. What money will I have! I don’t go out to work [too much anymore]. Once I fell down in the market. I pray to God to protect my life and
show me the right path. The issue is this. They say I have lot of money. But God only knows. What can I say!

With the words “the issue is this,” Maria becomes more charged, seeking to set straight a record, and placing all her choices in context of her struggles and in that God in her witness.

Shobana: For your food itself it is difficult. They don’t understand [ I paraphrase her words].

Maria: It is difficult for a person. Even if one does not eat food three times at least one time we have to eat food. We can not live without taking food once[ Pause]. If you fall sick, who will take care of you! You have to take care of yourself, for everything and for food also. There is no use expecting anything from the children.

God knows everything about her, however, and so she takes her requests to him. After all, her prayers have been answered before.

She continues: I tell my difficulty to God and ask him what he is going to do for me. I tell him that I brought up four children. But now I don’t get anything. So I ask God what he is going to do for me. I pray to him that I should not fall sick and be bedridden. This is my only goal. I tell him that I have not forgotten and him and mother [Virgin Mary]. And he knows everything. I have lived my life with difficulty and worked for the fathers and sisters for thirty five years. For that service for which I got nothing I request you to give me liberation [moksham]. I work for liberation which is my only aim. To get the liberation of the soul only, for that I pray. I am not after money. My inclination is towards the liberation of the soul.
She makes a key distinction in wanting money for survival rather than it be a goal. She moves from seeking requests to noting a foundational orientation within her towards liberation where the soul will be united with the divine.

As she speaks of her experiences, she became more emotional and “breaks into performance” recounting her personal prayers, speaking of how she beseeches God.

Maria: Like Christ who was nailed they also nailed me here. But God will show me the way.

A few seconds later, she is on her knees, spreading out her hands above her and speaks again.

Maria: Father [referring to Christ] has told me the help I have given will always be remembered.

She has spoken to God and he has replied. She stays in that place for a while and then she returns to her seat. The emotional charge in her voice remains however.

Maria: It is like this, I have done a lot of work with this hand. You see how my hand and legs are worn out [she holds out her hands]. And you see my head also [she bends to reveal the balding patches on her head]. They reduced me to this poor figure. I live on porridge only.

She slowly wipes the tears that have welled up. I am very quiet the whole time, nodding slightly, suggesting I understand what she is saying. I know my camera was on, but I felt drawn into the performance and I maintained eye contact with her the whole time, not checking my camera at any point (although I was relieved that when I reviewed my tape later her performance had been recorded).
She then talks about how her sons have abandoned her. She mourns her plight as an aging single woman, thanking her good luck that with donations from a priest [from another Church, mentioned earlier in the interview] and other loans, she managed to build a home and raise her children. So it is clear that she is not condemning the Church as an institution in general terms as she acknowledges their help. Her frustration is directed at the local [Roman Catholic] church of the village and also particular behaviors of nuns and priests there. She now lives alternatively between her two daughters’ households as her older son was physically violent with her. When you are aged, only daughters protect, she says. She returns to her faith as an interpretative framework again, and again “breaks into performance,” stressing that she is speaking to God/Christ himself: I tell my difficulty to God and ask him what he is going to do for me.

After a pause, she says: I ask him what he is going to do for me. I have been nailed like Christ and I suffered like Christ. I have faith that Christ will hear me and give me liberation.

**Context specific and Context Free**

Kalpana Ram writes about lay and popular forms of Christianity in the district where the fisherwomen have appropriated and reinterpreted religious symbols to address their own experiences. She notes the Roman Catholic church encourages the popular rituals of Virgin Mary worship but the relationship between lay and popular forms of Christianity and the Roman Catholic Church is certainly a site of struggle (*Mukuvvar Women 45-75*). Maria’s narrative also points to contesting notions of Christianity—hers
and the local church’s who she feels exploited her, as it does social hierarchies between healers, since the local church is also a clinic and in fact the first promoter of herbal medicines for women in the area.

As noted earlier, some coordinators in MALAR are uncomfortable with the idea of religion as it represents to them “blind faith” or “superstition” to describe them. Speaking specifically about midwives, Kalpana Ram notes that the same expressions are used. She argues it has to do with the place of folk healing in general, of which midwife practices are a part, and also it has to do with the hierarchies within the indigenous healing systems themselves. She adds important nuances related to class and gender within the indigenous healing. She notes:

Unlike the relatively articulate counterdiscourses of Siddha Medicine, which is organized through male lineage and textualized palm-leaf manuscripts, the world of the rural midwives is shadowy. It is a measure of the additional powerlessness of being female as well as low caste that their knowledge is not only situated much lower in the indigenous medical hierarchy than the male practitioners of Siddha medicine, but they lack the formalized modes of transmission that are characteristic of the Siddha tradition. Instead, the knowledge of the midwife is a form of learning on the job (“Modernity” 72).

Speaking of local perceptions about these practices, she notes in her fieldwork ‘with several non-governmental organizations, as well as nuns in convent hospitals and medically trained personnel’ that while they were very interested in herbal medicine, they regarded the practices of the midwives as “superstition” (“Modernity” 76). In my viewpoint, the idea of “blind faith” and “superstition” is a line of argument that echoes some standard left-leanings groups’ perspectives on religion in general. Although MALAR does not have any explicit political leanings and the mobilization of diverse groups around the PHA prove grassroots and national level non-governmental
campaigns invigorate groups across the political spectrum under the same banner, several of MALAR’s organizational associations are left-leaning and this is reflected in many of its ideals. Kalpana Ram argues these views relate to class and the history of colonization. She notes:

While this may sound like a consistent secular rationalist opposition between science and religion, in reality the opposition is broken up by finely graded distinctions based on class and colonial practices. Christianity and biomedicine, although the sites of many conflicts on European history, formed a single integral mission in the colonies…this legacy continues to be used in order to define the rituals and beliefs of rural midwives and villagers in general, as superstition (“Modernity” 76).

She elaborates:

There are few middle-class or professional people in India who would not engage in practices such as attending temples, undertaking religious vows when a family member is sick and dying, or in situations such as childlessness. The labeling of particular religious practices as ‘superstition’ must therefore be understood as part of the ongoing practices of class distinctions (“Modernity” 76).

I would say that is a basis in the argument that religion may used to divide people and that it may also be used as a diversionary tactic by people engaging in politics (which is a viewpoint MALAR as a organization subscribe to). I would argue the resultant wariness about religion is “consistent secular rationalist opposition” (Ram, “Modernity” 76) I concur with Ram, though, that it is the case these characterizations quickly slip into cultural evolutionary perspectives, remnant of the Colonial era, and are markers of class. It is interesting that Maria is also a mid-wife, but MALAR encourages these practices and women healers in general but are just wary of particular rituals within that repertoire, so MALAR’s perspectives adds more nuance to this situation. It is also interestingly that the nuns in the local Church Maria has worked in have belief in her work, as she herself
notes. But the class issues are very much in evidence as they don’t recognize her work in economic terms and reward it adequately, though they may not see it as backward.

In my reading, Maria addresses her social situation and is “authoritative” (following Hymes) about her belief as a site for empowerment—for one, it energizes her to keep moving on. This happens through her prayers (in performance) themselves and also in the promise of salvation and belief in Christ’s blessings. A. K. Ramanujan’s exposition on context-sensitive and context-free thinking in his essay “Is there an Indian Way of Thinking” is also useful for me here. He says about context-sensitive thinking:

Various taxonomies, gunas or qualities (and their material basis), tastes, characters, emotions...are basic to the thought-work of Hindu medicine and poetry, cooking and religion, erotics and magic. Each jati or class defines a context, a structure of relevance, a rule of permissible combinations, a frame of reference, a meta-communication of what is and can be done (53).

Further:

All societies have context-sensitive behavior and rule: but the dominant ideal may not be the ‘context-sensitive’ but the ‘context-free.’ Egalitarian democratic ideals, Protestant Christianity, espouse both the universal and the unique, insist that any member is equal to like any other in the group. Whatever his context—birth, class, gender, age, place, rank etc.—a man is a man for all that (54).

Crucially, he notes:

Yet societies have underbellies. In predominantly ‘context-free’ societies, the counter-movements tend to be towards the context-sensitive: situation ethics, Wittgensteinian notions of meaning and colour (against class logic), the various relativisms including our own search for ‘native categories’ in anthropology, holistic movements in medicine (naturopaths who prescribe individually tailored regimens) are good examples. In ‘traditional’ cultures like India, where context-sensitivity rules and binds, the dream is to be free of context (54).

He notes that in the Indian context, the “last of the great Hindu anti-contextual notions, bhakti, is different from the above: it denies the very need for context” (54).
elaborates: “Bhakti defies all contextual structures: every pigeonhole of caste, ritual, gender, appropriate clothing and custom, stage of life, the whole system of home hierarchicus (‘everything in its place’) is the target of its irony” (54).

This is not to divide the world into pre-modern and the modern states and glorify either one. On the contrary, Ramanujan is highlighting the notions of context-sensitive and context-free as desires or imperatives not givens. He notes India has both the imperatives of context-free and context-sensitive in operation:

One might see modernization in India as a movement from the context-sensitive to the context-free in all realms: an erosion of contexts, at least in principle. Gandhi’s watch (with its uniform autonomous time, governing his punctuality) replaced the almanac. Yet Gandhi quoted Emerson, that consistency was the hobgoblin of foolish minds. Print replaced palm-leaf manuscripts, making possible an open and egalitarian access to knowledge irrespective of caste. The Indian constitution made contexts of birth, region, sex and creed irrelevant …though the battle is joined again and again (56).

He concludes:

Cultural borrowings from India to the West, or vice versa, also show interesting accommodations to the prevailing system…the individual esoteric skills of meditation are freed from their contexts into a streamlined widely accessible technique (56).

Given all this, Ramanujan notes: “yet in each of these kinds of cultures, despite all the complexity and oscillation, there is a definite bias” (57). In India, the bias is toward the context-sensitive, though in the same environment, there is space for the “anti-contextual” bhakti movements (Ramanujan, “Is There” 54). In the tradition of bhakti movements, I see Maria’s devotion and direct addresses to God, as a desire to escape all contexts that in A. K. Ramanujan’s words “rules and binds”(58). Kalpana Ram has noted there is a long history in Tamilnadu of bhakti expressions, which are usually non-
Brahminical traditions, that is, not based on scriptural practice mediated by priests. She notes:

The hallmark of this worship is ecstatic-mystic cults, often involving possession; a markedly sensual use of incense and flowers in worship, and an emphasis on direct unmediated relationship with the divine. The bhakti cults in Tamil Nadu began early. Krishna devotionalism reaches its peak in the seventh centuries onwards with the Alwar poets (Hardy 1983). Workship of Shiva associated with the Nayanar poets going up to the twelfth century (Mukuvvar Women 69).

Citing various studies, she notes:

In Camkam literature [corpus of poetry written in the period roughly between 1 and 6AD], some key features of Vaisnavite devotionalism include: an absence of a clear awareness of transcendence, which allows for the visualization of the divine within the confines of earthly reality, the sensual character of workship, the ecstasy of emotions in which the divine is felt to be present, and lastly presence of the exclusively female cults (Mukuvvar Women 69).

While in her practice of bhakti, Maria maintains an altar in her daughter’s house bedecked with flowers and is in that sense involves sensual practices, Maria’s performance particularly in how it engages especially with God as present in physical form in “earthly reality,” with whom she has a direct experience and to whom she expresses herself in emotional ways (Ram, Mukuvvar 69).

**Belief in times of Defective Modernization.**

There is another aspect to belief which touches questions of disappointments in life. Maria (like other community members, mentioned in Chapter Five) attributes the decrease in belief in herbal medicine since her time to chemical based farming. She makes four important points: there are less herbs available due to rubber plants [she has

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68 Workship of Hindu God, Vishnu
to go to the mountain side to get large amounts], they are less effective because of the chemicals, people don’t have as much as energy they used to have because the food they eat is essentially poison, and finally, as a result of this, they do not respond to herbal medicine and have to use “English” medicine only.

She associates agricultural practices with “English” medicine, in which she has very little belief. In fact, she is convinced that injections and more specifically vaccinations make people weak. It is just a theory of mine, she says, but I think there is something to it. Mark Nichter outlines how indigenous medicine comes to be constructed a remedy for “defective modernization,” looking at four cases where the Ayurvedic physician links indigestion to the “ills of capitalist extraction: overproduction of the soil at the cost of sustainable agriculture…and over reliance on short term fixes which mask problems of modernity” (“Political Ecology” 102). These are some of the themes that Maria notes as well, though she does not suggest that herbal medicine could cure these ills; rather, she laments that its value is being lost. What she does, however is the following, which is attributing diseases of the past only to the devil, connecting “defective modernization” with loss of belief also [which causes diseases to spread]. In a comment about medicines for pregnant women, she notes:

Pregnant women do not know about the medicines and the implications of preventive injections [referring to vaccinations]. Instead they should take one full coconut with water at seventh month and ninth month. And they should also take the juice of uzingcai (cardiospermum balicacabum/balloon vine). Those days diseases were treated like that. Now they put only injection if you get any disease. Those days some children did not have anything. Some survived and some died. Even pregnant women died and some survived. Those days there were Devils. I delivered four children. We should have faith in God. Total faith. If you have that you won’t die. The preventive injection is not good. It is bad for the children. Instead if mother takes coconut, uzingcai …it is good. Thirty-five years back this
was the medicine for us. The death was due to Devils and its anger was pacified to
prevent death, in all the villages by giving chicken [as offering to God] but if you
totally believe in Christ, the Devils won’t attack.

When I interviewed Uma whose practices I have described in detail in Chapter Five
and briefly in Chapter Two, she highlighted for me the importance of believing in a cure,
which she meant to mean herbal medicine.

Shobana: Do you feel that nambikkai is important ?

Uma: Nambikkai is very important . We should have nambikkai that we will be cured by
taking the medicines. If you say that it [herbal medicine] is an outdated tradition and take
it you won’t get cured. So nambikkai is very important.

This relates to intentionality of the person using a herbal cure as crucial to the
process of healing as I have suggested earlier, but also she says specifically that calling
something outdated does not help the cause.

Shobana: In the MALAR class too they tell you this?

Uma: Yes, in the class also they us taught this. Whatever it is that we take even if it is this
soil, if you take it with total nambikkai then there will be healing.

Given perspectives about the destruction of the land due to chemical agriculture,
it is ironic Uma should say if you have belief you can eat even soil and it will cure you.
CHAPTER 7

CONCLUSIONS

MALAR’s women are negotiating many challenges with relationship to gender roles and the opportunities open to women. Their communities at large are facing serious kinds of challenges with relation to health, whether it is from the scaling back of government health care or from economic vulnerability. As a movement emerging from the grassroots which is slowly building its own leadership and training models, it represents “lay” negotiations of these challenges, that are systematic and growing strongly. The negotiations are articulated in terms of rights-based perspective to health. These involve engaging with current attitudes towards health, involving persuasion on an everyday basis, repeatedly, one performance at a time. Connected to this idea of repetition is that these negotiations are also strategies to build communities of practice that will help to take forward these agendas of health.

I argue that these attempts at forging new directions in health intersect with other ongoing, dynamic attitudes and practices of health. MALAR seeks to build on those networks and practices while also revisiting many of them. The fact that these differently organized practices intersect sometimes seamlessly is particularly remarkable. The
MALAR women each engage with both the opportunities of the movement but also incorporate a variety of other experiences and agendas in their responses, whether it is in getting more recognition within the government health care or growing their own gardens. The underlying principles and the range of practices are themselves sophisticated, integrating a wide variety of information about biomedicine, indigenous medicine and interconnected social justice issues, but also the practitioners do so by using complex organizational methods.

The practitioners within the MALAR network exemplify what Lock and Nichter have noted about practitioners of folk medicine which is they “base their diagnosis and treatment on both abstract principles as well as embodied knowledge and guided sensibility and ad hoc experimentation as well as formulations found in texts” (6). The analytical framework of an agent centered view allows us to see the sophistication of these negotiations as well the co-present nature of all the health systems in play here. Further, the intricacies of the politics of culture in the way in they are always “larger-than-local” are demonstrated, where MALAR movement is a kind of filter one could say between local and global, outside and inside, traditional and modern (Shuman 354). But “lay” practitioners’ views, especially with relationship to belief, interrogate the limits of the resources offered by the universalizing principles of social justice and customs where each person has particular assigned roles—so that it is not enough that both those forces speak to each other more in a way that might empower women more, useful as that is, but also the strategies must contend with a sense of identity connected to a larger “cosmic” sensibility that seeks to escape all sense of context. This helps to understand better why
MALAR own programs skirts issues of belief. Religion is a divisive force and MALAR instead focuses on issues around on which solidarity can be built, though it acknowledges the value of belief in personal practice.

I briefly mention Chapter One, the precedents to self-help and ongoing health initiatives. More case studies would reveal the range of responses across the country and provide further understanding of a rights-based health perspective as rooted in cultural practices. Culture is something that can be understood not as a pre-existing entity but must be understood as involving complex emerging networks. Groups might appear to be naturally occurring or self-evident entities but when we examine them as networks, we can begin to see the strategies, principles and social roles of the actors involved. What emerges is that these actors —whether state, non-governmental and other community-based entities, interpret widely and in contradictory ways notions of development, empowerment, human rights and so on.

There is emerging a critical understanding of the question of “spirituality” within ecological movements such as in the work of Vijiya Nagarajan in the Indian context that would extend the scope of this study. There are some conflations (especially in paying attention of “lay” or “people’s” point of view) and contradictions between the traditional secular rights-based similar to that of MALAR and spiritually grounded social justice movements, such as those of Vandana Shiva’s. The claims of all these positions have to be interrogated, but as my study suggests, the question of spirituality within social justice systems is clearly a site of tension. I believe these are only going to gain more importance in the light of a world increasingly divided by the forces of "McJihad" and "Jihad," to
return to Barber’s articulations. My own inclinations are to be participant and observer in reclaiming from the forces of “Mcworld” and “Jihad” both the question of a spiritual practice, broadly defined, and the possibilities of an interconnected global world that is rooted in democratic principles. My sense is that movements like MALAR will be crucial in forging these alternative directions.
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