

# Policy Report

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*No. 23*

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**Living with Pain:  
Women's Everyday Lives and Health in Rural Bihar**

Kanika Sharma



**THE HINDU CENTRE**

*for*

Politics and Public Policy

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Living with Pain:  
Women's Everyday Lives and Health in Rural Bihar

**Kanika Sharma**

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The Hindu Centre for Politics and Public Policy  
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## ABSTRACT

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**T**hough quantitative evidence suggests that women are more likely to suffer from physical pain than men, little is known about their lived experiences. Nor are the processes and mechanisms through which social determinants of health cause pain well investigated or documented in India. This Policy Report, *Living with Pain: Women's Everyday Lives and Health in Rural Bihar*, discusses findings from qualitative fieldwork in rural Bihar, focusing on causes and consequences of pain among women agricultural workers, the group most vulnerable to physical pain. Pain, especially back pain, was found to be overwhelmingly common. The respondents embedded pain within the larger context of adverse health experiences throughout the life course. In addition, the backbreaking nature of women's household and paid work, lack of protective nutrition and rest, and pervasive domestic violence emerged as important contributors to pain. The overall healthcare system was found to be largely ineffective. Informal private health providers, while accessible, were likely to be harmful. Neglect and mistreatment were common at the

government health facilities, making women's medical encounters disempowering. The Report outlines a few potential policy approaches, and ends with a hope that pain among women would become more central to discussions on gender and health in India.

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Finally, and most importantly, I am indebted to all the women I interacted with during the fieldwork. Thank you for opening your homes, lives, experiences, thoughts and rich insights to me. Many of you asked me what would come out of my *padhaai* (research). I am still not sure. But this report, I hope, is a beginning.

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## GLOSSARY OF ACRONYMS

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GBD	:	Global Burden of Disease study
WHO	:	World Health Organisation
WHO-SAGE 2007-08	:	WHO's Study of Ageing and Adult Health, 2007-08
NFHS	:	National Family and Health Survey
NSS	:	National Sample Survey
AHS	:	Annual Health Survey
DLHS	:	District Level Household and Health Facility Survey
ANM	:	Auxiliary Nurse Midwife
ASHA	:	Accredited Social Health Activist
PHC	:	Primary Health Centre



## I. INTRODUCTION

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My knees pain so much that I can't bend them. It becomes difficult to even attend to nature's call. It has been over a year. Every day it pains, especially in the night. Pain travels to my thighs, lower and upper back, and shoulders. Sometimes even to the head. Even now my back is paining. Until someone presses it, or I take the medicine, I just can't function.

(U, late 20s, woman agricultural worker, rural Bihar)

**P**hysical pain is a silent epidemic across the world. According to the Global Burden of Disease (GBD) study, back pain was the biggest contributor to years lived with disability in 2016 (IHME, 2017). Tension-type headaches affected 26 per cent of the world's population, and migraine almost 15 per cent. Seven per cent people in the world had back pain, and 4 per cent had neck pain. The prevalence of these physical pains and the disability caused by them have gone up between 1990 and 2016, and is projected to increase further (ibid; Clark and Horton, 2018). However, these overall statistics hide the extent of gender disparities.

The GBD reveals a clear gender pattern in the experience of pain: more women than men suffer from common forms of pain, across the world. The proportion of women who had tension-type headaches (31.2 per cent) was almost 1.5 times higher than that for men (21.8 per cent). Nearly twice the proportion of women faced migraine (19.2 per cent) than men (10 per cent). The number of women facing low back pain was higher at 7.8 per cent as compared to 6.4 per cent men. 3.4 per cent men had neck pain whereas 4.6 per cent women had it (IHME, 2017). These disparities are even more widespread in India.

An analysis of the India sample of WHO's Study of Ageing and Adult Health (WHO-SAGE 2007-08) found that 37.2 per cent women reported back pain in the last 30 days before the date of the interview (Sharma, 2017a). This statistic is higher than both the proportion of women having back pain in the world, and that of Indian men as well (24 per cent of whom reported back pain in the last 30 days).

In India, pain is yet to be recognised as an important public health issue. Neither the new National Health Policy 2017 nor the old National Health Policy 2002 have any mention of pain (Government of India, 2017; Government of India, 2002). In the media, the word pain is

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present only metaphorically,<sup>1</sup> and not as a health issue. Academic and scholarly engagement on the topic has been negligible.<sup>2</sup> None of the national surveys or studies on population health and wellbeing, such as the National Family Health Surveys or the National Sample Surveys, undertaken by Indian governments have ever asked any questions related to pain. Consequently, pain is a neglected theme in health research and policy in India.

Within this neglect is the further neglect of pain experienced by women. In my quantitative analysis based on the WHO-SAGE 2007-08 survey, highlighted before, I had found that more women than men experienced pain, women experienced more severe forms of pains, and for longer durations (Sharma, 2017a). The WHO-SAGE 2007-08 is the only large-scale population-representative survey in India that asked questions on pain to more than 10,000 respondents in six Indian States.

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1. Based on an analysis of pieces published in Indian English newspapers between March 2016 to May 2017 and compiled by online news archivist Daily Kiwi.

2. To illustrate, a keyword search with word 'pain' in Economic and Political Weekly (EPW), one of the premier social science research and policy journals in India, revealed that the coverage is negligible (Sharma, 2017a). From the entire online repository of EPW, only three pieces were found to be relevant: an editorial in 2014 on impact of narcotics laws for pain sufferers; Prakash (1983) on ban on pain-killers; and an exceptional paper by Shatrugna et al (1990) on back pain.

Furthermore, analysing the WHO-SAGE 2007-08 data, I found higher pain among women across all ages. Men and women from richer households had lower prevalence of pain than men and women from poorer households. But women, even though they may be in the top income quintile, had a worse average score than men in the bottom-most income quintile. Similarly, within all social groups, whether “high” or “low” caste, Hindu or Muslim, women reported higher prevalence of back pain than men.

Finally, the data revealed a group particularly vulnerable to pain: women agricultural workers. As high as 50 per cent of them reported experiencing back pain, and spending about a week per month in pain. This contrasted with men who did agricultural work, who suffered 3 days of back pain in a month, or with women who did professional work, who suffered about 4 days of back pain in a month (ibid).

These quantitative findings make a strong case for a detailed enquiry into causes and consequences of physical pain among women agricultural workers in India. This report does so by documenting their lived experiences of pain, embedding them within their life and health contexts.

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### Pain and the overall context of women's health

My health is terrible. This area [pointing towards lower thighs and legs] pains a lot. I have a headache every night...Even now it is paining...I have to bend down to sweep the floor all day. My *daang* (back) hurts too.

(L, late 20s, woman agricultural worker and part-time contractual cleaner)

This research is based on qualitative interviews, participant observations, and witnessing medical encounters of women in a rural district in North Bihar. Before describing the methods and the findings, this section situates pain in an overall understanding of women's health in India.

Women in India face many health vulnerabilities, but only a few of them receive any attention. While issues of undernutrition, maternal health and birth control are addressed to some extent, those related to the hidden burden of infectious diseases among women, excessive female mortality in specific ages, mental health, and everyday experiences of illnesses that are women-centric are largely off the research and policy radar (Qadeer, 1998; Inhorn, 2006).

Pain is one such everyday experience. It is characterised by a 'range of biophysical, psychological, and social dimensions' (Hartvigsen et al,

2018:1). Women's health issues have traditionally been seen through a biological and reproduction centric lens (Inhorn, 2006). But pain redressal requires that the health research and policy framework be broadened to effectively include biopsychosocial life processes and social determinants such as gender, work, food, resources and availability and access to healthcare.

Pain has been called a gendered experience because 'the ways in which pain is conceptualised, lived, diagnosed and treated cannot be divorced from the structures of power and privilege through which bodies and identities are gendered' (Kall, 2012:4). Gender roles and gender division of labour, resources, rest and care, as well as gender perceptions about tolerance play an important role in determining who develops pain, and whose pain receives the necessary attention (Shatrugna et al, 1990; Bendelow, 1993; Doyal, 1995; Barker, 2005; Kempner, 2014).

Women pain sufferers don't receive the necessary attention from the health system. Across the developed world, studies have found gender bias in pain treatment when men and women have the same diagnosis (Hoffman and Tarzian, 2001; Chen et al, 2008; Fillingim et al., 2009; Billock, 2018). Even as these patterns in developed countries are

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alarming, little is known about gender bias in the treatment of pain in much of the global south.

Women's reports of pain are routinely looked with suspicion and are disregarded (Lillrank, 2003; Werner and Malterud, 2003; Pryma, 2017). In one of the few studies of gender and pain in India, Shatrugna et al (1990) call back-pain a feminine affliction and argue that women's reporting of pain is often delegitimised.

Pain's complexities as an *illness* experience add to the challenges. Unlike many pathophysiological *diseases*, pain does not always have a clear aetiology, is often difficult to observe or measure; and almost always has an element of subjectivity (IASP, n.d.; Fillingim et al., 2009; Goldberg and McGee, 2011; Foreman, 2014; Kempner, 2014; Hartvigsen et al, 2018). While acute pain may still be easier to manage, chronic pain<sup>3</sup> is harder to address. Many chronic pain conditions like

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3. Traditionally, the distinction between acute and chronic pain has been looked at in terms of duration, wherein Chronic pain has been considered as the pain that persists from 3 to 6 months or more. However, there is now a recognition that such a cut off is not useful because different kinds of pain require different time periods. Instead, Jackson (2011:4) offers a useful distinction: 'unlike acute pain, which either disappears or gets worse, chronic pain is not necessarily grounded in a pathology producing rapid deterioration - the source of the pain probably will not kill the sufferer'.

Fibromyalgia<sup>4</sup> still have no known causes, diagnosis or standard treatment (Barker, 2005).

These uncertainties are perplexing for the biomedical system which is epistemically rooted in specificity and measurement, and a cartesian understanding of the body and disease (Kleinmann, 1994; Bendelow and Williams, 1995; Barker, 2005; Jackson, 2011). Consequently, pain receives very little time and attention in medical training (Foreman, 2014; Vijayanand, 2016).

For already under-resourced, understaffed, and overburdened health services systems like that of India, dealing with a complex and multidimensional health issue like pain can be additionally challenging. And when the patient is a woman, ‘micro-patriarchies’ within the health system lead to the further neglect of the problem (Shatrugna et al, 1990; Inhorn, 2006).

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4. Fibromyalgia is a condition that causes pain, tenderness and fatigue throughout the body (National Institute of Arthritis and Musculoskeletal and Skin Diseases: NIH, 2011; Pryma, 2017). Its symptoms range from headaches, trouble sleeping, painful menstrual periods to problems with thinking and memory. Of all the people diagnosed with this condition, between 80 to 90 percent are women (ibid).



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Even as pain does not necessarily kill, it can make living incredibly difficult. As overall mortality declines, morbidities and chronic conditions such as pain take away more healthy years from life expectancies. Women around the world live longer than men, but they face a higher burden of these morbidities and conditions (Case and Paxson, 2005; Fillingim et al, 2009). In India, until only a few decades ago, women had lower life expectancies than men. They don't now, but the same forces and processes that lead to lower life expectancies among women in India in the past may be contributing to a higher burden of pain today.

This report is an attempt to understand these forces and processes, and place physical pain more centrally in health discussions in India.

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## II. METHODS

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**A**ny discussion on women's health and wellbeing must be based on the standpoint of women and their everyday life worlds (Doyal, 1985; Doucet and Mauthner, 2006; Inhorn, 2006). The world over, women have traditionally been kept out of the research processes that define and determine their health (Krieger and Fee, 1994; Inhorn, 2006; Kall, 2012). In much basic pain research, exclusion of female subjects and of gender as an analytical category is still a common practice (Greenspan et al, 2007; Jackson, 2011).

Resultantly, there exists a gap between the mainstream narratives around women's health and women's own experiences and priorities (Avotri and Walters, 1999; Inhorn 2006). As a counter, Inhorn (2006:376) suggests:

A great deal about women's health can be learned by letting women talk – by effectively and compassionately listening to them narrate their own subjective experiences of sickness and health, pain and suffering, oppression and resistance, good health and occasional joy that are part and parcel of women' health experiences around the globe.

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This study is focussed on *letting women talk* about their pain. Giving primacy to experience as a form of evidence for policy-making and public action (Dreze, 2017), the study attempts to highlight women's lived experience of pain as an evidence for policy making on health in general and women's health specifically. It tries to document women's experiences as embedded in their socioeconomic locations; their understanding of causes and consequences of pain; and experiences with the healthcare system.

The research is grounded within a feminist framework 'for its capacity to focus on women and their concerns' (Liamputton and Suwankhong, 2015: 265). A mix of qualitative methods, including group discussions, in-depth interviews, participant observations, and witnessing medical encounters has been used.

Fieldwork was done in Araria<sup>5</sup> district of Bihar in the months of March and April. Familiarity with the area through previous work and

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5. For a detailed demographic profile of the district, see Government of India, (2014). District Census Handbook: Araria. [http://censusindia.gov.in/2011census/dchb/1007\\_PART\\_B\\_DCHB\\_ARARIA.pdf](http://censusindia.gov.in/2011census/dchb/1007_PART_B_DCHB_ARARIA.pdf). Last accessed on May 29, 2018.

association with a local worker's union was one of the main reasons for selecting it for this time-bound study.

The initial phase of the fieldwork was spent in informal and unstructured conversations with women about their health. I travelled to four villages of the district. I started conversations talking about overall health and well-being, but pain dominated the conversations from the very beginning.

I supplemented these conversations with an illness mapping exercise conducted among a group of eight women from different parts of the district who had gathered for another meeting. On a piece of chart paper, we listed the health problems each one of them had had, as well as the common illnesses that women they knew had. This was to understand where and how many times pain featured among all the illnesses women talked about. Here as well, pain was the most commonly discussed health concern.

Quantitative findings from WHO-SAGE 2007-08 had showed that there is an epidemic of pain among women agricultural workers, with as much as 50per cent of them, or every second woman agricultural worker, reporting back pain in the 30 days before they were interviewed

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(Sharma, 2017a). Consequently, the selected respondents for the present study were all women agricultural workers.

While qualitative research cannot provide representative estimates, the lived experiences of the selected respondents likely parallel that of other women agricultural workers in rural North India. According to the estimates of the 2011 Indian census more than 57 lakh (5.7 million) women were agricultural labourers in Bihar (Government of India, 2013). The all India numbers were upwards of 6 crore (60 million) women (ibid).

I conducted in-depth interviews with the women I identified during interactions, mapping exercise, and observations at villages. There was no fixed sampling strategy or size for this descriptive study. I progressively selected respondents, although some features of snowballing sampling were met.

Overall, eleven in-depth interviews were conducted. Nine of the eleven respondents were Dalit, and there was one Adivasi and one Muslim respondent as well. Apart from doing agricultural work, one Dalit respondent was also a contractual cleaner at a health facility.

Given the very intimate nature of an experience like pain, substantial amount of time had to be spent in rapport building with the respondents. Interviews were taken in a mix of Hindi and *Thethi*, the local dialect. The interview guide was kept unstructured, open-ended and flexible so that women could freely talk on their own terms, although a few general trigger questions were included to maintain commonality. Verbal consent and absolute confidentiality were maintained along with in-depth explanation about the nature and scope of the research. The time of the fieldwork clashed with the busiest time of harvesting of corn and wheat in the villages, which meant working at the pace women were comfortable with.

Participant observation was done throughout the fieldwork. I lived in women's villages while conducting fieldwork, and accompanied a few of my respondents to the health facilities at different levels of specialisations, thereby witnessing and documenting their medical encounters. Studying medical encounters is a popular method in the field of medical sociology and anthropology (Lupton, 2012). In my case, they enabled crucial observations of doctor-patient relationships, and issues of accessibility and dignity in health services in the context of Araria.

### **The field-site**

Araria is a rural district in North Bihar, part of the Indo-Gangetic plain. As with other areas in North Bihar, landlessness and population density are high (Government of India, 2013), and floods are frequent. Seasonal migration to more prosperous States for agricultural and manual work by men is extremely common, and consequently women are left behind to battle illnesses, debts, catastrophes, and poverty on their own (Jha, 2004).

Araria fares poorly on many development and health indicators. The district factsheet of Araria brought out by the National Family and Health Survey 2015-16 (NFHS-4) shows that nearly half the children under 5 years are stunted, and 46 per cent are underweight (IIPS, 2017a). The Annual Health Survey 2012-13 reported infant mortality rate of 52 and under-five mortality rate of 76 per 1000 live births in Araria, with female infant mortality and female under-five mortality being higher than that of boys (Government of India, 2014b). The rate of under-five mortality in Araria is worse than Bihar's under-five mortality rate of 70 deaths per 1000 live births (*ibid*), as well as that of many countries in Sub-Saharan Africa.<sup>6</sup>

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6. Sudan's under-five mortality rate is 71; Malawi's under-five mortality rate is 69; and Ethiopia's is of 68 (World Bank, 2018).

A high maternal mortality ratio of 349 and maternal mortality rate of 44 were reported in the Purnia sub-division, of which Araria is a part (Government of India, 2014b). NFHS-4 also found 65 per cent of all women in the age 15-49 in Araria to be anaemic, three times the national figure (IIPS, 2017). Forty per cent of rural women in Araria had Body Mass Index below normal as compared to 26 per cent of all rural women in India. Half of the women in current age 20-24 were married before 18, and 11 per cent of women in age 15-19 were already mothers or pregnant at the time of the survey (ibid).

An overview of availability and quality of health infrastructure in Araria is provided by the District Level Household and Facility Survey 2012-13 (DLHS-4) (IIPS, 2014). None of the sub-centres in Araria had regular electricity, only 17 per cent had a toilet, and 35 per cent had water supply. Out of 16 Primary Health Centres (PHCs) in Araria, only one fourth had a functional vehicle, and less than one third had regular power supply. The survey found infrastructure at the Community Health Centres to be in a better state. The district hospital did not have a radiographer, ultrasound facility or two-dimensional echocardiography facility, all of which are essential for basic tertiary care (ibid).



### III. FINDINGS

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#### **Women talking health**

The simple question *aapko apna swasthya kaisa lagta hai* (how do you feel about your health?) opened floodgates of emotions, thoughts, and life stories. It is possible that women had never been asked by someone other than their friends or family about *their* perception of their *own* health.

Gender socialization from an early age discourages women to actively voice their opinions about their wellbeing. Such a question may challenge that, and give women the opportunity to actively reflect on their health. The responses to that question could also be treated as a self-rated measure. Researchers have shown that self-rated health is a useful measure as it may predict mortality better than objectively measured biomarkers of health (Goldman et al 2009).

When women talked about their health, they simultaneously talked about their life journeys, deeply embedded in their familial and social milieu. In many ways, they expressed their present health status as a

product of experiences they have had at different stages of life, as well as over time.

### **Health and the life-course**

None of the respondents knew their exact age, a characteristic common to rural women in North India, but childhood was commonly recalled as a period of deprivations and hunger.

At the age of 5 or 6, we used to be hungry the entire day. I would cry because of hunger. My helpless mother would give some stored paddy and I would beat it, get some grain out, and eat it with water. The whole day we would survive on that little raw rice. Then mother would get some *bajra* flour or wheat flour from somewhere. Today we eat at least 2 kilos of grain a day in a family of five. But at that time, we would make only 1 kilo for a family of seven. Food was cooked only once a day.

(R, mid 40s)

Women recalled starting to shoulder work responsibilities as children, which they believed impacted their education as well as wellbeing. Even now, girl children start doing household work when they are between eight and ten years of age. As I was talking to one respondent while she cooked, her daughter swept the house, fetched water, and cleaned the

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utensils before getting ready for school. She was a few months short of ten years.

There is a steep increase in the intensity and nature of the reproductive labour<sup>7</sup> that women in rural Bihar do once they get married. This is one of the reasons why women respondents regarded marriage as a crucial event for their health. All respondents except one were married before the age of 15, a trend which has marginally improved in recent times in the area.<sup>8</sup> A young married woman is the primary worker of her husband's household, a responsibility she must bear until she is joined by a younger woman (see also Jeffery and Jeffery, 1996). When I asked R if life became better after marriage, she said:

No. I was 12 when I got married. My period had not started. I did not know who my husband was. I was very scared. I cried a lot... I was made to stay in a room where animals were tied. The next morning, I was told to work in the field. It was harvesting season. I did not know the proper way, but still had to do it. Things were bad.

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7. Within feminist literature, reproductive labour is conceptualised as unpaid and paid forms of “various kinds of work—mental, manual, and emotional—aimed at providing the historically and socially, as well as biologically, defined care necessary to maintain existing life and to reproduce the next generation” (Laslett and Brenner, 1989: 383)

8. According NFHS-4 (2015-16), 49 per cent of the women in Araria were married by age 18 (IIPS, 2017a).

Childbearing phase has an overbearing influence on women's perception of their health. Most women saw their present health concerns as consequences of the problems that started during pregnancies.

During all four pregnancies, even the first one, I was very thin and weak. My mother feared for me...When I was pregnant for the second time, three or four months had passed without any check-up. I had pain in stomach and burning sensation with urination. But I couldn't feel the baby moving. I was getting weaker by the day. I told my mother-in-law, but she said she had given five births and had never heard of complications like these... By then it was seven months, the baby was still not moving... When my parents finally took me to a doctor in Nepal, the doctor did the ultrasound and said that the baby was not good. It had to be aborted to save me...Since then, the weakness has persisted.

(B, mid 30s)

A disconcerting finding of this study is the large extent of miscarriages, stillbirths, and neonatal deaths that women reported. Chronic undernutrition, early age pregnancies and lack of necessary care exacerbate the risks for pregnant women.

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I was married at 13 or 14 and got pregnant a year after. In my ninth month, I was feeling unwell and had stomach pain. We did not have any money so could not go to the hospital. Without any consultation, my in-laws got me some medicine from somewhere. I took it, and immediately started bleeding...I had miscarried...To avoid workload, I stayed back at my mother's home for three months. But as soon as I came back, I got pregnant again...But the baby died as soon as she was born...Two years later I got pregnant again, but it was a stillbirth. My in-laws did not want to bring me home for a long time.

(J, late 30s)

Abnormal vaginal discharge, specifically white discharge, was also frequently reported in the interviews. Despite being common, inaccessibility to effective healthcare and a culture of shame and silence contributed to the neglect of this problem.

Six months back, there was continuous white discharge like *choona* (stalked lime), often staining my clothes. I went to the village doctor who is also a *jamindaar* (Landlord). He doesn't take money to write a prescription, but his wife makes us do a lot of work. He gave me 5 injections and 60 tablets. It was fine for a few days. But when I fasted for three days for *chhat pooja*, there was bleeding mixed with white discharge...It was

terrible...I was embarrassed at going to the district hospital.

(D, late 40s)

Women linked vaginal discharge with weakness and body pains. This is in line with the findings of Patel et al (2005) which suggest that vaginal discharge may be a somatic equivalent of many medically unexplained conditions, including irritable bowel syndrome, pelvic pain and chronic back pain.

It is important to note that when women talked about the issues that are traditionally clubbed under the domain of reproductive health, their frame was not strictly biological. They simultaneously discussed young age, lack of care, strained relationships with husbands or in-laws, and scarcity of resources. Reproduction was, thus, articulated as a sociobiological process having long-term impacts on health.

Women's overall descriptions of their health, therefore, were not just from an immediate perspective but from a life course perspective which suggests that experiences at earlier stages of life probably set off a chain of risks that lead to cumulative health experiences continuing throughout life (Kuh et al, 2003). A childhood of hunger, deprivations and work responsibilities, early marriage and rise in reproductive

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labour, difficult pregnancies, excessive workload and lingering weakness, and a persistent lack of resources and care determine whether women in rural Bihar remain healthy or not. It is in this larger context of women's lives and their health that the question of pain needs to be located.

### **Living with pain**

Responses to the question *kya aapko shareer mein kabin dard hai* (do you have any pain in your body?) were often preceded by sad smiles, vigorous nodding, visual directions to the body part(s) that ached, and sometimes a quizzical look as to why I was asking the obvious. This question was asked not only to the interviewees but to many women I interacted with throughout the fieldwork. The most common response was: *chhab ki!* (but of course!).

Scholarship on pain is ripe with controversies over definition and conceptualisation of pain (Moseley, 2007; Bendelow, 2013). This, however, contrasted with the clarity with which women talked about the pain experience. I did not have to explain to any of the respondents what I meant by pain. Women knew exactly what it was and how it made them feel. It turns out, therefore, that investigating or studying pain is not very difficult if people's own definitions and experiences are given primacy.

The most crucial finding of this study is the overwhelming burden of pain among rural adult women. Back pain was the most commonly reported health problem by all the women I interacted with in the two months. Each respondent had pain at the time of the interview. Most of them had a cluster of pains. All of them had chronic pain. Some had episodes of acute pain in some body parts in addition to chronic pain in same or other parts.

**Table 1: Description of respondents and their pain**

Name	Age	Social group	Description of pain experienced	Onset (years / months ago)
R	Mid 40s	Dalit	Back pain radiating to legs	8-9 years
L	Late 20s	Dalit	Pain in legs and thighs; headaches; back pain	2-3 years
B	Mid 30s	Dalit	Back pain; pain in thighs and legs	10 years
J	Late 30s	Dalit	Pelvic pain; back pain	4 years
S	Mid 20s	Dalit	Back pain	5 years
U	Late 30s	Muslim	Pain in knee joints; back pain; pain in shoulders; headaches	1 year
D	Late 40s	Dalit	Back pain	15 years
G	Mid 40s	Dalit	Pelvic pain; back pain	6 years
A	Late 40s	Dalit	Pain above ankle; back pain	2 years
T	Early 50s	Adivasi	Pain in neck; headaches; pain in wrist joint	Neck & head: 6 years; Joint: 3 months
P	Mid 40s	Dalit	Pain in knee joint; body pains	6 months



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The number of days women spent in pain every month ranged from 8-10 days to everyday. Six respondents said that they had pain every day. Others like D, said:

I have pain at least 10 days of the month. During periods it pains a lot in the back and stomach. But without periods too I have back pain.

If not in pain every day, respondents spent at least about one third of a month in pain. This is higher than the average of a week per month that was shown by WHO-SAGE 2007-08 dataset. When multiplied by the number of years since the onset, the overall time spent by each respondent in pain turned out to be impermissibly high, and is therefore a matter of grave concern.

Women's descriptions of how they felt when they had pain pointed to pain's debilitating impact. For S, pain felt like 'something is piercing into my back, like needles'. P's pain in knee joints made her feel like her leg is broken. B spoke about pain making her feel that she needed to defecate but couldn't. U said that her knee pained so much that it made bending and attending to nature's call difficult. G described the feeling as:

It pains so much that I bang my head against the floor.  
I lie down, and ask someone to press my back and  
thighs... I can't even eat because of pain.

Not being able to eat because of pain was a commonly repeated expression. Food is vital not only for survival but also for the perception of wellbeing for poor families of rural Bihar. To not be able to eat, even when there is food available, itself attests to extreme suffering that pain causes.

The respondents frequently talked about not wanting to do anything when they had pain. For this group of women, whose families depended on their work inside and outside home, this feeling was difficult to deal with. As A put it:

During pain, I feel like lying down. I don't feel like working at all. I want to only lie down...But what can I do? If I don't work, what will I feed my children?

Despite pain's enervating influence on women's lives, gendered perceptions about tolerance, combined with lack of resources, contributed in making pain an unaddressed and prolonged experience.

R reflected:

We often talk about pain among ourselves. Someone comes and says she has a lot of pain in *kamar* (back). I

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tell her that I also have it, what to do? The conversation then turns to work, we talk about where the cattle are, whether food is prepared or not. This is how women share...We (women) don't think about our health enough...*chalo itna toh chal sakta hai* (okay, we can tolerate this much).

Men were not required to show the same level of tolerance towards pain. In many interviews, respondents talked about active care-seeking and high expenditures that family bore when their husbands had health issues, even as they themselves had not been able to get any relief. Men could take rest and avoid work if they had pain, a luxury that women said they didn't have. R further commented:

Men also have *dikkat* (difficulties). They also get back pain sometimes. If my husband does some work with *kachhia* (sickle), he starts complaining, 'oh! today I have a lot of pain'...But men can stop or leave the work if they can't do it because of pain. But we (women) continue. Even if we have pain, we sit a bit, and then start again...I told you na, women don't think about their *shareer* (body).

What women did think about a lot were the issues that caused them tension. Tension, or worrying too much, exacerbated women's experience of pain. As D said:

When there is tension about something, my head starts throbbing with pain...Like yesterday there was so much tension about the ongoing land dispute with the landlord. I felt as if my whole body has become *looꝛ* (without strength) with pain.

Land disputes, husband's illness or hospital bills, inability to arrange dowry for daughter, unavailability of work or pending wages, and outstanding loans were some of the commonly discussed matters that women were tensed about. Most of these issues are socioeconomic in nature. There is, therefore, a definite intersection among the socioeconomic factors, psychological stress, and physical pain in women's lived experiences.

### **Backbreaking Work**

The socioeconomic factor that emerged as the biggest theme in this study is work. The colloquial term used for work is *khatna*, which broadly means to spend one's body. Women regarded the work they did as *khatna*, and perceived it as one, if not the main, cause of pain.

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For L, her back pain is caused by *nubar ke jhaadu lagana* (sweeping the floor in the forward bent position). G's back pain worsens after she does the daily work of carrying the sack of fodder from long distances, usually about 5 to 6 kilometres. The sack weighs about 15 to 20 kilograms. To lift it, she firsts put in on the thighs, then on shoulders and finally on the head. P remembers lifting and carrying a sack of *santhi* (dried sticks used as fuel for cooking) that led to acute pain in one knee. S thinks it is the work in the fields that causes her pain:

It pains a lot in the morning, when I work in *baad* (fields). It is the worst during harvesting seasons. I tie a *gamchha* (a cotton towel) tightly around my waist to be able to work. I recently cut the wheat crop, which caused so much pain. Risking my life, I have to work.

A usual day in the life of an adult woman with primary work responsibilities generally starts before 6 am. She first sweeps the entire house, and plasters the *choolha* (stoves) daily and the floor every third or fourth day.<sup>9</sup> Sweeping is done in half-forward bend position, while plastering requires squatting and bending forward. Then she washes the utensils, an exercise which requires pumping the water out from the

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9. Women in rural North India frequently cover walls, floors, or biomass-based cooking stoves with a mud-cowdung paste. This process is called *lepna* (plastering).

hand pump many times. Throughout the day, water is pumped out a few hundred times using one hand to push and pull the handle with mild strength, bending slightly forward.<sup>10</sup> Prepping and cooking the food begins early morning before the family members set out to work. Grinding the *masala* and cooking food take about an hour, all of which is done in squatting or sitting half-bend forward positions. All the household work is done by women and girls.

If it is the harvest season, like it was at the time of the fieldwork, the woman thereafter leaves for the field. For cutting the wheat crop, she bends forward, holds the thorny crop with one hand, and applies force through the other hand using a sickle. She simultaneously makes *bojba* (load) of the cut crop. The process of cutting goes on till the afternoon when the harsh sun makes it hard to continue. The woman then heads home, finishes remaining household work like getting the fodder, tending to the cattle, and washing clothes. She heads back to the field in the late afternoon to work again. After she finishes with the day's cutting, she carries several loads, weighing around 7 to 8 kilograms each, on head to the landlord's house. By late evening, she returns

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10. For a respondent, I started counting the number of times she had to pump to get water. She had done more than two-hundred pumps from the morning to the afternoon.

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home, and starts prepping and cooking food, tending to the cattle, and feeding the family. It is usually not before 9 pm that she goes to bed, which translates as 12 to 15 hours of hard labour every day.

There is a clear gender division of labour in the household work. R linked it with the gender differentials in health and pain:

Men don't do household chores like *chouka-bartan* (cooking and cleaning) ... They also don't look after the children... If the house needs repairing or if bamboo needs to be cut and brought, then they do it. But that kind of work happens sometimes, once in months, and not daily. If some other work needs to be done, we (women) have to tell them, they won't think of it on their own like we do... Younger boys of 16-17 years of age don't do anything, they are their own masters. But girls have no say; if they see dirt, they will have to sweep, if there's no food, they will have to cook... By this measure, girls and women must get more exhausted, and they do. But who understands this?

In the fields too, the work is divided by gender. The area where fieldwork was done sees a high out-migration of men for employment to what is colloquially called *Dilli-Punjab*. But in the sowing and

harvesting seasons, men usually return home. Even as both men and women work in the field, the tasks they do are different. In the wheat harvesting process, women are mainly responsible for cutting the crop and carrying loads, while men work on the thresher machines that separate the grass and chaff from the grain. Cutting and carrying loads of harvest are entirely manual work, whereas work on the threshing is more technical in nature.

Similarly, for sowing of rice, A explained:

Men prepare the *biraar* (sapling to be planted) and give it to women who bend down in mud and sow it...Men prepare it while sitting, whereas we (women) have to bend down from early morning. Once men finish with *biraar*, they go for lunch, and sometimes join in sowing in the late afternoon...But we have to keep sowing. *Nuhar ke* (by forward bending), our backs pain, but we keep sowing. The mud makes it difficult to lift the legs. Legs and feet pain too.

The body postures that women are required to adopt for work strain their bodies, especially the back. Most of the tasks require bending



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down or forward in monotonous positions for long hours, what women referred to as *nubarna*. Shatrugna et al (1990) have shown that such postures lead to overuse of only a few muscles of the back while other muscles begin to sag, upsetting the architecture of the back and causing pain.

Apart from the daily work in homes and seasonal work in the fields, women also engage in occasionally available work under the National Rural Employment Guarantee Act (NREGA). Even as the NREGA was regarded as a vital source of subsistence for the families, women talked about suffering pain after doing the labour-intensive work under it. As per R:

We have to lift and carry the *mitti* (mud) the whole day. Where does its heavy weight affect? Our backs. For making the road, we have to dig the earth. The surface is so hard, we have to use the *kudali* (mattock) hundreds of times, straining hands, shoulders and backs. We have to use the entire body's strength. Our arms, chest and back pain... It is a very difficult work, but we do it because there is at least some money in it... Many women who are weak get ill after working there... And when there is delayed or no payment, their tension increases.

Returning from a day-long work at an NREGA worksite, a young woman asked me if I had any medicine for her back pain. Before I could say anything, a young man who was standing by joked that she must not be in the *habit* of working, and that is why she had the pain. The androcentric perception of the relationship between work and pain among women might be that of a habit or practice: the more you work, the more body adapts and less is the pain. But in women's own views, in the testimonies reported by Avotri and Walters (1999) and Bisht (2014), as well as in the arguments made by Shatrugna et al (1990), given the nature of women's work, which Swaminathan (1997:52) described as 'backbreaking endless drudgery', the more work women do, the more pain they have.

### **Weak bodies**

*Kamzori* (weakness) was the most repeated word along with the word pain in women's discussions on their health. Women viewed weakness both as a cause and a consequence of their pain. All the respondents had taken medicines for *kamzori* at some points in their lives, which mostly included multivitamin and iron folic acid tablets, and sometimes, calcium supplements.

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These essential nutrients were largely absent from women's diet. Women usually took two meals a day, once in the late morning and then in the night. Their typical morning meal was a large proportion of rice with a little amount of *sabzi* (vegetable curry), mostly cooked with potatoes. In the night, women ate *rotis* with either the same or newly prepared *sabzi*. There was little variety in the *sabzis*. Because vegetables had to be bought every day and were expensive, they were always prepared in less quantity. Landlessness meant that even seasonal and easy to grow leafy vegetables like *saag* had to be bought, which limited their adequate consumption. Diluted *daal* (pulses) was eaten once or twice a week. Oil was used scarcely in every day cooking.

Except the two respondents who had a cow at home, none of the women were able to consume milk. U had not taken milk for over a year:

Can a poor person drink milk?! It is 35 *taka* (rupees) per kilo. I have four kids, all of them would want it. Unless I buy at least 1 kilo, will it be enough? I can't afford that.

Drinking tea is not common among women in the area too. I do not recall seeing any of them eating fruits in the two months I stayed and interacted with women across villages.

Parts of rural Bihar have recently undergone change in terms of food practices. The growing grip of a religious cult, variously called *kanthidhaari*, *daas*, *satsang* or *shivcharcha*, has turned communities, mostly Dalits, into strict vegetarians. Women and girls have been influenced by this practice the most, and a large proportion has stopped taking any form of animal protein (other than milk which they cannot afford). When I asked B if she ate meat or eggs, she responded:

I used to eat but my mother is a *daas* and she kept complaining that the food I cooked smelled of *maas-machhi* (meat and fish). So, to assure her, I also stopped eating. Then I began going to the *satsang*, and didn't feel like eating meat anymore. My husband and children eat meat.

Other than religious beliefs, which also included regular fasting, affordability was one of the biggest hurdles in women's access to food.

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As G explained:

It has been six months since we ate meat...We can eat only when there is money, no? Half kilogram of *kbassi* meat (mutton) costs 200 rupees. In that much money we can get vegetables for five days. That's why we don't eat meat much.

Intra-household gender inequity in food consumption was found to be pervasive. Boys and men were always the first ones to eat every meal. They were also more likely to get larger portions, especially of meat and sweets. Children ate earlier, and then later with mothers, elder sisters, or older women as well. On the other hand, fathers and older men ate by themselves. Thus, men always had their own separate plates, while women and children often shared plates.

These findings are echoed in other survey research as well. The NFHS-4 finds gender differences in food consumption: 'men are slightly more likely than women to consume milk or curd regularly, as well as fruits. Men are less likely than women to completely abstain from eating chicken, meat, fish, and eggs' (IIPS, 2017:303). Similarly, in the SARI survey (Coffey et al, 2018) and the India Human Development Survey

(Desai et, al 2011), between 40 per cent and 60 per cent of rural women respondents reported that men eat food first.

Women's nutrition was thus woefully inadequate. According to the Dietary Guidelines for Indians 2011, women engaged in heavy work such as the ones interviewed here are supposed to eat 480 grams of millets and cereals per day, 90 grams of pulses, 300 millimetres of milk and milk products, 200 grams of roots and tubers, 100 grams of green leafy vegetables, 200 grams of other vegetables, 100 grams of fruits, 45 grams of sugar, and 30 grams of fat (National Institute of Nutrition, 2011). Based on my participant observations, it was clear that much of these nutrition requirements were not being fulfilled. While women may have been getting just enough carbohydrates (or perhaps just slightly less than the recommendations), their intake of pulses and fats was much below the recommendations. If *saag* was available, women would be able to fulfil recommendations for leafy vegetables, but only in some seasons. For fruits, sugar, milk and milk products, women's intake was effectively nil.

Among many nutrient deficiencies in women's regular diet, one of the most severe is that of calcium. Calcium plays an important role in avoiding back pain (Shatrugna et al, 1990). Chronic calcium deficiency,

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combined with anaemia, absence of fat, protein deficiency and inadequate vitamin D in the body, weakens the integrity of the bones (ibid; Shatrugna et al, 2005). Even if the back muscles are strong, which is not the case for women agricultural workers who overuse certain muscles due to work, fragile bones cannot support the architecture of the back. This results in pain as well as osteoporosis among women (ibid).

Apart from lack of protective nutrition, inadequate rest also made women weak and vulnerable to pain. In the busy work routine of women, rest has little or no place. When I asked S about getting rest, she responded:

I don't get time. In the last three days, I have not been able to even sit down for once. With you only I am sitting. The only rest I get is the night's sleep.

Women also related their *kamzori* and accompanying pain with what they called the *operation*. They strongly believed that their bodies started weakening and pains began after they underwent the invasive procedure of tubectomy. Tubectomy continues to be the main method of contraception in India, much ahead of vasectomy, the relatively safer method of male sterilisation (IIPS, 2016). Despite being common,

female sterilisations are routinely performed in substandard conditions in most rural areas of India (Sharma, 2016). Women from poor socio-economic strata find it hard to get the necessary rest and care after the procedure (Pettigrew, 1984).

The Standards for Female and Male Sterilization Services, 2006, recommend rest of two weeks before resuming full activity (Government of India, 2006). But the respondents reported working throughout their pregnancies as well as soon after the tubectomy. Even though tubectomy itself may not have a causal link with pain, as Pettigrew (1984) noted, the clinical and socioeconomic milieu in which it happens may make full recovery difficult.

### **Pervasive Violence**

Women's health was further harmed by the high prevalence of domestic violence in the area. A 22-year-old woman was given *Talaaq* over the phone. When she tried to bring her small children and her dowry with her, her husband's sister beat her up, pulling her hair so hard that some of it came off. Another woman in her mid-twenties had run away from her husband's house fearing for her life. Her mother-in-law, sister-in-law and husband beat her up, hit her head with a washing paddle, and ran after her with a burning stick.



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Domestic violence is so common that only those cases come to light where a direct threat to life is apparent. Routine incidents of battering, verbal abuse and harassment often get normalised. When I asked S if she faced any *maar-peat* (physical violence), she gave a hesitant smile and said:

Sometimes. When my husband gets drunk...Earlier he used to beat me daily but now it has reduced...2 or 3 months ago, he came home drunk and lied about it. I told him I could smell it. He started beating me up, broke the mobile phone...I ran to the neighbour's house...Earlier he used to beat me with *karchhi* (ladle) or whatever came to his hand... It was very bad. Only I could bear all this, someone else would have left him.

All the respondents had faced some form of domestic violence in their lifetime, although this research could focus only on physical violence due to time constraints. Women reported a higher degree of violence in younger ages, especially after marriage, and a gradual decrease as their children started growing up. The respondents talked about facing physical violence not only by husbands but also by in-laws. Husband's alcoholism was the most commonly reported immediate cause of

violence, followed by fights with in-laws over work allocation and distribution of resources within the household.

Research from developed country contexts has shown that women described physical violence as the root cause of their pain (Hamberg et al, 1999). Chronic pain has also been shown to be correlated to severity of lifetime violence (Wuest et al, 2008).

For A too, the link between the experience of physical violence she faced in younger age and her chronic pain was clear:

When I walk now, this area (lower half of one leg) pains...During winter, the spot where he (father-in-law) hit me, pains a lot.

She remembered the incident vividly:

I was very young. My mother-in-law asked me to do some work. I told her I wasn't feeling well, it was very cold. When my father-in-law came home, she must have told him. He did not ask me anything. He had a *penthi* (stick) in hand, and he straightaway hit me hard with it. It (leg) had swollen a lot. For 15-20 days, I could not walk properly, I had to limp... That area pains a lot

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now... Whenever there was any tension, they would beat me up.

Battering can lead to serious injuries. The woman who had run away from home had a swollen head which pained so much that she could not touch it. S talked about the *nishaan* (marks) that remained even two months after the incident.

NFHS-4 reports that nearly one fourth of all rural married women (15-49 ages) in India who experienced physical violence by husbands sustained injuries like cuts, bruises or aches (IIPS, 2017). Nine per cent had serious injuries like sprains, dislocations and burns, while 6 per cent had deep wounds, broken bones and teeth (ibid). It is known that any injury or wound requires adequate nutrition, rest and care to heal. Based on the earlier discussion on the life circumstances of women in rural Bihar, such healing may clearly not be possible.

Thus, domestic and intimate partner violence has direct and indirect links with pain. Traumatic brain injuries caused by hits can lead to headaches and migraines (Verizon Foundation and Florida State University, 2014). Back pain can be caused by 'pushing, lifting, or pulling while twisting the spine, and can also be caused by herniated disks from injuries, tense muscles from stress' (ibid:5). Chronic pain is

also shown to have a link with domestic violence (Hamberg, et al 1999; Campbell et al, 2002; Black et al, 2011). In addition, trauma, stress and anxiety caused by domestic violence are risk factors for many pain conditions, including chest pain and abdominal pain (Verizon Foundation and Florida State University, 2014).

A recent review of 10 years of research on domestic violence in India shows that while gynaecological and mental health issues have been covered to some extent, impact of domestic violence on physical health has not been studied adequately (Kalokhe et al, 2016). The findings of this study further underscore the need for a detailed investigation into the linkages between violence and overall physical health with specific attention to pain.

### **A precarious system**

In the pre-dam era, as one anecdote goes, Araria was completely cut off for four to five months of the year because of floods. For those months, the region was stateless. Today, even as the state is omnipresent, it remains largely absent from Araria's healthcare system.<sup>11</sup>

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11. Apart from managing deliveries in hospitals and sterilizing women.

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Describing what happens when a woman falls severely ill, R said:

The husband will first take her to the *jholawala* doctor at the chowk (quack in the village market). Some money will be spent there. But if she doesn't get better, then they will take her to private at K<sup>12</sup>. Then they can go to Araria private. They can also go to Purnia private. This is what villagers usually do.

State-run health services don't feature in people's plans at the time of care-seeking. It is commonly known that the public health services system in Araria is crumbling. Like many parts of India, but with more intensity, it is being increasingly taken over by a sprawling unregulated private health sector. The strongest grip is of the informal and untrained private practitioners or quacks, medical store owners and traditional healers in the villages. Most villages, no matter how remote, have quacks, sometimes three or four of them. The public health services through Accredited Social Health Activists (ASHAs), *aganwadis* and sub-centres function primarily as the sites for vaccinations and

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12. To anonymize the place and identities, only initial of the specific name has been used. K refers to a nearby bigger village about 7 kilometres from R's village.

maintaining government records. While the sub-centres open occasionally, the private healthcare providers are always on call.

At the second tier of government health services structure, comprising of additional PHCs and the PHCs, high absenteeism and weak infrastructure result in overall low patient turnout. The referral hospitals at the blocks, equivalent to the Community health Centres, have made some improvements in maternal and child health services. But they are overburdened with patient load and are underprepared in terms of facilities and staff. On the other hand, private clinics with more equipment and diagnostic facilities than the government set up have come up at the block level.

The private referral chain, with private providers at village and block levels referring patients to private doctors at the district, works faster than the government referral system. The district town sees a thriving private practice by trained doctors, some of them also serving in the government facilities. By contrast, the government-run district hospital witnesses chaotic queues of unattended patients, non-functional diagnostic facilities, chronic scarcity of medicine stocks, and lack of requisite standards of hygiene and cleanliness.

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The divide between public and private healthcare has gotten deeply ingrained in the public perception of healthcare quality. Given its shortages, there is an increasing trust deficit in the government health setup, leading to its underutilisation and adding further to the general lethargy. Private healthcare at all levels is preferred for its ready availability and responsiveness.

But the private health set up is highly unregulated in terms of price and accountability, nor does it necessarily quality healthcare. There is no fixed fee that a quack takes, and it fluctuates as per the condition and the medicines he gives. Drugs are invariably sold at prices higher than the MRP in medical stores in rural areas. At block and district levels, high costs are incurred in multiple tests and hospitalisation. Absence of public transport facilities causes additional expenses on private transportation. Loss of wages and draining of reserves combine to make an illness episode a huge financial burden on the family. This forces families to choose whose and what kind of illness can be addressed. Women and the conditions that don't necessarily kill, such as pain, are often not the choices.

### **Village doctors and *suiyyas***

Women relied heavily on the village doctors for most health issues, including pain. On asking what she does when there's pain, S replied:

I go to the doctor at the chowk to get medicine. I take it in the night, and there is some relief. But it starts paining again in the morning. I keep going to get the medicine every two to three days.

Village doctors, or the quacks, are typically young to middle aged men from the same or nearby villages. Most of them own a shop at the *chowk* (market) that have allopathic medicines, and some of them have benches where patients can lie down and be given injections or drips. It is not clear what kind of medical training they receive but one village doctor hesitantly informed me that he “practised” under an orthopaedic for four years, and then with a child specialist for some time.

This group of informal healthcare providers speak the same language as the women do, are part of a similar cultural context if not from the same class or caste, and are accessible round the clock. They often allow delayed payments of fees or medicines, and sometimes even accept



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payments in kind, mostly grains. These flexibilities are important for women to be able to seek care.

When a woman comes with a complaint of pain, according to one quack, she is given paracetamol tablets and some medicine for indigestion or stomach gas. A recent review of evidence on treatments, however, does not recommend use of paracetamol both in acute and persistent low back pain (Foster et al, 2018), the most common pain women went to doctors for. If the pain is too much, diclofenac injections<sup>13</sup> are given.

The quacks are known for giving *suiyya* (injections) and *paani* (drips) indiscriminately. This allows them to make quick money. At the same time, injections and drips administered intravenously or intramuscularly often have an immediate effect, both felt and perceived. For women workers wanting to get back to work as soon as possible, *suiyyas* become the necessary evil. P describes her experience:

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13. Diclofenac is a nonsteroidal anti-inflammatory drug. See more at: Diclofenac Sodium 75 MG Injection, (n.d). <https://www.mayoclinic.org/drugs-supplements/diclofenac-oral-route/description/drg-20069748>. Last accessed on June 24, 2018.

I did x-ray (of my knee) for two hundred rupees. The doctor who sits at the bazaar said that there is nothing wrong in the x-ray, you have pain in *nas* (vein). If you take *suiyya*, the pain will go away. I took at least forty *suiyya*. Forty! He took 30 rupees, sometimes even 50 rupees per *suiyya*...I took it every alternate day for two months...It was fine when I was taking *suiyya*, I could walk and even do work...But now, even after taking *suiyya*, pain doesn't go away...I think I should show it to a *haddi ka doctor* (bone specialist or orthopaedic). But there's no money.

Injections are also given generously by the government health workers in villages. S talked about going to the sub-centre to take the *suiyya* for her back pain instead of the quack because there she could get it for 10 rupees. B was considering going to the Auxiliary Nurse Midwife (ANM) at the village sub-centre again:

When there is *safed paani* (white discharge), I have pain in the abdomen, thighs and back. I feel very weak and dizzy. J said she also had this problem...I went to see the ANM last year. She gave me 5 *suiyya*, and took 2 rupees. It was fine for a while, but started again.

Even as the *suiyya* may have given some immediate relief, none of the respondents reported that the effect was long lasting. Yet, it was the

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preferred method of treatment by both the patients who wanted faster relief, and by the rural healthcare providers who believed that injections ensured better compliance than medicines.

Popularity of injections, owing to 'local beliefs about illness and concepts of efficacy', 'economic interests of private providers' and 'lack of communication between patient and provider', has been reported in other parts of the developing world (van Staa and Hordon, 1996: iv). Anthropologists have used the term 'injection doctors' to describe this flourishing phenomenon (Simonsen et al, 1999).

WHO recommends 7 steps necessary for injection safety: clean work space, hand hygiene, sterile safety engineered equipment, sterile vial of medication and diluent, skin cleaning, appropriate collection of sharps, and appropriate waste management (WHO, 2016). Out of all these, the only step that may have been followed by the quacks in rural Bihar is that of having a safe equipment, thanks to the growing use of disposable syringes. In extreme cases, quacks with shops in open markets injected women intramuscularly on the thigh with their *saaris* (dress) on.

Unsafe and unnecessary injections<sup>14</sup> are shown to have serious health impacts, including pathogen transmissions leading to ‘hepatitis B and C, HIV, Ebola and Lassa virus infections and malaria’ (Simonsen et al, 1999: 789); abscesses (Kotwal, 2005); and traumatic nerve injuries (Shah et al, 2016).

Women in rural Bihar, therefore, are not only in pain but also in constant danger of infections and traumatic conditions caused by unsafe practices of the village doctors, who continue to be their first and often only point of contact, mostly by circumstances but also sometimes by choice.

### **Neglect and abuse at government health facilities**

Below, I describe medical encounters of three different women going to government health facilities.

G had difficulty in standing and walking because of severe pelvic pain. She had covered a distance of two hours by an auto and spent sixty

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14. Unnecessary Injections are defined as ‘one where oral alternatives are available, where the injected substance is inappropriate or harmful or where the symptoms or diagnosis do not warrant treatment by injection’ (Gore et al, 2013: 1157).

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rupees to reach the district hospital. She entered the emergency OPD, and from another room emerged a doctor looking at his phone. After taking his seat, he asked her name, her husband's name, and gave a quick glance at her to guess her age. G wasn't asked to sit. Once he was done filling the details in the register, he asked her what was wrong. Before G could finish telling about the site, the history or the sudden relapse of pain, the doctor had already handed out a prescription: a ranitidine injection<sup>15</sup> and a dicyclomine injection.<sup>16</sup>

When R entered the room of the government doctor posted at the PHC 15 kilometres from her village, the doctor asked her name and the problem. R said she had *dinaai* (fungal infection), and started showing her hands and shoulders where she had it. The doctor didn't look up,

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15. Ranitidine is used for treating stomach and intestine ulcers, and throat and stomach related problems due to excessive acid production. It should be given in injection form only when it cannot be taken orally, which was not the case with G. See more at Ranitidine injection-Zantac, (n.d.). [https://www.medicinenet.com/ranitidine\\_injection/article.html](https://www.medicinenet.com/ranitidine_injection/article.html). Last accessed on May 22, 2018.

16. Dicyclomine is used to treat muscle spasms in stomach and intestine, and for irritable bowel syndrome. See more at Dicyclomine Injection, (n.d.) <https://www.drugs.com/pro/dicyclomine-injection.html>. Last accessed on May 22, 2018.

and handed out the prescription. R added that she also had back pain. This angered the doctor, who said, *'why don't you tell everything all at once?'*

R replied:

I am telling you. You didn't even look up. You didn't ask any questions. I was showing you where I have pain in my back. I have pain here, at this point.

The infuriated doctor said:

How can I touch you to see where you have pain?! Get lost from here.

After taking 40 injections from a quack, P still had no relief from knee pain, and so her son took her to the district hospital. P had forgotten to carry her Aadhaar card, and was denied OPD registration at first. Thanks to the intervention of a known nurse, she was registered. She was seen by a general physician who had been already informed by the nurse that she had knee pain. He asked her to move her leg once. He did not ask any questions, and handed out a prescription of calcium tablets, analgesics, diclofenac gel, and a medicine for muscle tightening that was not available at the hospital pharmacy. P spent a total of four minutes in the OPD.

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All three medical encounters followed a pattern: women experienced indifference and callousness at each place. The doctor did not look up; women were not asked to sit; they were not physically examined; no history was taken; vitals were not checked; doctors did not ask any questions nor allowed queries; the total interaction lasted less than five minutes; women were talked down upon; and their pain did not improve. The multiple and interacting power hierarchies of class, caste, gender and knowledge worked against the women, making these medical encounters disempowering experiences.

The experience at the PHC left R disturbed:

How do deaths happen at hospitals? They happen like this. After a patient's death, doctors claim that they checked her, and make reports that death happened because of this disease or that. But now I understand, they don't see the patients when they are alive. Like today he didn't even look at me, and if I somehow die, he will make a report that she had *kehoon ka kami* (anaemia)...In big hospitals too this happens. It has become the *niyam* (rule) of *sarkaari* (government) hospitals to scold and mistreat us... People from outside, people who are educated, come and tell us that we are irrational or that we have bias

against government services. But who knows the *haqiqat* (reality)?

Many respondents talked about mistreatment not only by the doctors but also the staff at the government health facilities. A commonly shared experience was of physical abuse of pregnant women. Attending nurses often hit pregnant women if they screamed out of pain. Some nurses also became violent if the labour was not starting and their shift was about to end, as that would mean they wouldn't be able to ask for money for that delivery. Exhorting money was a common practice, and all workers, from ASHA, ambulance driver, cleaners, ANM to the nurses, had fixed demands.

A recent development at all tiers of the government health setup in Araria, except the sub-centre, is of having uniformed guards in the premises. In the wake of attacks on doctors in government hospitals, guards have now been appointed to manage the *bheed* (unruly crowd). These guards roam around with a baton, prod patients to form or remain in queues, and provide security to the doctors on call. Instilling fear in the name of smooth functioning, these guards might be a representation of how the state now envisions healthcare: top-down, provider-oriented, and devoid of any personal and sympathetic touch. In such a vision, someone like R and her pain may not find a place.



## IV. CONCLUSION

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This report has brought out the lived experiences of pain of women agricultural workers in rural Bihar. Women agricultural workers are particularly vulnerable to back pain as per quantitative findings from WHO-SAGE 2007-08. They also constitute a large number of people – more than 6 crores according to the estimates of the 2011 census. The heavy burden of pain borne by this large group should be a matter of research and policy concern. It is not, currently.

The report embeds pain within the larger context of women's health experiences across the life course; the backbreaking nature of women's work; lack of protective nutrition and rest; pervasiveness of domestic violence against them; vagaries of informal and private healthcare; and disempowering experiences of women at government health facilities.

Women's lives, health and experiences of pain in rural Bihar are intricately multidimensional, and policy agendas will need to acknowledge that. The following paragraphs suggest a few directions that can be taken. By no means are these suggestions to be considered

comprehensive, and much further research and dialogue are needed to design, monitor, and evaluate policy interventions. Along with policy interventions, improving women's overall position within and outside the household is essential.

Broadly, the suggestions outlined here can be split into two categories. First are those issues that are quite important but are not on the radar of mainstream policy approaches at all. The second set of suggestions belong to an agenda which, although being pursued by researchers, practitioners, and sometimes even governments, still needs a push.

In terms of ideas that are already under discussion, but have not been implemented, are pursuing a broader agenda of women's health and not just maternal health and invasive contraception; improving food and nutrition security through the public distribution system and maternity entitlements; stronger local campaigns to address domestic violence along with stricter implementations of existing laws, as well as newer legislation outlawing marital sexual violence; ensuring accountability, transparency, and safety in private and informal healthcare; increasing easy and informed access to effective medications for pain; strengthening public health services system; and

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making doctors, health personnel and other practitioners gender-sensitive and the overall health system gender-just.

Among the issues that are not on the agenda, but should be, are promoting contextually suitable technical innovation in agricultural and domestic manual work (such as longer handles for brooms which reduce the need to bend); encouraging gender equity in household and outside work; discouraging fasting and patriarchal practices that harm women's nutritional intake; improving medical curricula, texts, and training of medical doctors on pain; training local health workers such as ASHAs and ANMs on pain management; removing technical barriers such as mandatory Aadhaar and physical barriers such as uniformed guards in people's access to government health services; and actively promoting research and evidence generation from a variety of disciplines on pain in general and women's pain in particular.

This is, admittedly, a tall order for public policy. But many current programmes, laws, and policies that are taken for granted today, such as the provisions of the Hindu Code Bill, laws against untouchability, the Right to Information or provision of daily hot cooked mid-day meals in schools, were seen impossible just a few decades ago. Yet, because of social action, changes in ethical norms, democratic

pressures, and State and central government efforts, these initiatives were enacted and implemented (Dreze, 2004). There is no reason why public health in general and women's health in particular should remain neglected in India. Indeed, if the overwhelming burden of physical pain among women and its debilitating impact on their quality of life becomes recognized and unacceptable, social change and policy initiatives will be easier to pursue. This is a big task, but one that is essential to women's lives and wellbeing in India.

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