Double Victims of Latur Earthquake

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This paper deals with the invisibility of gender dimension in the relief and rehabilitation process. It highlights the way an unthoughtful rehabilitation intervention strengthens patriarchy and subjects women to physical and mental pain. Here, the focus is on the use of a pervasive medical technology, recanalisation, with a plea to preserve the social fabric, but which makes women mere 'tubes and wombs' instead.

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INTRODUCTION

Rehabilitation and resettlement (R&R) after a natural disaster is a long and trying process of human adjustment for any community. So far, the main concern of the state authorities during the interim period, has been to cater to the basic needs of the people living in transit camps. The survivors, on their part, make attempts to restore the physical, social and economic equilibria for sustaining the societal system. This results in a range of social dynamics between relationships that go unnoticed. Power is pronounced and behaviours are shaped according to felt needs, and in the process, those who control resources emerge as victors. The way in which gender inequalities are explicitly articulated is critical.

In September 1993, the Latur and Osmanabad districts in the Marathwada region of Maharashtra were hit by a ruinous earthquake. The aid and cash that flowed in helped the victims to recoup from the initial trauma. However, the agents involved did not aim at bringing changes in the existing societal structures, and as a consequence, the edifices of polarised and patriarchal society remained.

The demographic changes due to the deaths were perceived and responded to according to the said persistent patriarchal norms. Widower remarriage was accepted and viewed as desirable, while widow

remarriage was considered undesirable. Families who had lost their sons were seen as dual victims compared to those who had lost their daughters. The grief and empathy was not gender neutral; more the male deaths in the family, more the empathy and grief.

While people grappled to adjust, patriarchy, in its characteristic style, did not succumb to the course of natural events. Instead, it expressed itself vehemently, and was strengthened with the pervasive use of medical technology that made women mere 'wombs and tubes'.

Recanalisation[1] ensured initial rehabilitation efforts. To mask their vested interests, a few zealous 'social rehabilitators' attempted to reverse the fertility behaviour of those women who, in the past, had adopted family planning measures to curtail their family size, but had lost their (male) offspring(s) during the earthquake. The plea of the social rehabilitators was to save marriages, preserve the social fabric and reestablish the initial social order.

Recanalisation is an accepted clinical method in medical circles. However, before attempting operations, doctors establish a few parameters, like the age and present health status of the woman, time elapsed after sterilisation, and the type and anatomic location of the tubectomy performed, for it to be a success. The doctors also state that it is not a simple operation as it is to be conducted by a gynaecologist under general or spinal anaesthesia. It involves making an incision of four inches and 8-10 sutures are made to cover the wound, and it takes about an hour to perform the operation. Medical professionals do not rule out complications and prolonged morbidity if after care is neglected. While the mortality rate is low, the risk of life due to tubal pregnancy is high. Clinical research gives a 60:40 success rate to conceive, but does not guarantee a male child.

Government hospitals do not encourage recanalisation since it goes against the ideology of family planning. The cost of such an operation in a private clinic ranges anywhere between Rs. 5,000-10,000.

RECANALISATION IN LATUR

In March-April 1994, six months after the earthquake, 40 women were operated for recanalisation in a private hospital at Latin- in batches of 7-12 women. Each batch was discharged after 8-10 days when the exterior sutures were removed. All women underwent routine medical examination before the operation, though it is not clear whether all the women qualified on all the parameters.

Villagers estimate that around 100-150 women were operated upon. Other than the stated 40, the rest were operated at private clinics. The first few operations were done free of cost, and once they had established practice, patients were charged a fee.

The doctors and the health services system have been oblivious to the high morbidity and health problems prevailing among these women today: the constant suffering from body aches and backaches, fever, irregular menstrual cycle, swelling over the uterus, anaemia and several other problems. Savitri,[2] a woman from Sastur, had to undergo a hysterectomy, due to tubal pregnancy after recanalisation.

The women were not aware of the gravity of the operation. They were given no information about it. Most of them thought that it was a simple process like the tubectomy performed earlier. Today, many feel scared when they realise the seriousness of the operation and its long-term implications on their health. The doctors operated indiscriminately upon these women without taking the age factor into consideration, for this is directly related to the risk of abnormality in the new born. One is provoked into assessing the degree of violation to a person's body, by holding back information from the person whose life is at risk.

The 40 women who were operated upon at the said hospital in Latur, belong to the villages of Killari, Mangrul, Rajegaon, Pet Sangvi, Talni, Nandurg, and Sastur. They were in the age group of 25-42 years.[4] A local doctor with an LMP qualification of Killari village, along with a few volunteers, visited the villages close to the state highway. They went from house to house searching for those who had lost their children in the earthquake to convince them about the validity of the operation. In Talni, the doctor took the *Panchayat* into confidence and the operation was openly announced in the village. In cases where either the couples or the family showed some reluctance towards the operation, the doctor made efforts to convince them. For instance, in Mangrul village, one woman's father-in-law, considering the poor health of the woman, was not in favour of the operation. Medical investigations also ruled out its feasibility. However, the local doctor convinced the woman's husband that they could have a child after the operation. The operation was, hence, performed.

The marketing strategy of the technology assured the people that recanalisation as an operation was probably the surest way to conceive and to have sons. What lured people into having the operation was that it was performed free of cost. Free transport was provided for the

woman who were to be operated upon. People had to only pay for their meals and their personal expenses. A local doctor stated, 'We provided them a chance to have a son'. The commercialisation of wombs escalated hopes for a (male) child. What is tragic is that hopes were raised even for those women who had a mutilated fimbrian or had lost one tube, all due to the callous attitude of doctors who had not cared to see the state of the extant anatomy of the patients.[6]

RECANALISATION AND PATRIARCHY: AFTER ONE YEAR

The typical odyssey of oppression of these women began with the elevated hopes (due to technology) to meet the social dictates of patriarchy. It was discomforting to comprehend the way a woman's body was completely delinked from her subjectivity. In these societies, the institution of marriage determined the reproductive behaviour, which in turn promoted women's status, patriarchal heritage and family lineage. Family members, peer groups and natal family members of the women, all influenced the women to opt for the operations. The desire to have a patriarchal lineage cuts across caste, education, socioeconomic status and even age. A 58-year old retired school teacher, had a grandson. In the quest to have a son, he forced his 42-year-old wife to opt for the operation. Families, were willing to borrow money or take loans on the compensation cheques or even sell their crops in order to have an operation performed. Almost all women, though scared, opted for the operation with a fatalistic attitude. '...We have lost everything in the earthquake... if we have to die we will...' 'I was scared but there are no choices...' The agents of social rehabilitation preyed on these helpless women by advertising technology to their advantage.

Women who underwent the operation became 'objects of reproduction' for society. The whole society began to look for signs of pregnancy in these women. The bodies of women ceased to be in their private realm, instead they were public commodities. Laxmibai, like many others, was humiliated by the people in her community, for her incapacity to conceive again. The women have realised that their plight will not end with one pregnancy, for they have in store a set of (prospective) pregnancies, till the right product — a male child — is delivered. This has reduced women to (male) child producing machines.

Technology had promised to provide an old age security in the name of children, and in turn, save marriages. Neither of the promises holds

true in most cases. Instead, constant stress and disharmony prevail in the lives of couples who have used a considerable part of their resources for the operations. The pervasive apathy and complicity towards these women's lives and health by society and family, coupled with their inability to reproduce has robbed them of their dignity. In the bargain, they have become double victims of a natural disaster. There are many like Shamalbai from Mangrul who persistently suffers from a number of physical ailments after the operation. The NGOs, the doctor who had initiated the operations and health functionaries are insensitive towards their health. In addition, the depletion of family resources has reduced access to health care and, hence, aggravated the morbidity among them.

Husbands have waited anxiously and impatiently the desired product that is, the male child. Threats and plans for remarriage are made in the absence of any signs of pregnancy, placing women under constant duress. One woman stated, 'As the date of menses approaches, I wait and hope to miss my periods, for it would mean that I have conceived. But, when I get them, I feel helpless once again.' Another woman stated, 'When I came out of the debris it was my second birth, I died once again after the operation, as in spite of it, I am not able to conceive... the expectations have been raised in vain... my life is meaningless now... my husband is remarrying since I have not conceived in the last one year.'

Men can negotiate exchanges that are favourable to them. The bargaining position of women is different: they have to keep in view their own vulnerability and welfare besides the overall welfare of their family. Their choices and decisions are shaped within a network of social relationships. The threat of remarriage by their husbands undermines their self-worth and dignity as they know that their choices will find no social support.

Women who have resigned themselves to their husbands' remarriage go through compounded trauma and depression: one of loss of children followed by a break of a relationship. Chandrakala, Laxmibai and a few others, have given consent to their husbands to remarry, but are going through a traumatic phase. They show signs of depression: sleepless nights, loss of appetite, dryness of mouth, self-blame, lack of concentration or interest in any kind of activity.

In my whole survey, I met only one woman who was confident of her husband not remarrying. She showed a marked difference in her physical and psychological condition from the others who were

experiencing constant threat of remarriage from their husbands. She alone exhibited strength and confidence.

Some among those who have not been able to cope with the pressure to reproduce or the threat of break up of marriage, show signs of pseudo-pregnancy. Suman from Mangrul, 35 years of age, claims that she is four months pregnant. She complains of staining and irregular periods. Her biggest worry is the slow growth of the foetus. The tests of pregnancy are negative; yet the belief continues. Nearly all these women are experiencing abnormal menstrual cycles after the operation. However, these women consider the irregular periods as signs of miscarriage. Their 'solace' is that at least they have conceived.

Sheer frustration and helplessness is not uncommon in most women who have not conceived. They feel that their physical agony is undermined both by the society and their families. They express anger towards the doctor. For them, it is he who had raised hopes which provoked the families to seek an option for patriarchal lineage. They had otherwise resigned to fate and destiny.

CONCLUSION

The R&R processes are not merely reconstruction of houses and villages. Tragedies are mainly human and an imaginative R&R policy could aim at transforming the social relations, whether they are related to land, caste or gender. Societies which are otherwise inequitous and static, need a major 'culture shock' therapy, which can best come from without. Presently, there are a large number of schemes within the R&R framework that envelop economic, social and engineering dimensions. The class-gender dimension cuts across all these but only the class issues are, as yet, to an extent recognised. The invisibility of the gender dimension has a powerful impact too, as has been illustrated in this paper.

NOTES

1. Recaruilisation refers to a medical operation performed on a woman who has had a tubectomy done to prevent pregnancy.
2. None of the names are real. Fictitious names have been used to maintain confidentiality.
3. Clinical research suggests that children born to mothers of 35+ years have a greater risk of being abnormal.
4. The researchers met women who hailed from these villages only.

5. Fortunately for this family, this woman alone has successfully given birth to a child.
6. The local doctor maintained that they kept the family and women ignorant of this medical information because it would have shattered them psychologically. A few families realised it when they visited other doctors because they had not conceived.