Amsterdam Masters in Medical Anthropology

Women's Perceptions of White Discharge and Health Seeking Behaviour in an Urban Slum in Chennai City, Tamil Nadu, India

By

Mala Ramanathan

Supervisor: Dr. Anita Hardon

Thesis submitted for the Masters Degree

Faculty of Political and Social-Cultural Sciences
University of Amsterdam
Medical Anthropology Unit, Anthropological-Sociological Centre
Oudezijds Achterburgwal 185,
1012 DK Amsterdam, The Netherlands

August, 1998
Amsterdam Masters in Medical Anthropology

Women’s Perceptions of White Discharge and Health Seeking Behaviour in an Urban Slum in Chennai City, Tamil Nadu, India

By

Mala Ramanathan

Supervisor: Dr. Anita Hardon

Thesis submitted for the Masters Degree

Faculty of Political and Social-Cultural Sciences
University of Amsterdam
Medical Anthropology Unit, Anthropological-Sociological Centre
Oudezijds Achterburgwal 185,
1012 DK Amsterdam, The Netherlands

August, 1998
Acknowledgements

This is a thesis work that has been undertaken as part fulfilment of the requirements of the Masters’ degree in Medical Anthropology at the Medical Anthropology Unit, University of Amsterdam, The Netherlands.

I am grateful to Dr.Anita Hardon my guide for encouraging me to work on this topic, guiding me through my fledgling efforts in Medical Anthropology and supporting me throughout the process.

I would also like to thank Dr.Sjaak van der Geest and the other faculty at AMMA who tried to instil the anthropological instinct in me.

I would also like to thank Dr.Mohan Das, the Director of SCTIMST and my colleagues at AMCHSS for their efforts in supporting my study here in Amsterdam.

I am grateful to Dr.Sumathy Rao, Dr.Sundari Ravindran, Dr.Tavamani, Dr.Narashiman, Dr.S.S.Acharya, Dr.Padmini Swaminathan and Dr.K.Nagaraj for their efforts in Chennai and Trivandrum for their efforts in supporting my field work.

The women of Vaiyapuri Chattam who took me into their homes and talked patiently to me and answered all my baffling questions and sustained me throughout the fieldwork, I owe an everlasting debt. I am grateful to Rajathy and Dhanam who were my promoters in Vaiyapuri Chattam for facilitating my acceptance into Vaiyapuri Chattam.

To Preeti, who sustained me with encouraging e-mails and listened patiently as I discussed my thesis and Dennis for patiently editing segments of the thesis go my heart felt thanks.

Last, but not the least I would like to acknowledge a great debt that I owe to my family, my husband, Dr.Udaya Shankar Mishra and my son Ashwin Mishra who waited patiently for their wife/mother to come home and encouraged me to give it my best.

Thank you, All.

Mala Ramanathan.
### Contents

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Chapters</th>
<th>Page numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Introduction</strong></td>
<td>5</td>
</tr>
<tr>
<td>1.1.</td>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>1.2.</td>
<td>Background</td>
<td>6</td>
</tr>
<tr>
<td>1.3.</td>
<td>The statement of the problem</td>
<td>9</td>
</tr>
<tr>
<td>1.4.</td>
<td>Objectives and research questions</td>
<td>11</td>
</tr>
</tbody>
</table>

| 2.    | **Review of Literature**       | 13           |
| 2.1.  | Reproductive Tract Infections  | 13           |
| 2.2.  | Global prevalence of RTIs      | 14           |
| 2.3.  | Health consequences of RTIs     | 15           |
| 2.4.  | Health care seeking for RTIs    | 16           |
| 2.5.  | Prevalence of RTIs in India    | 17           |
| 2.6.  | Reproductive Health Programme in India | 19       |
| 2.7.  | Anthropological studies of RTIs/White Discharge in India | 20 |
| 2.8.  | Need for the study             | 23           |

| 3.    | **Methodology**                | 24           |
| 3.1.  | Study type                     | 24           |
| 3.2.  | Data collection techniques     | 28           |
| 3.3.  | Sampling                       | 33           |
| 3.4.  | Data collection                | 37           |
| 3.5.  | Data processing and analysis   | 38           |
| 3.6.  | Ethical considerations         | 38           |
| 3.7.  | Experiences with fieldwork     | 39           |
4. Findings and Discussion

4.1. Women’s health problems 40
4.2. Experience of *vellai padudal* 42
4.3. Perceptions of *vellai padudal* 44
4.4. Treatment seeking for *vellai padudal* 50
4.5. Health service providers in Vaiyapuri Chatram 57

4.6. Discussion 58

5. Conclusions and Policy Implications 61

5.1. Conclusions 61
5.2. Policy Implications 63
Appendix I 64
References 67
Chapter 1.
Introduction

1.1. Introduction

Women are distressed by certain of the symptoms of gynaecological morbidity such as leukorrhea and menstrual disorders (Nichter, 1981, 1981a). Early anthropological studies on women's distress caused by white discharge viewed such illnesses as 'idioms of distress' attributed to psychosocial distress. These studies, used a somatic construct to illness descriptions and considered women's complaints of white discharge and menstrual disorders as 'an alternative means of expressing their psychosocial distress' (Nichter, 1981a). This view is relevant, as the illness is contextualised in terms of the cultural and social position of the women. However, by adopting such a somatic construct to this illness and treating it as a form of folk illness which, therefore requires psycho-social remedies does in a way belittle the physical distress. On the other hand, epidemiological studies on gynaecological morbidity move from women's complaints of physical distress and examine the clinical validity of such complaints using extensive medical testing procedures (Bang, et al., 1989; Zurayk, et al., 1993; Bhatia and Cleland, 1995). These two sets of studies represent two polarities in terms of conceptualisation of the illness. There is, therefore, a need for incorporating these two extreme positions in an understanding of this illness and this study, attempts to bridge the gap.

While considering women's complaints of white discharge from a morbidity move from women's complaints of physical distress and examine the clinical psychosocial perspective, the need for the provision of appropriate health care to mitigate such an illness gets more often than not, ignored. The provision of appropriate health care to meet the reproductive health needs of men and women in the community is one of the hallmarks of the newly articulated Programme for Action of the 1994 International Conference on
Population and Development. Most of the nations of the world are signatories to this document and are committed to its implementation. From a gender sensitive and reproductive health perspective, it then becomes important to understand the women's perceptions of this illness, namely white discharge and learn of the women's' health seeking patterns. Such an understanding would perhaps assist in evolving reproductive health programmes that are culturally sensitive and build on the existing knowledge base.

In this research exercise, I therefore attempt to study women's perceptions of white discharge and the health seeking behaviour. The findings are reported in five chapters, the first of which details the need for the study, the statement of the problem, the objectives and research questions that need answering. In the second chapter, I briefly review the available literature on reproductive tract infections (RTIs), some relevant studies that were conducted in India on gynaecological morbidity. The third chapter outlines the methodology, outlining the study type and design, the research themes, the sampling, the data collection techniques and a brief description of the study area. The fourth chapter outlines the major findings that are described in terms of the perceptions of white discharge and health seeking of those with experience of white discharge and those without experience. The chapter also contains a brief description of the informants and the health facilities available to them. The fifth and final chapter briefly summarises the study and presents the major conclusions and policy implications.

1.2. Background

Existing studies in India of women's reproductive health problems usually fall into two categories, researching causes and determinants of maternal mortality or the incidence/prevalence of RTIs. Following the Bang et. al., (1989) seminal work on RTIs in rural Maharashtra, there have been several similar community based studies conducted in different parts of the country (Bhatia and Cleland, 1995; Bhatia, et. al., 1997). Some other studies have been of limited use as they
have considered specific hospitals or categories of patients such as commercial
sex workers or patients at STD clinics or the cancer hospital registry (Luthra, et.
al., 1992). Other studies have looked at the women's perceptions of white
discharge alone without relating it to their health seeking behaviour (Narayan
and Srinivasan, 1994; Bang and Bang, 1994; Jaswal and Harpham, 1997).

The prevalence of gynaecological morbidity among women in India is
known to be high, but women do not seem to seek any medical assistance in
this regard and if they do, they seek it outside the public health care system
(Bang, et. al., 1989). This study indicated that about 92 per cent of the women
of the reproductive ages, who participated in the study in two villages in Gujarat,
had indications of at least one problem (Bang, et. al., 1989). In the state of
Karnataka, Bhatia, et. al., (1997) found that about 54 per cent of the women
suffered from one or the other gynaecological health problem (Bhatia, et. al.,
1997) and this study had a participation rate of 90 per cent. Even though
awareness of the problem was not low (about 55 per cent) only about 8 per cent
of these women in the Gujarat study had sought any assistance in the past (Bang,
et. al., 1989).

Anthropological studies on women's perceptions of such problems,
especially in India are rare. One such study uses an ethnomedical model to study
this issue (Oomman, 1997), among rural women in Gujarat. She represents
women's perceptions of white discharge as a 'semantic network of illnesses'.
Such a model allowed for the linking of the women's socio-economic situation
with their cultural perceptions of gynaecological ill health. In a similar way,
Ramsubban (1997) attempted to link the women's perceptions of weakness in a
low class setting in Mumbai, to a host of illnesses, one of which was white
discharge.

Nichter (1981a) noted that among Havik Brahmin women, complaints of
'bili hoguvudu' or 'white going' were actually a means of expressing
psychosocial distress in a manner that was acceptable to the community. He
calls it an 'idiom of distress'. The presence of alternative sources of medical care, such as Ayurvedic practitioners specialising in women's health problems served to mitigate these problems among such groups (Nichter, 1981). Mutatkar notes that leucorrhoea and anaemia are problems that affect women in rural and urban areas as well (Mutatkar, 1995).

These epidemiological and anthropological studies are needed to understand the extent of prevalence and the women’s perceptions of their various illnesses. What has been lacking is studies on the women’s perceptions of these illnesses and how these perceptions and other factors at a community/household and individual level affect their health seeking behaviour. This knowledge would help in designing better programmes that would enable the health care delivery systems to assist the women better.

In India, the Ministry of Health and Family Welfare is engaged in restructuring the old target oriented Family Welfare Programme into a Reproductive and Child Health Programme, which puts the health of individuals as central to its programme instead of the more population control oriented programmes of the past. In keeping with this shift, targets that used to be set for health workers vis-à-vis contraceptive methods have been abolished (Govt. of India, 1996). This shift has been in line with the Programme for Action adopted at the International Conference for Population and Development, Cairo, 1994, of which the Government of India is a signatory. Therefore, research on the problems of health care seeking, especially of women in the disadvantaged situations could be useful to make informed policy decisions regarding the programmes for health.

During the course of some interviews with women in the reproductive ages on issues of reproductive health, the researcher found that some women did not think of white discharge as a health problem that needed bio-medical assistance. They spoke of it as a problem that needed to be endured by some women because it was a part of womanhood. If it became acute, they could use
some home remedies, but there was no way of solving the problem. Certain others felt that it was caused by ‘unhygienic’ or ‘unclean’ practices that they had such as using not-properly washed menstrual cloth or exchanging of underclothing or due to partners who had infections themselves. While they felt that some of these could be solved by preventive measures like using clean clothing etc., they could not refuse sexual relations with husbands (even if they suspected them of being the cause of their own illnesses).

1.3. The statement of the problem

The main problem is therefore the minimal available knowledge of the cultural construction of white discharge and the manner in which this influences women’s health seeking behaviour.

Women’s perceptions of white discharge may be affected in general by the cultural construction of health in the community, especially in India where traditional health systems like Ayurveda, Unani and Siddha, have served the needs of the population for several centuries. Nichter (1989) has noticed that humoral and other ideas of ethnophysiology characterise the health care practices that prevail in rural south India. It is possible that the general notions of health and diseases that prevail in the community affect women’s perceptions of their own illnesses, the causes and consequences.

Women experience health problems throughout their lifetime but problems associated with their reproductive tracts are particularly difficult for them because of the ‘Culture of Silence’ (Mueller and Wasserheit, 1991) that surrounds this health problem. Usually, they are too ashamed to discuss or refer to such problems because of the associations with sexuality and reproduction, which are relatively taboo subjects in most Third World situations.

The woman’s situation, in terms of her access to resources, her age, the number of children that she has all serve to strengthen her position in her marital
home (Mendelbaum, 1970) and this also enhances her chances of being able to access health care, should she need it.

But however much autonomous she is within her own household, the relative position of her household in the hierarchy of the society, especially matters like the caste, religion of the household, its economic situation in relation to others in the community are also factors that would affect her access to resources (Vlassof, 1993). Apart from the socio-economic and cultural factors that affect woman’s perceptions of WD, there are other factors associated with the way they interpret the symptoms associated with it and the way they try to find solutions for this illness.

Whether or not women seek health care for this problem and then the type of care sought may depend on several factors. The nature of the community in which she is situated and the access it has to health care would influence health care seeking greatly.

Thus, health seeking can be viewed from the perspective of Klienman’s model for health systems, that distinguishes three partly overlapping sectors in health care: the popular sector that comprises the lay, non-professional domain where illness is first recognised and treated; the folk sector that consists of local healers and traditional birth attendants and other specialists and the professional sector that is the domain of medical specialists belonging to professionalised health systems like Biomedical, Ayurvedic, Unani, Siddha or Chinese medicine (Kleinman, 1980). It is expected that the women’s perceptions of the treatments and the knowledge of the resources available to the women and significant others associated with her would influence her health seeking behaviour.

In addition, the various health sectors have their own characteristic mode of operation. For example, women seeking reproductive health care from the public sector in India had not been informed of the side effects or
contraindications of the different contraceptive choices available to them (Ramanathan, 1996). Women have found their access to health services limited by the absence of doctors, especially female doctors at the health centres, or the unsuitable working hours of the facilities or by the lack of adequate facilities (Ravindran, 1993) or by the uncaring attitude met out to them (Gupta, 1993).

It has also been noticed that service providers tend to function at a different knowledge level and usually belong to a different social class from the users of these services, which sometimes can serve as a barrier to communication between the two (Simmons and Elias, 1994). All these characteristics of the different health sectors may perhaps influence the women’s utilisation of the services provided by them.

1.4. Objectives and Research Questions

General Objectives

There are two general objectives of the study.

To identify women’s perceptions of WD in the selected community.

To understand how these perceptions and the women perceptions of the health care resources available to them influence their health care seeking for WD.

Note: Several reproductive morbidity share one symptom in common, that is, vaginal discharge and women often identify such problems under this generic term of WD. Since this is a study based on Women’s perceptions, we will use only the term WD and not reproductive morbidity, which is more of a biomedical construct.

Research Questions

1. What are the women’s perceptions of health and ill health?

2. Do these perceptions affect their perceptions of WD?
3. How and when do women experience white discharge?

4. When and how does WD become a problem?

5. What are the causes that women attribute to it?

6. What are the women’s perceptions of the consequences of WD on their everyday lives and how do they cope with it?

7. What are their perceptions of the long-term consequences of experiencing WD?

8. Do women think that it could be solved?

9. What are the different treatment choices that are available to the women?
   - at home
   - outside the home, like Traditional Birth Attendants (TBAs), Elder women, etc.,
   - alternative health care system practitioners (Ayurvedic, Unani, Siddha, Homeopathic or some indigenous practitioner,
   - biomedical practitioners.

10. Which of them would she prefer and why?
Chapter 2.
Review of Literature

In this chapter, we provide a brief description of Reproductive tract infections (RTIs), of which the issue under discussion, namely, white discharge or vaginal discharge is a symptom. The global prevalence of RTIs, the health consequences of RTIs and the nature of health care sought are also briefly described. The discussion is based on relevant anthropological literature.

2.1. Reproductive Tract Infections (RTIs)

The RTIs consist of bacterial, viral and protozoal infections of the upper and lower reproductive tracts for both sexes and most of them are also sexually transmitted diseases (STDs). Not all STDs are RTIs and some like Syphilis, Hepatitis B and AIDs are also systemic diseases (Mueller and Wasserheit, 1991). Women are particularly vulnerable; not only because of their biological vulnerability but also because of the synergistic effects of biological, social and cultural factors that increase the burden of this disease on women.

For example, some of these RTIs increase a woman’s chances of contracting sexually transmitted diseases. Women with RTIs may have physical symptoms as vaginal discharge, discomfort during intercourse and severe abdominal pain. RTIs can result in peritonitis (inflammation of the lining of the abdominal cavity), ectopic pregnancies (gestation in the fallopian tubes), cervical cancer and transmission of the HIV virus that causes AIDs. Some of these RTIs cause primary or secondary sterility resulting from post infection blockage of the fallopian tubes, foetal loss and infant death due to premature birth, low birth weight or congenital infection (Mueller and Wasserheit, 1991). Children are also affected by vertical transmission of certain RTIs such as Herpes, which cause infections of the skin, mouth and also cause permanent neurological damage or death. Other morbidity conditions associated with
reproductive morbidity are urinary tract infections (UTIs), anaemia, hypertension, obesity and syphilis (Zurayk, et. al., 1993).

<table>
<thead>
<tr>
<th>REPRODUCTIVE MORBIDITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetric Morbidity</td>
</tr>
<tr>
<td>During pregnancy</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>During delivery</td>
</tr>
<tr>
<td>After delivery</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>


At very severe levels RTIs render women infertile. In many third world societies, women achieve status through motherhood and in such societies the social costs of infertility, apart from the direct emotional costs, are too high. It could cause her to be abandoned by her husband and the community. In spite of the serious consequences of some of these RTIs, women do not seem to recognise the disease or seem to seek health care at the biomedical clinics, for this problem. This could be due to their own perception of one of the most frequently mentioned symptom of RTIs, namely vaginal discharge which is referred to as 'white discharge', and the causes they attribute to this illness.

2.2. Global prevalence of RTIs

It is only recently that studies have been undertaken to understand the burden of illness caused by such morbidity in several third world settings. A compilation
of studies in Africa, Asia and Latin America indicated that certain RTIs affected anywhere between 10-19 per cent of the women in Africa, 1-11 per cent of the women in Asia and 6- 12 per cent of the women in Latin America (Wasserheit, 1989). There have been since then, studies in Egypt indicating that only three per cent of the women studied were free from all the gynaecological morbidity studied (Younis, et. al., 1993). In Bangladesh, a study found that about 22 per cent of currently married women in the reproductive ages reported symptoms consistent with reproductive tract infections (Wasserheit, et.al., 1989). In India, Bang, et. al., (1989) found a high prevalence of gynaecological morbidity, about 92 per cent among women in two villages of Gujarat state. Of all these gynaecological morbidity, reproductive tract infections constituted 50 per cent of the total burden, indicating the high contribution of RTIs to all gynaecological morbidity.

2.3. Health Consequences of Reproductive Tract Infections

Some of these RTIs cause primary or secondary sterility resulting from post infection blockage of the fallopian tubes, foetal loss and infant death due to premature birth, low birth weight or congenital infection (Mueller and Wasserheit, 1991). Children are also affected by vertical transmission of certain RTIs such as Herpes, which cause infections of the skin, mouth and also cause permanent neurological damage or death.

RTIs can cause infertility in males. This is caused by partial or complete blockage of the sperm ducts or by disorders in sperm production. This results in low sperm counts or low abnormal sperm. Infections, for men, begin in the lower reproductive tract (the urethra) and if untreated, may ascend through the vas deferens (sperm duct) to the upper reproductive tract (the epididymis in the scrotum where sperms are produced). Epididymitis, the equivalent in men of PID in women, if untreated, may result in infertility in up to 50-80 per cent of the untreated cases.
Apart from the increased physical vulnerability for women, they are also culturally more vulnerable to the consequences of RTIs in men. For instance, should RTIs result in infertility either her or her partner, she has to bear the burden of 'bareness', since many third world communities ascribe infertility only to women. As a consequence, she could be abandoned or her partner may seek out another woman. If the male partner was indeed the origin of the infection, his seeking out another partner serves to extend the web of illness further. In societies where the women are dependent on men for economic support, this could have severe consequences for their survival (Mueller and Wasserheit, 1991).

2.4. Health Care Seeking for RTIs

In many third world societies, women have a marginalized role in society and within the family. Their health needs are not a priority either for their communities or for their families. This patriarchal domination over resources is so complete that very often women internalise pain and suffering resulting from their reproductive role as part of womanhood (Mueller and Wasserheit, 1991). Since the women's reproductive role is closely aligned with their sexuality and there are strong socio-cultural controls exercised over women's sexuality in these societies, women are sometimes not able to seek assistance for these problems.

Apart from this 'culture of silence' that characterises women's behaviour with respect to RTIs, they also tend to undervalue themselves and their needs. This has resulted in their giving low priority to their own health status relative to their husbands (the breadwinners) and their children, and perhaps kept them from seeking health care services for RTIs (Khattab, 1992).

Because of their relative lower levels of literacy and exposures to other interpersonal sources of communication, there is a lack of awareness among women about the potential consequences of problems like RTIs. They may see it as a part of womanhood or as a part of the general suffering that has to be
endured because of womanhood. Further, since their access to familial resources are limited due to their relative lower position in the hierarchy of power within the household, their access to health care is also affected adversely (Khattab, 1992).

From the perspective of the health service delivery, health professionals have had a patronising attitude towards women's perceptions of their health and have failed to treat women with basic human dignity. They have considered only biomedical perspective on illness causation and have failed to take cognisance of the synergistic effects of socio-cultural and economic factors on the well being of women (Khattab, 1992).

Thus, not only biological factors, but also socio-cultural and economic factors serve to increase the vulnerability of women to RTIs. Because the illnesses related to marginalized groups do not find a place in mainstream research, RTIs have remained the silent epidemic that affect third world women.

2.5. Prevalence of RTIs in India

As has been mentioned earlier, there have been studies on Reproductive morbidity, both obstetric and gynecological, in India. One of the earliest studies, undertaken in two villages of Gujarat state, found the prevalence of gynecological morbidity to be rather high, about 92 per cent (Bang, et. al., 1989). This study used both self-reported symptoms as well as laboratory tests to identify diseases. Vaginitis, cervicitis and PID constituted about 50 per cent of the burden of gynecological morbidity, making it the single largest contributor. This study noted that: 'The gynecological complaints volunteered by women during the history taking were often under estimates-especially with regard to vaginal discharge and menstrual troubles- because of the concepts of normality...’ (Bang, et. al., 1989). In spite of the fact that symptoms did indeed predict diseases quite accurately, only 7.8 per cent of these women ever had a gynecological examination in the past even though 55 per cent of them were
aware of having gynecological disorders. There were women who did not report any vaginal discharge but after lab. tests, had indications of gynecological infections. This is a worrying factor because health care seeking by women is associated with the presentation of symptoms such as discharge. This study, however, did not have a very high participation rate with just about 59 per cent of the women participating, and therefore the results can be taken as indicative, rather than conclusive.

In another study of self-reported gynecological morbidity in South India (Bhatia and Cleland, 1995), one third of the women reported one current symptom. While this study showed that more than fifty per cent of the women had indeed sought treatment for specific symptoms, in a majority of these cases, the women consulted either private doctors or traditional and other healers (Bhatia and Cleland, 1995). Since it is known that several RTIs can remain asymptotic it becomes necessary to match self-reported symptoms with laboratory testing. Another study by Bhatia et. al., (1997) did this, to demonstrate that at least two out of three women had at least one clinically diagnosed reproductive tract infection. This study also analysed the predictors of clinically diagnosed RTIs and found that the odds of having this condition among women with only one pregnancy were about 50 per cent less than among those with two or more three pregnancies (Bhatia, et. al., 1997). Lab detected vaginitis was significantly higher among urban women and among those who had undergone sterilization in the sample. Clearly, undergoing sterilization can be considered a risk factor for vaginitis. Wasserhiet et. al., (1989) also report such findings in rural Bangladesh.

It should be mentioned that the study by Bhatia et. al., (1997) has the advantage of 90 per cent of the respondents agreeing to under go laboratory tests and therefore more representative of the community's realities than any of the previous studies.
A recent study using an approach similar to that of Bhatia et. al., estimated the community level prevalence of sexually transmitted diseases in Tamil Nadu (APAC, 1998). This study which was conducted three randomly selected districts of Tamil Nadu found that 41.5 per cent of the women surveyed complained of vaginal discharge. This research details the health facilities accessed for such complaints and it was found that more than two thirds of the study population (68 per cent) preferred private clinics (APAC, 1998). The prevalence rate for any STD in this study was 15.8 per cent, a prevalence level that would be considered high. In this study the percentage of refusal of laboratory testing was even lower than the study of Bhatia. et. al., with only 3.9 per cent refusing examination.

Clearly, we can see that in India there are indications of high prevalence of gynecological morbidity combined with low levels of health seeking, at least from the public sector, for such problems. This is evident from the study of Bang et. al.(1989) where although 55 per cent of the women were aware of having gynecological problems only 7.8 had ever been examined in the past. The study by Bhatia et. al., (1997) and APAC (1998) also points to another issue that health care if at all sought for these problems, is usually in the private sector or with traditional or other healers.

Other studies in India on the prevalence of RTIs have used certain special groups like commercial sex workers or hospital registers to estimate RTIs(Luthra, et. al., 1992) and therefore such information cannot be used to look at community prevalence.

2.6. Reproductive Health Policy in India

The Government of India has committed itself to the Programme for Action at the ICPD, 1994 and has at least attempted to overtly bring about changes in the rhetoric surrounding the delivery of health services to women in India. Previously, women were the recipients of Maternal and child health services and
these services had been critiqued for ignoring the Women at the cost of the mother. The MCH services included contraceptive services but did not take into consideration the overall reproductive health needs of the women. Such contraceptive services were of poor quality and were delivered under a target-oriented approach, which caused the health providers to view women as so many targeted sterilization acceptors or IUD users or Oral pill users. This policy of targets to be fulfilled by health workers for each contraceptive had an impact on the quality of services delivered and the consequent implications for women's health (Ravindran, 1993) and the treatment given to them by the public health services have been well documented (Gupta, 1993; Ramanathan, et. al., 1995).

Currently, the Government of India has abolished targets for health workers and at least at the policy level seems committed to the reproductive health approach advocated and accepted at ICPD, 1994 (Govt. of India, 1996).

2.7. Anthropological studies on RTIs/white Discharge in India

Women's perceptions of white discharge have been studied in the early eighties from the perspective of the illness experience and Ayurvedic therapy that takes into account the psychosocial dimension of the illness (Nichter, 1981). In the description of the practice of Ganapathy, the Ayurvedic Vaidya, Nichter has focused more on the somatic construct of the illness than on the treatment seeking behaviour. Among the south Kanarese women, Nichter also noted that regardless of class and caste, women overwhelmingly preferred Ayurvedic treatment for menstrual disorders and leukorrhea (Nichter, 1981a). Ayurvedic practitioners identified three important points associated with these complaints.
First, these practitioners identified the aforementioned complaints as humoral imbalances as well as illnesses presented by women in psychological distress. Secondly, it was noted that Brahmin and Muslim women were significantly over-represented (in relation to population size) as patients presenting these complaints. Thirdly, all six practitioners recognised Brahmin and Muslim women’s mobility outside the home environment was restricted and a trip to a practitioner constituted one of the only opportunities for them to approach an outside source of guidance or support.


The symptom of white discharge is seen to have complex cultural meanings and multiple aetiology. Of a sample of 100 clients experiencing psychosocial distress, 39 complained of white discharge. Fifteen of these women had presented with a personal history of families in a state of discord (Nichter, 1981a). Therefore, it was possible to also see complaints of white discharge as one of the idioms of distress – a coping strategy used often by marginalised groups - here the women in states of distress.

Another similar study based in Gujarat compared two explanatory models, one an ethnomedical model for ‘dhola pani’ (white discharge) using the women’s perceptions, and the second, the biomedical framework for the determinants of gynaecological morbidity (Oommen, 1997). Here, the ethnomedical explanatory model based on women’s perceptions views white discharge as having multiple aetiologies and complex meanings.

Ghar ki kamjori (economic weakness/poverty) as the root cause of illness. Conditions directly resulting from poverty include anger, worry, anxiety, lack of food to eat and long days of work. These conditions produce kamjori (physiological weakness) which makes a woman susceptible to illnesses associated with sterilisation operations, copper-T use, abortions, delivery problems, eating hot foods, sexual intercourse and lifting heavy weights. While women do not have a ‘germ theory’ of illness it can be argued that they have a sense of illness pathology, reflected in the above factors. The resulting common illnesses are dhola pani (white water), kapda ro bimari (menstrual problems) and sharir bahar aave (prolapse).

- Oommen, 1997:11
Oomman (1997) observes that the biomedical and the ethnomedical models include 'poverty' and 'pathology' but in the former socio-economic factors are seen as background factors that operate through intermediate factors such as health serviced utilisation and medical risk factors such as malnutrition. In the ethnomedical model, women identified poverty as the single most important cause of their illness and not as a background variable.

In a qualitative study of 60 ever married women living in Mumbai's slums, Ramsubban and Singh (1997) also report that the somatisation of mental stress caused by the need to keep the household going in conditions of extreme poverty, is evident in the way women speak about weakness. In this study, the authors note that health seeking for weakness or any other problems, including vaginal discharge was at best episodic and haphazard. The local doctors whose services are sought dispensed allopathic pills for one day and asked the patients to come back the next day. If the acute symptoms persist, the women may go back but most often economic compulsions intervene (Oomman, 1997).

Another study of women's perceptions of white discharge using a somatic construct was undertaken in Bangalore (Chaturvedi, 1996). Women's perceptions of white discharge were found to be closely related to their experiencing it. While half of the women who complained of white discharge considered it abnormal, only 7 per cent of the women who had not reported white discharge, thought of it as abnormal (Chaturvedi, 1996). This is a study where the emphasis is on psychiatric treatment. In this treatment setting, women did not mention white discharge voluntarily. The author speculates as to whether the phenomenon of white discharge resembles the 'Dhat syndrome' in men, in being related to the loss of vital fluid and sexuality. He concludes that the passage of non-pathological vaginal discharge is an important aspect of a woman's health belief system, particularly in women who have somatic complaints.
2.8. Need for the study

From the available literature it is evident that barring a few studies like that of Oomman (1997) and Ramsubban and Singh (1997) a majority of the studies on the subject have had an epidemiological-biomedical orientation or an entirely anthropological-psychological orientation. As such their sensitivity to gender issues and the reproductive health perspective are limited. In this study, I attempt a synthesis of the biomedical and anthropological perspective to understand women's perceptions of white discharge and the consequent health seeking behaviour.
3.1. Study Type

There have been earlier studies in India on the woman's perceptions of WD, but these did not link these perceptions as one of the factors that need to be looked at, while looking for explanations about health care seeking. Given this, the present study is both exploratory and descriptive in nature.

Study Design

It is a qualitative study which looks at women living in an urban slum in Madras/Chennai City. It focuses on perceptions of WD and health seeking behaviour. Health seeking behaviour can be affected by the physical availability of health resources and this could vary from one location to another. In order to avoid multiple options vis-à-vis the health care, the study is limited to one slum location only. In this way, the actual health facilities in terms of distance from home, cost involved reaching the facility, time taken to reach it and other similar factors will be more or less the same for all respondents. However, individual perceptions of these factors will be different.

Research Themes and Variables

This is essentially an exploratory study that is qualitative and as such certain themes that need to be explored and certain background variables have been identified and detailed below. Some of the characteristics of the women and the households in which they live can be treated as variables, but for the study, they will provide the background characteristics of the women.
Background factors

Women’s household situation
- number of members in the household
- type of the household (joint/nuclear/etc.,)
- number of children
- household income

The household relative to other households in the community
- caste to which the house belongs.
- religion of the household.
- household income relative to other houses?

The woman’s personal characteristics
- age
- pregnancy history
- marital status
- contraceptive history
- educational level
- the education of her husband/partner
- work status
- husband/partner’s work status
- whether or not she has any access to monetary resources
- the woman’s autonomy regarding decision making for matters pertaining to her health, vis-à-vis her husband/partner.

Perceptions of Health
- women’s perceptions of good health
- women’s knowledge of the various health care options in her neighbourhood that she could access.
- women’s perceptions of when and how women become ill
- how these general perceptions influence her perceptions of WD
Experience of WD
- Women experience WD at different times in different magnitudes
- Labelling of WD

Perceptions
Women’s perceptions of WD
- what is normal in general/ for her?
- what is abnormal in general/ for her?

(Folk) Notions about causes that affect these perceptions
- humoral notions
- beliefs about hot and cold
- beliefs about the flows of bodily fluids
- beliefs about her body or the human body and its functions

Women’s perceptions of the consequences of WD
- immediate physical consequences
  - experience pain
  - discomfort
- Other consequences
  - implications for other activities

Women’s Health Seeking Behaviour
- when do the women perceive WD as a problem?
- what is normal/abnormal?
- when do they consider it severe and needing assistance?
- what do they do about it?
Treatment Seeking

Perceptions about treatment
- her own perceptions of the efficacy of various treatments
- her definition of severity
- her evaluation of its suitability and efficacy where she is concerned
- her knowledge of the costs involved for these treatments
- her ability to access funds for these treatments
- her knowledge of home remedies
- the existence of an illness management group around her

Knowledge and resources available to the women and significant others in her illness management group
- her age, work status, funds available within the household, funds available from other kinsfolk, etc.,
- the social support that she has.

Health Sector

The informal health sector
- her knowledge of the availability of TBAs or knowledgeable others in the community
- her knowledge of the presence of local pharmacies that may provide remedies
- the knowledge of her illness management group about the above two issues
- the existence of private doctors (Ayurvedic, Homeopathic, Allopathic, Unani or Siddha) in the neighbourhood
- the knowledge that the women gain from the various media sources that are available to them.
The public health sector
- women's perceptions of the types of facilities available to them
- the perceptions of the characteristics of the providers there (gender, age, caste, religion, etc.)
- the characteristics of the service delivery units (when it functions, how far away it is, how much it costs to go there)

3.2. Data Collection Techniques

For this study, a combination of data collection techniques will be used. As a prelude to the study, three experts, who have experience working on women’s health issues in Tamil Nadu, were interviewed. These key informant interviews helped in identifying appropriate methods of approaching the subject of white discharge in interview or discussion situations and also to select appropriate locations for the study.

Apart from these three key informants, there were interviews with two other key informants from the selected community, who helped the researcher in situating the issue of WD for women and do free listing of the various illness that affect the women in that community.

The key informants were:

- One expert who has worked on women’s health issues in the slums of Chennai for most of her career. She helped to identify an appropriate slum; one in which she has herself worked in so that she could facilitate the researcher’s entry into the community.

- Two women health workers from the community who have extensively worked on Reproductive health issues in the selected urban location. These women helped to locate women, initiate friendly discussions and interviews with the women of the community. These two women from the community also assisted in listing the various women’s illnesses and provide information about the community in general.
Two FGDs were held in the selected location to discuss the women's perceptions and health and illnesses in general and the illnesses that affect women in particular. Apart from general information about the different health services that are available to the women in the community, these FGDs helped to confirm the information about health and illness in India collected from the literature survey and also provided information about the local variations in these beliefs.

Twenty six women, twenty one of them married and five single who lived in the selected location were interviewed over a period of time, keeping the themes that had been listed earlier as a frame of reference. A Profile of these women and their husbands has been included in Appendix I.

During the in-depth interviews, some projective techniques using a slate and chalk or paper and pencil were attempted, asking the women to draw the source of WD (anatomically) and also the places in the body (the lower abdomen, the back, the hip, etc.) which experience pain due to WD. However, most women were unwilling to attempt this. Though there were very few illiterate women in the group interviewed, most of them were not comfortable with the idea of drawing their idea of the body and mark out the places that pain. In fact, of all the 26 informants, only three married women attempted it.

Subsequent to the in-depth interviews with the women, from a list of all possible health resources that the women said that they utilised three of the most frequently mentioned private facilities were identified. These private practitioners were interviewed with the aid of a checklist. Since it was not be possible to obtain permission from the Government of Tamil Nadu to interview specific practitioners within a larger system such as a hospital\(^1\), all such resources were not interviewed.

\(^1\) If the hospital is in the public sector, then Government permission is needed to interview any one doctor working in it. This permission would itself take about a month and therefore it is not feasible to include interviews with such
Validity of data collected
Possible biases in data collection

In choosing participants for the study, the researcher did not have much control over the selection process, because the informants were self-selected. One of the women of the community who had been working in an NGO for women's health programmes but had since quit for personal reasons facilitated the entry into selected slum. She had extensive contacts and took the researcher to one location where the women usually meet, namely the water collection spot. Here several women who were waiting to collect the City Corporation supplied potable drinking water were introduced to the researcher. The women were told of the nature of the research being undertaken and asked if any of them were willing to be interviewed. Two of the women asked the researcher to visit them the next day. These two women helped to link with several other women in that street and through this process several informants volunteered for interviews. The same process was repeated in two other streets of the same slum. To the extent possible, no informant was left out of the research process because of reasons of caste.

It is possible that in this process, women who seemed ‘more interesting’ or ‘less resisting to being interviewed’ may have been selected. But since the researcher was aware of this bias, and made an attempt to include women who were initially hesitant to talk or those who felt that they did not make interesting cases, it is hoped that the impact of this bias on the study will be limited.

The FGDs were to be conducted at the initial phase of the study, as a means of introduction for the researcher into the community. However, organising FGDs in the community was only possible after the researcher became a familiar figure among the members of the community and therefore were actually conducted after about 10 days of field work. Women in the doctors in the research plan.
community were intensely suspicious in the initial phases fearing that the information that they provided by them either individually or as a group would find its way to the Radio networks or television networks as a programme. Therefore FGDs could be organised only in the later stages of the fieldwork. However, these FGDs provided a wealth of information on the women's perceptions of different illnesses and the possible causes for the same.

The information obtained about the women's perceptions of WD and health care seeking from the FGDs helped to validate and elaborate the information collected during the in-depth interviews.

The information about the sources of health care were checked by visiting, observing and interviewing these resources mentioned by the women.

Apart from this use of multi-methods to triangulate, initially the findings of the study were meant to be discussed in a small workshop with a small subset of the informants in the study site. Conclusions were meant to be drawn through a consultative process that involved the informants themselves.

However, during the course of the in-depth interviews, it became clear that women did not want to be identified as those who have certain particular (namely white discharge) health problems, nor do they want to be participants in any process that involved others. This was because white discharge was seen as something that is not talked about to others, except a few intimate women friends. Since not all the participants were on such intimate terms with each other, even small discussions among them would be difficult. To overcome this problem, most informants were met with several times. The findings were cross validated by interviewing a small panel of experts who have worked on women's health issues in the slums of Chennai City and a group of health workers who belong to and work within the selected community. In addition, some of the informants were also involved in this process to validate the findings.
3.3. Sampling

This study was exploratory and as such did not require rigorous sampling for statistical validation purposes. However, from some earlier interviews with women on the same topic, the researcher was aware that perceptions of white discharge vary with the age of the women, marital status, their social and economic class and personal experience with white discharge.

In this study, socio-economic class was expected to be more or less the same for all the informants because an urban slum (similar economic status) community in Madras/Chennai City was selected. So, it was expected that the socio-economic status and access to health care is the same for all the women living within this community. However in practice this was not so because there were differences between the households with some of the women having better access to health care because they had more financial resources than others.

To accommodate a wide range of perceptions, both married and unmarried women were included in the study. It was difficult to interview single (unmarried women) about white discharge, but with the assistance of other married women in the community, five single women were interviewed. In the married category women belonging to two broad age groups - married, young women, between ages 15-29 (to represent women in the early stages of family building) and married older women, aged 30 and above (to accommodate the later stages of family building) were interviewed. The sample includes one woman who was widowed and two who were said to be separated from their husbands.

In all, 21 married women and 5 women who had never been married had participated in the study. In addition there key informants from the community and one expert-key informant had been interviewed.
The study also includes semi-structured interviews with three of the most frequently identified private health care providers for the community.

For the FGDs, only married women were included. Of the two FGDs, one was for older women (aged 40 and above) and the other for younger women (aged below forty). It was felt necessary to have two separate groups because younger women usually do not feel comfortable enough to discuss matters pertaining to sexuality in the presence of women who might be similar to their mothers or mothers-in-law in age. While doing the study, it was found that younger women could discuss such intimate matters that were impersonal in a larger group, but the older women were very uncomfortable in a group setting.

Apart from this, there were two group interviews with a group of NGO workers who work in the community at two different stages of the study, one before initiating the study and the other while the study was in progress. The group interview at the beginning helped to identify the key words that are used within the community and the group interview during the data collection process helped to validate the findings.

In addition, a female gynaecologist who has been working in Madras City for the past thirty years, a male General Practitioner in the private sector who has an extensive practice consisting of similar lower socio-economic groups and three academicians who have experience working in Madras city were the experts who were also consulted to cross validate the findings of the study.

The table given below summarises the sample sizes for the different data collection methods being used.
### Study Area

As has been mentioned earlier, the study was conducted in one selected slum location of Chennai City. Chennai is the capital of the southern state of Tamil Nadu in India and is the fourth largest Metropolis in India. It has a population of about 5 million and of this, at least about one third live in slums (Ramanathan, 1992). The slums of Chennai are small in size when compared to slums in other urban locations within India (Ramani, 1985) but the total number of slums within any part of the city is relatively much more when compared to anywhere else in India (Ramanathan, 1992). The chances of locating a small sized slum that is relatively homogenous in terms of its households are quite high in this city. Moreover, the local language of this state, Tamil, is spoken by the
researcher. Therefore, for logistic convenience, this City was selected for the study.

The slum for fieldwork was selected after consulting the expert Key informant who heads an NGO group that works among the urban poor in Madras. This NGO is engaged in promoting literacy and health education among the urban poor women. It also links up with a private health facility that offers reproductive health services to women in its area of operation. Such services are free of charge.

The link up with such a health facility was extremely productive as we could offer medical care to the women who said that they had certain health problems and needed health care. Since the health workers of the NGO visit all the women of the community, no stigma attaches to any women visited by these workers. During these visits the health workers offered their services to the women who sought them through the researcher.

The slum selected was located in the central part of the city. For purposes of convenience this slum will be referred to as Vaiyapuri Chatram in all the future discussions. Vaiyapuri Chatram consists of tenements build under the urban reconstruction scheme about twenty five years ago. However, it has now spilled over into several hutments (that outnumber the tenements). There were about six hundred households in the selected area which forms the border between three urban divisions, one of which is an upper middle class section. Vaiyapuri Chatram is close to the major arteries that link the city to the outskirts and is also very close to the City's newly constructed whole sale vegetable, flower and fruit market.

Vaiyapuri Chatram had a separate street for Adi-Andhra community, a community that was considered untouchable in the past. Two women from this community have also been interviewed.

2 The name of the slum has been changed so as to make it anonymous to
There are several private medical facilities in the vicinity but for common ailments the people of the slum make use of the Corporation's Health Post that is about 800 -1000 metres away. In addition, Vaiyapuri Chatram is very close to a large teaching Hospital, the Kilpauk Medical College Hospital which is just about one kilometre away. There are also about three private hospitals and about eight to ten medical practitioners near Vaiyapuri Chatram, and five of them work within the slum itself.

3.4. Data Collection

The initial interview with the expert key informant who is the chief of NGO was undertaken in the last week of May. Through her, it was possible to select a site for the study and interview health workers working on that site. The initial free listing with three members from the community and the in-depth interviews were conducted from the first to the third week of June. The FGDs with women from the community were conducted in the second week of June.

As the in-depth interviews with the women progressed, it was possible to identify other women for interviews. The in-depth interviews took approximately three weeks, from the first to the third week of June. In the last week of June, a preliminary analysis was done to identify the most frequently mentioned health care providers in the community and these facilities were observed and the providers interviewed. Thus the fieldwork started in the last week of May and continued till the last week of June, taking in all, five to six weeks.

After the interviews in the community were completed, the last week of June was utilised to interview some of the female gynaecologist, the male GP and one academician. In the last week of July, two other academicians were also consulted about the findings.
3.5. Data Processing and Analysis

The FGDs were recorded and relevant notes were made for manual content analysis. When the informants permitted it, in-depth interviews were also recorded and transcribed partly for the analysis. The researcher’s own notes supplemented with these transcripts were used for the analysis.

The analysis of the interviews was in terms of the themes identified by the women, trying to find linkages between the various themes.

3.6. Ethical Considerations

The information collected was kept confidential and no attempt has been made to either identify the slum location or individual informants in the study report. All informants were told of the purpose of the study and their oral permission sought before collecting any information from them.

In most communities white discharge can be stigmatising, especially for the woman experiencing it. The researcher therefore chose to talk about women’s health problems in general as the topic of research during the entry into the community and subsequently.

Another problem that requires consideration is the provision of health care for women who say that they experience WD that they consider abnormal. The researcher helped such women link to the NGO’s health services in the neighbourhood of the community. (the key informant No.1 was of assistance in this context).
3.7. Experiences during Data Collection

At the time of data collection, Chennai City was strife with rumours about an AIDs scare. Most members of the community had heard stories of how some unidentified AIDs victims were waiting by the road sides trying to hitch hike and were in the process injecting syringes full of contaminated blood into unsuspecting motorists who stopped. Three persons were reported to have been killed by mobs who suspected them of being AIDs carriers in slums that were in the out-skirts of Chennai. So during the initial phase of the study, there was a need for some caution especially because all strangers in the community were beginning to be viewed with suspicion. The key informants within the community and the health workers associated with the collaborating NGO facilitated the entry into the community to a great extent.

Initially, the researcher was very hesitant to broach the question pertaining to experience of white discharge and attempted to approach the question in an indirect way. This lead to lot of waste of time and also misunderstanding by the informants. Whenever the topic was sensitive, like experience of white discharge or husband's infidelity, the researcher understood very soon that straight questions produced the best results. Women hesitated to mention these issues to her directly and actually became quite lucid when they were asked direct questions about such issues after the initial phase of the interview. This approach helped very much during the in-depth interviews with the women in the community.

A great handicap to the fieldwork was the inability to obtain accommodation within Vaiyapuri Chatram itself. However the researcher made up for this by spending the whole day in Vaiyapuri Chatram, participating in the women’s day to day activities the water -tap gossiping sessions, discussions about the political situation, the movies and the community pujas and other social functions that took place during the field work.
Chapter 4.
Findings and Discussion

4.1. Women's Health Problems

Younger women identify problems caused by insertion of Copper-T, lack of adequate health care following sterilisation, lower abdominal pain, irregular menstruation, painful menstruation, painful intercourse, itching in the vaginal region and boils in the breasts and vaginal region as the health problems most commonly experienced by women.

Older women, especially those beyond forty years who participated in the FGDs added to this list by including joint aches, frequent menstruation, menopausal symptoms like continuous bleeding and irregular bleeding, cancer and hypertension. Women who participated in the FGDs were concerned about the implications of continuous bleeding on the health of the woman in the menopausal stage and its impact on their ability to work. They were also concerned about the possibility of having their uterus removed if the menstrual problem persisted. This was a reflection of what happened to some of their acquaintances who had such menstrual irregularities at older ages and had to undergo hysterectomies. Of all these illnesses identified by both groups, *vellai paduda*\(^3\) (white discharge) and menstrual disorders were the most frequently mentioned.

Younger and unmarried girls mentioned lack of or infrequent menstruation as a problem because, as a 21 year old single girl put it:

"... it is not good if periods do not come. Once I did not get periods and a lady told my mother to give me dried fish to eat. After eating that, my periods started again".

\(^3\) *Vellai padudal* literally translates to white spotting. But such a translation does not easily convey the meaning. So I continue to use the conventional expression ‘White Discharge’ as the translation and use *vellai paduda* as the illness term.
For the parents menstruation represents an important bodily function the absence or interruption of which causes concern. There are two reasons, one cultural in that it indicates the readiness of a girl for marriage. The second reason is that there could be a suspicion of pre-marital pregnancy. This probably justifies the interest expressed by all regarding this issue.

Married women in the reproductive ages recognised vellai padudal, lower abdominal pain, itching of the vaginal area, painful menstruation and intercourse, backache as health problems that affected them most often. Parvathi⁴, a married 23 year old woman who had been married for 6 years and had no children said:

“ I get terrible pain during periods in the lower abdomen. I am never able to do any work”.

Viji, a married woman who has vellai padudal said:

“ I think I have vellai padudal because of weakness. Even though I eat food and we do not lack for food, I do not have any sathu (essential nutrition)”.

Ambuja who is a twenty five year old mother of a child had this to say about her back ache:

“Now-a-days I am not able to do work. I have edupu vali (hip pain). [She indicated the two sides of the pelvic joint, the right and left side of the buttocks]. I am not able to do house work or collect water”.

The illnesses are considered severe if they interfere with their ability to run their households. Such a condition inconveniences all the members of the household and this situation is most dreaded by women.

⁴ Names have been changed for anonymity.
4.2. Experience of Vellai padudal

All women experience vellai padudal to some extent. It depends on the position of the woman’s physical constitution on a hot-cold continuum. A cool body is less prone to experiencing severe vellai padudal than a hot body. It is also related to timing with respect to the menstrual cycle. Having vellai padudal is normal and all women have it at a certain point of the menstrual cycle. All the married women were of the unanimous opinion that this sort of vellai padudal that was normal occurred a short while before the start of the period.

Then, when do women consider vellai padudal to be abnormal? This varied by the marital status of the woman and their actual experiences. Therefore in this analysis, I have distinguished the information in terms of women who were married and women who were not and those with experiences of abnormal vellai padudal and women without this experience. The information is presented in these categories, whenever experiences differed among these subgroups.

Characteristics of Abnormal vellai padudal

Normal and abnormal vellai padudal can be clearly distinguished by three characteristics, the timing of commencement, its consistency and colour and its volume. It should be mentioned that I have categorised women into these two categories of normal/abnormal by their own illness descriptions and their own labelling. But it should be remembered that each of these categories are not unambiguous dichotomies such as timing: all the time/not at all, consistency: thick/watery or volume: less/more. Each woman positions herself along a continuum of each of these characteristics and she decides for herself, keeping in mind other physical and socio-cultural circumstances as to whether or not to consider the discharge as abnormal.
Timing of *vellai padudal*: *Vellai padudal* that always occurs at a certain time of the menstrual cycle is normal. If it occurs at some other time then it could be as abnormal. As one woman who wanted to describe an abnormal situation put it:

"Except at the time of menstruation it was always coming".

This sense of timing as has been mentioned earlier, is with respect to the women’s menstrual cycle.

However some times the timing could also mean - after sterilisation, or after the c-section for the second child or after my husband started an affair with a certain woman - to represent the timing of commencement of severe symptoms with respect to some event in the woman’s life.

A woman who has experienced *vellai padudal* for the past 11 years said:

"It started when Raj was born. He was born in 1987. I have had low abdominal pain and *vellai padudal* since then. Hari and Barani were born after that. After Barani was born I had the operation".

Consistency and colour: *Vellai padudal* that is similar in consistency and colour to that experienced routinely by the woman is normal, and not a matter of concern. When it is too thin or watery or too thick or like a semi-solid then it is considered abnormal. Identification of abnormality includes colour. For instance a woman said:

"I do not think that if it is white then it is a problem. But for me it is like Cheli (mucus)".

Here she indicates both colour and consistency of the discharge as indicative of its abnormality.

---

5 The sterilisation operation is simply referred to as operation.
4.3. Perceptions of Vellai padudal

Women's perceptions of vellai padudal clearly differed by their marital status and their personal experience of it. I discuss here the various causes that women attribute to having vellai padudal and the expected consequences of having this problem.

Unmarried women

Causes for vellai padudal:

Unmarried women who had no experience of vellai padudal felt that it was caused by weakness - physical lack of strength and energy. They tend to related white discharge as being similar to menstrual blood. While the later was indicative of good health the former was not.

Young unmarried girls who had some experience with vellai padudal and thought that it was abnormal related it to the timing with respect to the menstrual cycle. They were unsure of the reasons for this but attributed it to other health problems that they experienced in the past. Such illnesses could result in weakness that facilitates vellai padudal. They were very often embarrassed by this, and the very young women never mentioned it to anyone.

Raji, a eighteen year old who has just finished her high school said:

"I have vellai padudal. I have not spoken about it to anyone. I feel that it cannot be talked about. I just wash myself with soap and wash it off my panties. I have had this for only four months now. I became a big girl four years ago and did not know what it (vellai padudal) was like, now I know."

The other problem with having vellai padudal for these young girls is the need to wash these articles of clothing like menstrual cloth and panties at all odd time since the public atmosphere of Vaiyapuri Chatram's common facilities.
"I use to wash the cloth in the bathroom and dry it and keep it for the next time. Now a days I just throw it away because of having to wash very often. I am shy of washing it in front of the men."
says Pari, a 32 year old unmarried woman who has severe vellai padudal that smells like water used to wash fish.

Women wash the menstrual cloth late at night or in the early morning and put out the clothes to dry in corners of the house where they would not be noticed and put them away before the rest of the community are up and about. Or else, they hang these clothes in the small cubicle made for privacy during bathing. But even this arrangement is too public for young unmarried girls. Most often both unmarried girls and married older women are not able to put out the pieces of washed cloth that are used to make a home made sanitary towel to dry in the sun. These clothes are not exposed to the disinfecting influence of sunlight. Other normal clothes fare better because there is no embarrassment attached to washing them.

In this context, it is important to consider the opinion of the expert gynaecologist who has worked among these groups extensively. In her opinion, menstrual hygiene is of a very low order due to lack of adequate water or improper storage of menstrual cloth and this results in fungal and other infections. She recollected that an occasion when she had a case of worms in the vaginal canal caused by the use of unhygienically stored cloth.

Older married women did not express any embarrassment about washing or drying the menstrual cloth. It is possible that this sort of embarrassment is characteristic of younger/unmarried women who have just started to menstruate.
Consequences of *Vellai padudal*:
These younger unmarried women felt that the important consequence of having *vellai padudal* was becoming weak and tired and being unable to work normally. This perception was shared by those who had experienced *vellai padudal* and those who had not.

**Married women**

Causes for *vellai padudal* among married women with no experience of *vellai padudal*:
The married women who had no experience of *vellai padudal* in the past felt that it could occur because of weakness and too much work. Among this group, menstruation was seen as being indirectly linked to *vellai padudal*. Parvathi the 23 year old woman who had been married for 6 years and had no children said:

> “I have some *vellai padudal* about the time of periods, just before it. It is a slight amount. I always had this sort of *vellai padudal* even before marriage.”

They also felt that for women who had hot bodies or whose husbands were in heat causing professions like driving could experience *vellai padudal* directly either because of their own constitution or indirectly through their husbands from whose bodies heat was transferred to their wives. Such women would be more prone to having *vellai padudal*.

Women who had no personal experience of excessive *vellai padudal* had certain other illnesses like low abdominal pain, painful menstruation, urination, sores on the body, irregular periods and itching in the vaginal region. So while these women did not perceive themselves as experiencing *vellai padudal* most of them had symptoms of some reproductive morbidity. Menstrual irregularities and low abdominal pain were the most frequently
mentioned of these illnesses. According to the general practitioner who had an extensive practice in a low socio-economic sector of Chennai city, these were symptomatic of possible gynaecological problems. He said that usually he prescribed non-specific anti-biotics and in serious situations referred them to a neighbouring gynaecologist for treatment. He admitted that for him it was not possible to perform a pelvic examination. He also felt that Sexually Transmitted Diseases(STDs) and other infections were suppressed because of the extensive use of anti-biotics within the community. This served to suppress several illnesses that moved from acute to the chronic state within the community.

Consequences of *vellai padudal* among the married women with no experience of *vellai padudal*:

Married women who had no experience of *vellai padudal* felt that one of the consequences of *vellai padudal* was wasting. Women with *vellai padudal* became thin and listless and never had the energy to work. Another possible consequence that was mentioned by older women was that *vellai padudal* was actually an early sign of cancer and another woman felt that it could also be indicative of AIDS.

Causes for *vellai padudal* among married women who experienced it:

It was remarkable that, for this group the timing or commencement of *vellai padudal* was not closely related to the causes identified. Here in terms of timing, they referred to events in their family/reproductive life like: after the birth of the second son, or after I had the sterilisation operation. One woman attributed it to her early child bearing. Viji, who got married when she was

---

6 It should be mentioned that at the time of field work the slums of Chennai city were at the receiving end of an AIDS awareness campaign that went awry. These campaigns resulted in creating a fear psychosis that resulted in the killing of three strangers in a suburban slum area. These men were killed by mobs who suspected them of carrying syringes and needles of contaminated blood that could transmit HIV positive blood to unsuspecting victims. Awareness of the exact nature of HIV AIDS disease may not be high but the name of the disease is quite well known now.
sixteen years old and had two children by the time she was eighteen years old said:

"When I should have been playing about with other girls, I got married and when I should have been getting married, I had children. May be because I finished everything soon, I lack sathu (essential nutrition) and am weak."

Another woman who was 29 years old and had 3 children and had a spontaneous abortion, said:

"I underwent sterilisation after my third child, a daughter was born. My husband suggested the operation and I agreed with him. I did not have any problem with sterilisation until I started having vellai padudal after the operation. There is a lot of it and it is like urine. It makes my pavadai (underskirt worn to drape the sari) stained all the time."

There were several reasons put forward by these women for their experiences. One reason given for this illness was the husband’s occupation. Professions like leather industry (use of chemicals) or driving (related to petrol/diesel) were seen as heat generating.

Ambuja, whose husband works in the leather industry had this to say:

"My husband has some blood coming from the tip of his penis. He told me that because of working in the leather factory day and night his body had become very heated."

A woman whose husband works as a driver explained her vellai padudal and low abdominal pain as:
“I think it is caused by heat. It will become okay if I drink Limca\(^7\) (an aerated citrus like drink that is available in India). People say that if husbands work with petrol/diesel their bodies become heated and so we should give them butter milk, curd rice or lemon rice, all of which are cooling. I always pack this for him for his lunch. I have heat because my husband has a hot body. I drink butter milk or Limca to cool myself.”

The second important reason for *vellai padudal* identified by this group of married women who had experienced excessive vaginal discharge was their husband’s sexual contacts with other women. Seven of the 12 married women who experienced *vellai padudal* said that their husbands had sexual relations with other women. Of these seven husbands, three were having visible signs of discharge from the penis and this disturbs their wives.

Sati, who is undergoing screening for gynaecological problems at a leading government hospital for women said:

“I have seen pus on my husband’s penis and that is why I am so disturbed. My husband has been going to some places and I know about this. He beats me when I ask about this. Do you think I may have AIDS?”

Simi, who has severe *vellai padudal* says:

“I told him that if he has sores on his penis, either I must be doing bad things or you must be. As far as I know, I have not done any thing wrong. I cannot say the same for you. I was very angry and fought with him. Now-a-days I do not fell like going near him any more.”

Dana, who fell in love and married her husband when she was 14 years old (she is now 28 years old), said:

---

\(^7\) Lemon and other similar fruits are thought of cooling. It is possible that the informant has choosen Limca as a cooling drink because of the artificial lemon flavour used.
"I must have got this problem because of my husband's going to that woman. I have always suspected it."

Consequences of *vellai padudal* among married women who experienced it:

One woman suspected that *vellai padudal* could be symptomatic of AIDs. According to the women, *vellai padudal* is always accompanied with listlessness, tiredness, inability to work. *Vellai padudal* occurs with other physical discomfort like itching of vaginal region or a constant wetness necessitating frequent washing of underskirts.

The extra work pressure in slums which have less access to water (needed to wash), the need to shop every day for groceries and find the wherewithal to do it with, the need to send children to school and collect them every day, the burden of running households on limited budgets and the effort that has to be made to provide at least the basic minimum to all the members of the household, would stress them even more when the carry the burden of this illness. As a consequence they are also emotionally distressed.

These women also live with the fear that their *vellai padudal* will result in their alienation from the community because for many women it is a sign of STDs as well. If they do not have any sexual associations with other men, they blame their straying husbands as sources of their illnesses.

4.4. Treatment Seeking for *Vellai padudal*

For analysis of this section, I have used information obtained from the women, both single and married but who have experienced *vellai padudal*. In addition I have used the interviews with the health providers and the key informants and the experts to validate the information collected from the 15 women who experienced *vellai padudal*. 
Unmarried women

The young girls who are less than 20 years of age are too embarrassed by *vellai padudal* to mention it to any one. They tend to wash themselves frequently and become very conscious about cleanliness of their underclothing. Only when *vellai padudal* is accompanied with other physical symptoms do they seek medical assistance. For this the most preferred medical assistance is from the private medical practitioners who work around Vaiyapuri Chatram.

Married women

Women who experienced abnormal *vellai padudal* initially considered home remedies. The first measures adopted are largely self care measures that are seen as cleansing. They wash themselves with boiled and warm water, eat cooling foods like butter milk and lemon drinks. They talk to their mothers and other older or knowledgeable women in their neighbourhood. These knowledgeable women come into the picture mostly when the woman's own mother lives in a place that is distant. When Sati had to go to the hospital for her tests, her mother came over to run her household for her and allow her to take some rest and recover from the tests and treatment. If the mother is not available then she seeks the assistance of other women, who usually are slightly better educated and mobile (women who are health volunteers, adult literacy volunteers and other similar women).

These women recommend certain foods as a cure for white discharge. One woman's mother recommended that she eat a certain type of green leafy vegetable that has white flowers as a cure for *vellai padudal*. This vegetable was difficult to procure and cook in a household where the morning meal has to be ready before 8.30 hrs in the morning to facilitate the packing of lunch boxes for children and men who go out to school/work. One woman was told to eat drum sticks (a green long pulpy stick like vegetable that grows in India).
These dietary prescriptions were rarely followed. One woman who had been recommended a certain vegetable as a cure for vellai padudal complained that she took it with great difficulty two times but there was no effect and so she discontinued it. The older women in the group felt that if they had been living in the village they could have consumed the traditional herbal concoctions to cure vellai padudal, but none of my informants nor their acquaintances knew how to make those concoctions.

As a last resort, women visit the private health practitioners who function in the vicinity of Vaiyapuri Chatram. If the situation was acute and they had access to some funds, they would go to these private practitioners. When they do not have funds readily available, they go to the large Government teaching hospital that is situated within one kilometre of Vaiyapuri Chatram or to the City Corporation’s health post that is very close by.

Ellama, who had experienced vellai padudal that was like a flood said:

“First, I used to wash myself with warm water. Then when it became too bad I went to a private doctor whose name was mentioned to me by an older woman who lived next door to my husband’s home. She was kind to me. That doctor used had gloves and examined me and gave me medicines for 14 days. I regularly ate the pills and the vellai padudal went away, but after some time started again. I never went back to the doctor.”

Pushpa, who also had vellai padudal accompanied with abdominal pain went through a series of treatment options starting from washing herself to being recommended dietary cures. But these cures that work through the diet are difficult to follow as they involve time for procuring and preparing. Pushpa said:
"The woman in the neighbour's house told me to take sothu kathazhai keerai (a green leafy vegetable) boiled with palm sugar every morning before eating anything else. But I am busy packing the children to school in the mornings. There is no time for all this."

There are other remedies that women access. When the vellai padudal is very severe, one woman went to the major woman's hospital in the City. This is the story of Sati, who has been informed that she may have to undergo a hysterectomy as her upper reproductive tract has also been infected. Sati's story is typical of what happens in similar situations. Only when the situation is acute is appropriate health care accessed, and she herself summarised the story adequately.

"When the vellai padudal started, I did nothing. Only now, during the past six months am I taking any treatment. I have asked my mother to come and live with me for a while so as to be able to run the home. First, I used to wash myself with warm water. Next, some one suggested that I eat a certain green vegetable as a cure. I took that 2-3 times but nothing happened. Now I am going to Gosha Hospital (the large Government run woman's hospital in the central part of the city). They gave me 5 long pills to insert in the vagina and asked me to come back after that. The vellai padudal reduced a little after that. They asked me to come back after two weeks. They next took a long stick and inserted it inside and took something in a cotton. They said that is for testing and now I have to go back after two weeks again."

The doctor told her that there was a possibility that she may have to undergo a hysterectomy and this has frightened her. She has had to make a sustained
effort to continue going to Gosha hospital and this strains her resources even though she only incurred transport costs. Medical care at this hospital is free for her. She told me that it was difficult to find the bus fare for it.

But very often women do not move the distance needed to shift from herbal remedies and self cures to private practitioners. In fact, these large Government hospitals are not much preferred unless women are short of funds. The health workers in the community and the women made the reasons for this very clear. The hospitals catered to a large population. They were over crowded and so the patients had to wait for a long time in the queue for their turn with the doctor. This meant that for women, their housework cannot be finished before they visit the hospital.

Further, if there was any need for laboratory tests or X-rays to be taken, some tips (bribes) had to be paid to the persons operating these facilities. According to the informants (this information was confirmed in the FGDs and by the key informants who were from the community), if such bribes were not paid their chances of being attended to were not very high. In addition to these bribes, they have to spend some money on medication since not all the prescribed medicines are available at the Government facility. Then, such medicines have to be bought at a private pharmacy. The whole process, when transportation costs are also added becomes a costly proposition, even though medical care at such a facility is free.

Women do not seem to prefer these large Government facilities also because they have male doctors wandering about. Even if the particular doctor treating the patient is female, other male doctors are said to wandering about and this embarrases the women. For these women vellai padudal is not something that can be spoken about in public places especially in the presence of strangers. One of the women who had severe itching and vellai padudal went to a pharmacy in the vicinity of Vaiyapuri Chatram and asked for medication for sores. She used the ointment thus obtained for the vaginal
itching. She said that the itching initially did reduce but after a while returned with the same intensity.

Another strong reason for the women not seeking health care outside the home unless the *vellai padudal* becomes acute is the fear of infidelity accusations either by the husband or by the community. Since houses are situated very close to each other there is very little visual and auditory privacy is available. In these circumstances, it is embarrassing to be accused of infidelity by one’s husband or to accuse one’s husband of the same. Either way there is a loss of face within the community.

Manju who is married to her maternal uncle said:

“My husband gets drunk and beats me. It is painful. He speaks bad things about me that I have relations with other men. I know that if I go for treatment he will become suspicious. He will say, why are you going? How did you get this disease?”

Another women who has been educated up to higher secondary and was teaching in the adult literacy programme gave up her employment because of a similar problem created by her husband. She said:

“He used to always beat me and I have told him that it is not good. He always apologises but starts again. Recently he started getting suspicious and said that I should not talk to anyone in the neighbourhood. He has been like this since the birth of my son. Other people also talk about these things and make up stories and he listens to them and beats me.”

Wife beating and infidelity accusations seem to routine affairs in the community. Women were beaten by husbands who were often under the influence of alcohol when they did this. Further, some of the husbands, at least two of them at the time of field work had set up homes with other women. One of these husbands has been asking his wife to sign a letter granting her husband permission to marry a second time. Such a situation leads to emotional as well as financial distress as many of the wives depend on
their husbands for economic sustenance for themselves and their children.
This distress leads to hopelessness in their lives that lets them ignore even
their acute ailments, unless it interferes with the day to day functioning.
Ambuja, whose husband’s relationship with another woman has lead him to
ask her to sign a paper giving him legal permission to marry a second time,8
pointed out that her husband knew that she would not permit him to shout
nasty things in the street for fear of community disapproval and because of that
she would sign any paper. She said:

“He is going to marry her within two months. I know that I
have to go to the doctor for this vellai padudal. Even if the
doctor treats me for free, I will have to spend money on
medicines. Now he is the husband) is not giving me any money
to run the household. Where can I go to the hospital?”

Another woman whose husband had a long term affair with another woman 10
years ago and is now with her said:

“I can never tell any doctor that I feel pain during intercourse.
This is not talked about. I cannot tell about vellai padudal. I
have sought all the medical care that I could. There is nothing
left. I married this man of my own choice. If you go to the
barber’s shop to have your hair cut, you have to tolerate what
ever he does. One cannot tell him stop now. Once my daughter
is married (she has only one daughter), then what is left in life
for me? It will not matter after that whether I live or die.”

Such desperation and helplessness is not common at all ages but some of the
women seem to reach such a stage in their mid forties.

8 Such a permission is not legally valid and bigamy is prohibited by the law
but none of the parties involved seemed to be aware of it.
4.5. Health Service Providers in the Vicinity of Vaiyapuri Chatram

There were five private practitioners (one of them did not have a degree in either bio-medicine or in alternative medicine); three voluntary health services, one of which was for leprosy; two large private hospitals; one City Corporation Health Post and a large Government teaching Hospital near Vaiyapuri Chatram. The voluntary health services did not cater to women's ailments and the two private hospitals were not frequently utilised (too expensive) by the people living in Vaiyapuri Chatram.

The women went to the Government facilities and the City Corporation's health posts when ever needed. They also went to two women practitioners in the vicinity. Sometimes the services of the other doctor, who ran a 24 hour clinic within the slum was also utilised for minor ailments.

For purposes of the study it was not possible to interview the doctors in the Government or City Corporation facilities. This is because special permission is needed to conduct interviews and the permission takes about three months which is more that the time scheduled for field work and thesis writing. Permission could not be obtained in advance as Vaiyapuri Chatram was selected as the study area only after reaching the field.

As a consequence, I interviewed the two female medical practitioners and the doctor at the 24 hour clinic to obtain their perceptions of the common ailments among the people of Vaiyapuri Chatram.

These doctors said that a majority of their female clientele came to them with complaints of *vellai padudal*, and the percentage of their practice that constituted this complaint ranged from 4 per cent for the male doctor to 60 per cent for the female gynaecologist. However the doctors say that they were forced to give non-specific treatment because if they recommend
pathological testing in private laboratories the costs would be prohibitive to cause the patients to go away without treatment or to seek another doctor.

Partner notification even in the case of severe STDs is not done. The Gynaecologist who had been practising in this area for 10 years explained:

"I was quite sensitive to this initially and very enthusiastic. I set up practice in this slum and whenever I met women who had symptoms of STDs I sent for their husbands and counselled them. Very soon a group of husbands threatened to close down my practice if I informed the wives about the possible sources of STDs. I cannot also rule out the possibility that the woman herself is not involved elsewhere. So I restrain myself to symptomatic treatment. In serious situations I refer them to RTC." 

Another female doctor who treats the women of the community mentioned that most of the infections she treated were fungal infections which could as well have non-sexual modes of spreading.

These doctors and selected experts also confirmed that multiple sexual partnerships in the urban locations are on the rise and that could be the reason for the high prevalence levels of STDs within Tamil Nadu itself (APAC, 1998). This study bears out the finding with respect to multiple sexual partnerships with seven of the 12 married women with experience of vellai padudal saying that their husbands had relationships with other women.

4.6. Discussion

Women are seriously distressed by vellai padudal. This is seen as symptomatic of several reproductive morbidities, which include STDs in their

---

9 The large teaching hospital in the vicinity of the slum. This name has also
scope. They attribute a host of reasons for it, starting from excessive body heat to spousal infidelity. But health seeking for this illness as seen from the perspective of Klienman’s model of the three systems of health care is mostly restricted to the popular (washing) and folk (dietary remedies) sectors. Whenever the patients seem to take recourse to the professional sector, the assistance received is mostly inadequate. Such care as is provided does not prevent recurrence not does it cure completely as the remedies are largely symptomatic.

What are the reasons for this? Previous anthropological and other studies in India seem to indicate that complaints of white discharge are indicative of women’s mental distress caused by psycho-social problems (Nichter, 1981a), presence of gynaecological morbidity (Bang, et. al., 1989) or to economic distress caused by poverty and deprivation (Oomman, 1997).

This study attempts to synthesis the biomedical and the anthropological constructs using a reproductive health perspective. It looks at women’s situation within the household - her roles within the household as a mother and as a wife and her relationship with her husband, in addition to the above mentioned factors like the socio-economic situation of the household. This is more or less common to all the members of the household, but within the household system lie factors that render women vulnerable to this illness and also to some extent obstruct health care seeking and this study has attempted to identify these.

It is true that access to health care is limited due to reasons like lack of financial resources and the need to bribe hospital staff, lack of medicines and privacy, but these factors are common for all ailments for which health care may be sought. Then these are not the only factors that prevent women from seeking health care for vellai padudal. Women are additionally distressed by vellai padudal because it is seen as caused by unclean sexual contact. Such an

been changed to provide anonymity to the community studied.
aetiology has minimal biological justification, as according to one of the
doctors the women's infections are mostly fungal. Given the low levels of
menstrual hygiene it is possible that fungal infections predominate. However
because of the perception of *vellai padudal* as having sexual connotations,
should either of the spouses stand accused in this context (by means of visual
evidence such as *vellai padudal* for women and pus or sores on the penis for
men), then the consequences are severe. For women it is more problematic
because of the unequal access they have to household resources. In these
circumstances, seeking health care for this illness could be stigmatising and
lead to discord within the household, especially between husband and wife.

Nichter suggests that complaints of white discharge emanate from
women in households that are distressed in some way and women use this
illness description as an idiom of distress. Oomman (1997) and Ramsubban
and Singh (1997) seem to suggest that complaints of white discharge and
weakness are reflective of the overall distress that women face including
economic, socio-cultural and physical. This study moves in another direction
by identifying *vellai padudal* itself as a source of discord within the
household, especially within the dyad of husband and wife. It is sometimes
the fear of discord that prevents health care seeking for this problem.
Chapter 5.
Conclusions and Policy Implications

5.1. Conclusions

Complaints of vellai padudal exist within the community of women in Chennai’s slums and this illness seems to distress them physically and psychologically as well. Though every woman experiences vellai padudal routinely, it can become abnormal on the basis of changes in three attributes; timing of commencement, consistency and colour, and volume. There were noticeable differences in the women’s perceptions of vellai padudal by their marital status and personal experiences.

Vellai padudal is very often accompanied by itching or low abdominal pain. Even women who did not have vellai padudal suffered from other illnesses, whose symptoms were indicative of gynaecological morbidity. Women who did not have vellai padudal felt that it was caused by weakness or due to heat in their bodies or their husband’s bodies. It was also thought that this illness could be a symptom of very serious diseases like cancer or AIDS.

Women who experienced vellai padudal related it to their husband’s occupations that were heat generating which by transfer of bodily fluids, affected them. Another reason for vellai padudal was the husband’s sexual contact with other women. So even though they identified lack of sathu (essential nutrition) as a possible cause, married women with experience of vellai padudal connected it to their relations with their husbands - either because of the husband’s heat generating occupation or because of his extramarital sexual contact. It is this sexuality connection that renders this illness stigmatising for its sufferers.

Treatment seeking for vellai padudal was at three levels: self care at the household level - washing with warm water; traditional dietary remedies -
eating certain green vegetables and drinking cooling fluids; and lastly visiting the organised medical sector consisting of private practitioners and Government facilities. The third option was used only when the symptoms were acute.

Health facilities, either Government or private involve financial costs. Women had problems finding the time and money to seek health care for *vellai padudal* because of this. Visits to Government facilities involve sustained efforts in terms of time and money since they involve complex diagnostic procedures, but the services are actually free. Private practitioners charge for services. Even so, Government facilities are used as a last resort or due to referrals because of the lack of privacy, the overcrowding necessitating enormous efforts by way to waiting time to seek treatment and the need to pay tips (bribes) to appropriate persons to negotiate a smooth passage through such a facility. Such costs are significant for many households of Vaiyapuri Chatram.

*Vellai padudal* is identified in the minds of its sufferers with spousal infidelity for both men and women. Since infidelity accusations and gender violence have a place in the lives of these women, they relate *vellai padudal* to possible marital discord. Fear of such discord, combined with limited access to resources and the difficulties involved in accessing health care in large Government facilities actually come in the way of women seeking appropriate care for *vellai padudal*.

In addition, there are several misconceptions within the community especially with respect to AIDS and *vellai padudal*. This is perhaps a consequence of the enthusiastic AIDS awareness campaigns in the mass media. When information provided is inadequate or not properly delivered it can give rise to the development of other myths surrounding this illness, namely, *vellai padudal*. 
5.2. Policy Implications

It may not be possible for the state to intervene in the household to improve husband-wife relations, but it can at least improve knowledge of the members of the community by targeting appropriate health education campaigns regarding vellai padudal and promoting health care seeking.

One of the other factors that have been noticed in this study is that private health facilities are not equipped to deal with the laboratory tests that are needed for adequate diagnosis. There is a need therefore, for large Government Hospitals to set up facilities that cater to such women speedily and with adequate privacy. This can be done by having fixed day camps in the Corporation Health Posts that are located within the community or by shifting the focus of operations to these health posts themselves.
Appendix I

Profile of the Informants from Vaiyapuri Chatram

1. Age distribution of the women

<table>
<thead>
<tr>
<th>Ages</th>
<th>Married</th>
<th>Not married</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 20</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>20-24</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>25-29</td>
<td>8</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>30-34</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>35-39</td>
<td>4</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>40-44</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>45-49</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>50 and above</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>5</td>
<td>26</td>
</tr>
</tbody>
</table>

2. Age at marriage of the informants

<table>
<thead>
<tr>
<th>Age at marriage</th>
<th>Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>20-24</td>
<td>2</td>
</tr>
<tr>
<td>25 and above</td>
<td>2</td>
</tr>
<tr>
<td>Not known</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
</tr>
</tbody>
</table>
3. Number of children surviving

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>5 and above</td>
<td>1</td>
</tr>
<tr>
<td>Total women</td>
<td>21</td>
</tr>
</tbody>
</table>

4. Experience of vellai padudal

<table>
<thead>
<tr>
<th>Experience</th>
<th>Married</th>
<th>Not Married</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced vellai padudal</td>
<td>12</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Did not experience vellai padudal</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>5</td>
<td>26</td>
</tr>
</tbody>
</table>

Profile of the husbands

5. Age of the husbands

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Husbands</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 25</td>
<td>1</td>
</tr>
<tr>
<td>25-29</td>
<td>4</td>
</tr>
<tr>
<td>30-34</td>
<td>2</td>
</tr>
<tr>
<td>35-39</td>
<td>9</td>
</tr>
<tr>
<td>40-44</td>
<td>2</td>
</tr>
<tr>
<td>45 and above</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
</tr>
</tbody>
</table>

Two women did not have husbands
6. Occupation of husbands

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of husbands</th>
</tr>
</thead>
<tbody>
<tr>
<td>petty traders</td>
<td>3</td>
</tr>
<tr>
<td>daily wage earners</td>
<td>2</td>
</tr>
<tr>
<td>construction workers</td>
<td>4</td>
</tr>
<tr>
<td>blue collar worker</td>
<td>7</td>
</tr>
<tr>
<td>plumbing</td>
<td>2</td>
</tr>
<tr>
<td>driver</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

7. Monthly household income in Rupees

<table>
<thead>
<tr>
<th>Income</th>
<th>Number of households</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than Rs.1000</td>
<td>9</td>
</tr>
<tr>
<td>1000-2000</td>
<td>9</td>
</tr>
<tr>
<td>2000-3000</td>
<td>2</td>
</tr>
<tr>
<td>above 3000</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>
References

AIDS Prevention and Control Project; 1998

Bang, et. al.; 1989

Bang R. and A. Bang; 1994
'Women's Perceptions of White Vaginal Discharge: Ethnographic Data from Rural Maharashtra' in Listening to Women Talk About Their Health, (eds.) Gittelsohn, et. al., Har-Anand Publications, New Delhi, pp.: 79-94.

Bhatia J.C. and John Cleland; 1995

Bhatia J.C., John Cleland, Leela Bhagavan and N.S.N. Rao; 1997
'Levels and Determinants of Gynaecological Morbidity in a District of South India', Studies in Family Planning, 28(2), pp.: 95-103.

Chaturvedi, Santhosh K, 1997
'Popular Hidden Illness in Asian Women Related to Lay Beliefs Regarding Normal Vaginal Discharge', in (ed.) Lynne Hunt, Proceedings of the Third Asia and Pacific Conference on the Social Sciences and Medicine, Perth, 1996, Volume 1, Section 7, Gender and Health, Faculty of Health and Human Sciences, Edith Cowan University, Perth, Western Australia, Sponsored by The Ford Foundation.
Government of India; 1996


Gupta, J; 1993


Jaswal, Suriender K.P. and Trudy Harpham; 1997


Khattab, Hind; 1992


Kleinman. A; 1980


Mueller Ruth Dixon and Judith Wasserheit; 1991


Mendelbaum, D.G.; 1970

‘Family Roles: Girl and Women’ in **Society in India. Volume I. Continuity and Change**’, University of California Press, pp. 82-94.
Mutatkar R.K.; 1995

Narayan N. and S. Srinivasan; 1994

Nichter.M; 1981

Nichter.M; 1981a

Nichter.M; 1989

Oomman, Nandini; 1997
Ramanathan, M; 1992

Ramanathan, M, T.R.Dilip and Sabu S.Padmas; 1995
'Quality of Care in Laparoscopic Sterilisation Camps: Observations from Kerala, India', in *Reproductive Health Matters*, No. 6, November 1995, pp.:84-93.

Ramanathan, M; 1996

Ramasubban, Radhika and Bhanwar Singh; 1997
'Gender, Reproductive Health and Weakness: Experiences of Slum Dwelling Women in Bombay, India', paper presented at the seminar on *Cultural Perspective on Reproductive Health*, Rustenburg, South Africa, 16-19 June, 1997, IUSSP Committee on Reproductive Health and University of Witwatersrand, Dept. of Community Health.

Ravindran, Sundari, T.K.; 1993

Simmons, Ruth and Christopher Elias; 1994

Wasserheit J.; 1989

Vlassoff, Carol; 1994

Zurayk, Huda, Hind Khattab, Nabil Younis, Mawaheb-El-Mouelhy and Mohamed Fadle; 1993