

Breaking the 'cycle' of exclusion

Clearly the concept of sanitation, its very definition, falls way short of its requirement ~ which is hardly surprising because the science of sanitation has been dominated by a 'male' perspective, Dr Dhrubajyoti Ghosh tells ADITI ROY GHATAK

It is a problem that encompasses at least 40 per cent of Indian women; those in the realms of the dispossessed. Extend it to their similarly placed sisters in all of Southeast Asia and it may involve some 100 million women. Their state of abject "inconvenience" — for want of a more socially acceptable term — would mean that they have been bypassed by managed sanitation programmes in the region, forced to address their cyclical bleeding in the darkness of night with devices that are, at best, unhygienic and, at worst, fatal.

Clearly the concept of sanitation, its very definition, falls way short of its requirements, which is hardly surprising, according to Dr Dhrubajyoti Ghosh, because the science of sanitation has been dominated by a "male" perspective. Dr Ghosh, a UN Global 500 Laureate renowned for his phenomenal work around the east Kolkata wetlands, was bewildered when he first encountered this curse afflicting women in Bengal villages. "This was a problem that everyone knew about, a critical health-related issue that existed in every home, yet it was ignored by administrators, sanitation engineers and even development workers."

For the women themselves, it had to be treated as a matter of shame, a disease to be washed away when no one was looking; the reused fabric often dried in some dingy corner — an open invitation to cervical cancer so rampant in Indian women placed in such conditions. Dr Ghosh — who had to quit as chief environment officer under the West Bengal government's environment department — came across this problem when asked to identify the lacuna in the state's health service by health minister Surya Kanta Misra. An intensive tour of the Bengal countryside and close conversations with the womenfolk opened a can of worms.

It was in a village that an elderly woman told him about the agony of a girl, caught in the vortex of poverty, ignorance and societal indifference, forced to give gender hygiene the go by and conceal her shame. This was the essence of the horrifying revelations made to this former engineer of the state government who was working as a senior fellow at the Centre for Studies in Social Sciences, who shared some of his findings around making a breakthrough in this



interview with *The Statesman*. Excerpts

Can you talk about some aspects of this shameful failure around gender hygiene

The exploration of health issues in the Bengal countryside provided a major indictment of our word as managers of a civilised society but nothing could be more humiliating than the village women who are forced to manage their menstrual cycle using a piece of discarded fabric that is repeatedly washed in unclean water and sometimes used even without drying. The appalling hygiene does not have to be spelt out; village women suffer from protozoan infection, bacterial infection, urinary tract infection and a host of other diseases — that infect the men as well. Without doubt this is the worst oversight in health care designs for people in general and disadvantaged women in particular.

Has this problem never been addressed by India's many family welfare programmes?

To my mind, family welfare is too focused on attaining demographic targets and has been conspicuously ignoring the recurring distress and the chain of diseases resulting from an improper management of the menstrual cycle. In fact, there was an evident taboo around discussing this affliction, which is why it took months of exploration before someone opened up. Even the thought of using disposable napkins never seemed to have occurred to them, and not only because of cost factors. This was a never-to-be-discussed issue. Period. Clearly, there is the deep-seated apathy of "rural women beyond 30" towards anything around their healthcare.

What was this gender hygiene programme that

you initiated?

Having understood the sheer size of the problem, we had to find a solution. I knew that the solution would have to come from the village and guided by us. I also knew that it had to be an affordable solution and the only thing that pointed itself out was to get women to organise themselves in Self-Help Groups and manufacture the napkins themselves.

What were the main problem areas?

First, we had to learn how to make the napkins because no one would share the knowledge with us. It was left for us to figure out what the components should be, where they could be accessed from and then establish a process to manufacture it hygienically. It took us several months to sort this out, using very simple technology. We also had to form Self-Help Groups that would understand the need for this drastic change in their personal hygiene management.

How about energising

the Self-Help Groups?

Where we erred was in the formation of the initial Self-Help Groups that seem to have come forward in expectation of financial gains and, after an abortive phase, we have now achieved a more reliable set of groups of women, making and selling packs of nine napkins at Rs 15 each that is definitely superior to the closest branded product and costs less. In fact, the current crop of Self-Help Groups makes it for around Rs 11 a packet and keeps a margin of four rupees. We named the product Paushi (after the village where it was first made) and today we have a modest outreach over five Bengal districts.

Where do you see the programme going from here?

support base for the programme.

What is your take home from this experience?

We need to treat the Gender Hygiene Programme not just as a health intervention agenda but a women's empowerment programme through SHGs that earn by producing and selling napkins. It involves no costly machinery nor big capital. Its is a low-cost, labour-intensive process protocol that needs only an hour of training. Evidently, village women are endowed with a natural aptitude to quickly adapt to these kinds of skills. Essentially, GHP is founded upon a completely different rationale that links the producer and a user. For those women who are served by the retail market dispensations, the producer-user relationship is like "You (manufacturers) make it and we use it", whereas for all those women covered by the GHP, the relationship is, "We make it and we use it". This brand campaign theme emerges from within the programme itself.

Do you expect a big bang impact?

No sweeping change will take place automatically; the role of the government, healthcare agencies at the local, regional and global levels, philanthropic centres, donors, socially initiated groups/individuals come to the fore. The task is twofold: to dismiss the age-old taboo that grips the "lesser" gender and show them the road to emancipation that they can create for themselves.

Alongside the "soft" agenda is the "hard" agenda around creating a reliable and accessible database on the present state of Menstrual Cycle Distress and the long run impact of GHP in lowering the extent of gynaecological morbidity. Parallel examples can be drawn from the worldwide programme on HIV/Aids, where constant monitoring of sensitive population is one of the major components of the total agenda. For GHP, such a monitoring programme will be relatively simpler; indeed, GHP has a clear chance of becoming one of the most widely spread, least expensive health initiatives in South Asia.

The interviewer is a former Assistant Editor, *The Statesman*

