

# Technologies of Self

## Poverty and Health in an Urban Setting

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Michel Foucault's subtle differentiations between the different forms of writing as examples of the government of oneself offers important insights on the philosophical cultivation of the self.<sup>1</sup> But can those insights be put into conversation with the search for care in neighbourhoods inhabited by low-income families in the urban milieu of Delhi? In this essay I describe some experiences with illness trajectories and the modes of subjectivity through which questions of belonging and cultivation of the self are addressed in households in one low-income neighbourhood. My ethnography is drawn from an ongoing study of the pathways between urban poverty and health in seven neighbourhoods in Delhi.<sup>2</sup> While the act of writing is not central to the lives of the people I describe, the specificities in their modes of narration stand out in sharp relief against the kind of questions raised by Foucault on the relation between truth and subjectivity.

The essay on "self writing" opens with the declaration that "These pages are part of a series of studies on the 'art of oneself', that is on the aesthetics of existence and of the government of oneself and others in Greco-Roman culture during the first two centuries of the Empire" (p. 207). The form that is of interest to me is that of the "correspondence" – letters in which information is exchanged on one's activities, successes and failures, good luck or misfortune, but also through which the writer makes himself present to the receiver. An important part of the correspondence was in the form of health reports that included detailed descriptions of body sensations, impressions of malaise and various disorders one might have experienced. The letter was also a way of opening oneself to one's correspondent in the unfolding of everyday life. "To recall one's day, not because of the importance of events that may have marked it, but precisely even though there was nothing about it apart from its being like all others, testifying in this way not to the importance of an activity but to the quality of a mode of being – forms part of the epistolatory practice" (p. 218). Thus the coming into being of the subject happens not at the moment of crisis but in the reflections on how feelings of malaise or experiences of disorder are part of everyday life. And further, the reality of these experiences is testified by making oneself present to the gaze of the other. This conception of subjectivity forged in the workshop of everyday life is quite different from the analytical take in the anthropology of illness narratives that traces the emergence of subjectivity at the critical moment when the body ceases to work. While I do not deny the importance of crisis in generating a discourse that connects the self to the world, I am interested in seeing the working of the ordinary in terms that Foucault's essay opens for us.

#### >Bhagwanpur Kheda

One of the distinct features of low-income localities in Delhi in terms of their medical environment is that they are saturated with practitioners from different streams of medical training.<sup>3</sup> While a genealogical analysis of the various kinds of medical degrees that proliferate in the areas (e.g. MBBS, BAMS, BUMS, BIMS, Ayurveda Ratna, Vaidya Visharad, in addition to RMP or PMP) provides an important insight into the processes of state formation, from the perspective of the households there are two dominant cross-cutting distinctions through which practitioners are classified. The first distinction is between practitioners with certification and those without. The second is between government facilities (*sarkari*) versus market operated ('private').<sup>4</sup> Thus although BAMS (Bachelor of Ayurvedic Medicine and Surgery) and MBBS (Bachelor of Medicine and Bachelor of Surgery) are from the streams of *ayurveda* and biomedicine respectively, they are placed in the same category as *practitioners with degrees* in the narratives of the households, and are distinguished from those without any degree. This may appear surprising to those who assume that the pluralism of medical systems runs across the lines of modern versus traditional medicine, but the households go more by the fact that both kinds of practitioners have degrees and both dispense the same kinds of medicines (analgesics and antibiotics) for sickness. The second distinction (between *sarkari* and 'private') is embedded in narratives that refer to crowding and the long queues at government dispensaries to receive free consultation and medications. This is contrasted with the convenience of being able to access the 'private' practitioners at any

time without delays although this is an expensive option.<sup>5</sup> I would like to tag the fact that state, market and community are present in everyday life – in fact, people's testimonies to their mode of being assume the gaze of the state and the community, although these, as we shall see, are not distinct forms of belonging. The markets around the neighbourhoods are absorbed within the community, for some purposes, and engender brokered forms of sociality, for others.

The literature on the interface between poverty and health had led me to assume that the basic issue in health care for the poor would be the lack of access to practitioners: so I was surprised to see that in fact there was a high incidence of use of practitioners even for minor illnesses such as colds, coughs or headaches. Further, serious illnesses could remain undiagnosed for long periods despite the fact that those who were reporting sick were routinely visiting the practitioners in the locality. To get an idea of the kinds of actions taken consequent upon illness in a particular week consider Table 1, which is based upon data collected in the locality over a sixteen-week period through a weekly morbidity survey, in which the trajectory of illness and of household decision-making was tracked in 40 households with 270 individuals.

Table 1: Patterns of action consequent upon illness reported that week in Bhagwanpur Kheda

Action	Frequency	Percent	Cumulative
No Action Taken	319	21.75	21.75
Practitioner Visit	508	34.63	56.30
Consulted Pharmacist	48	03.27	59.65
Medicine bought without Current Prescription	389	26.52	86.16
Two or More Actions	203	13.84	86.16
Total	1467	100.00	100.00

As this table shows, out of the 1467 instances of reported sick weeks over a 16-week period, there were only 21.75% instances when no action was taken that week. In all other cases there was either a visit to a practitioner, or medicines were bought from the pharmacist on the basis of an existing prescription.<sup>6</sup> Let me now address the question: in the context of the frequent recourse to practitioners, as in Table 1, how did the narration of illness on different sites become a testimony to modes of being? The coming into being of the urban subject is here suspended between complex negotiations of community, market and state within the life world of the urban poor.

### >One Morning at the Government Dispensary in Bhagwanpur Kheda

In the course of our work with the practitioners in the area, several members of our research team conducted participant observation with randomly selected practitioners from each locality. This is how I came to be in the government dispensary on a hot July morning. The attending physician was sitting on a chair next to which there was a stool for the patient. There was barely any place for me to sit, so I stood near the door watching the interactions between physician and patient. Even at nine in the morning there was a huge queue outside the room in the corridor. Scuffles were breaking out and the physician had to interrupt his consultation by admonishing the crowd from time to time or turning his back to the patient he was seeing and saying that unless some order was restored in the queue outside, he would not see any patient. At this display some self-styled leaders would shush everybody into a queue and ask people to be quiet. I noticed that there was no washbasin to wash hands, no gloves and no instruments such as a thermometer or an instrument to measure blood pressure or a weighing scale. The temperature was touching 40 degrees centigrade – the fan in the room did not work since there was no electricity. I should also note that in two hours that morning the physician attended 104 patients, spending less than one minute per patient, and also that even when clinics (including private ones) were not overcrowded, practitioners in the locality spent an average of two-and-a-half minutes per patient. I describe an encounter to show how the state gets embedded into the narration of illness.

The thirtieth patient to present herself was an old lady reporting symptoms of cough, cold and intermittent bouts of fever. As soon as she sat on the stool reserved for patients and handed over her OPD card, the physician said "*Kya bimari hai?* – What is the illness?" The woman said "Doctor Sahib, I have fever, cold, cough, I feel weak – I was going to Raju Doctor – the private one – he gave an injection but see Doctor Sahib – what to do, we are poor people – we..." The physician interrupted her in mid-sentence and said, "Have you come here to tell me stories or to get treatment?" Meanwhile he wrote a prescription on her card – as with every other case of cold, cough and fever, he wrote "Caps x TDS x 2". I had already learnt that "Capsule" referred to tetracycline, which was the only antibiotic available in the dispensary that month, and the physician had given the same prescription to every patient with similar symptoms. The woman now folded her hands and said, "*Aapki daya hai, sarkar hi to ma-bap hai* – it is your beneficence, the government is our mother and father". Again the physician interrupted rudely, "Don't waste my time – I am not here to hear your stories..." Anyway the next patient in line was pressing to enter and so the encounter ended.

A comparison of illness in the correspondence of Seneca (referred to in Foucault's essay with which we began) and the mode of telling here quickly reveals that the voice is thwarted in mid-sentence. The patient has no way to make her story known. She gets the medicine and that is proof for her that her visit has yielded some result. And this, for this patient as for the many others we interviewed, becomes the mode through which the state is present in the life of the subject. *Vahan hamari sunvai nahin hai* (We are not heard there) is the dominant expression used to refer to one's encounters with government hospitals and dispensaries; yet there is also a sense that one has claims over the state so that when all else fails, the *sarkari* facilities will be available.



### >The Brokered Subject and the Pressure of Voice

Walking in the streets in Bhagwanpur Kheda one comes across practitioners who have a single room with one telephone and perhaps an oxygen cylinder lying on the side, but whose billboards announce “We also have facilities for MIR, CT SCAN, X RAY, PREGNANCY TESTS”. I asked a practitioner who had a degree in integrated medicine (BIMS) where he conducted these tests. He replied that he knew many diagnostic laboratories in the area and, for a commission, he took patients to these facilities. This encounter was indicative of a major role that practitioners in low-income neighbourhoods play in the lives of households – that of brokers to the outside world.

Seventy percent of the illness episodes we recorded in the 16 weeks of the survey in this locality lasted less than one week. In these cases households would go to a local practitioner, or even send a child to pick up medicines. “*Bukhar hua tha, dawa le aaye mote dactar se* – There was fever, we got the medicine from the fat doctor” is how the explanation would rest.

More than 6% of the episodes recorded in the 16 weeks, however, lasted three weeks or more. In such cases, faced with life-threatening illnesses, families began to despair of therapy within the local context. The worsening of illness to the point that it became life-

threatening always led to a search for therapy outside the local into the world of specialists and hospitals, when brokered forms of sociality began to be visible. One form of brokerage was with modern institutions, for which not only the practitioners but also members of kinship and neighbourhood networks acted as intermediaries. Relatives who worked in hospitals as janitors or ward boys figured prominently in stories for their crucial roles in getting admission to hospitals or appointments with an attending physician; the use of these 'contacts', in which the physician was cast in the role of patron, was widely acknowledged.<sup>7</sup> But while on the one hand relatives were sources of support, their voices were also experienced as lethal – they inserted themselves in the space of the imaginary when the hold over the real was seen to slip.<sup>8</sup> The following excerpts from an interview conducted by Rajan Singh of the ISERDD health research team with a recovered TB patient show the struggle in authoring the real.

### >Sangeeta's Story

How did you discover you had TB?

*I had many problems, a lot of weakness, so much so that it was difficult for me to sit.*

So you had weakness – did you have any other problem?

*No brother, but it was that I did not feel like eating, nothing seemed to interest me, my heart did not engage.*

And fever?

*Yes there was constant fever, there was also coughing.*

For how long did you have this?

*Some days, some weeks. See, first I started to take medicines: private [in English] was started.*

So, which practitioner did you go to first?

*See first medicines from here and there. The local doctor gave medicines – I was not getting better. Then my daughter was born – because I was feeling quite sick, they took me to hospital for the birth (it was my time).<sup>9</sup> I would feel great pateshani [trouble] in my throat – so they took me to hospital for my throat – initially they roamed here and there [idhar udhar le ke dole]. Then my daughter was born – still I could not eat anything – so then I had gone to my Mummy's place. I could not still eat anything. So Mummy took me to sarkari hospital – there they did an X-Ray – so in the hospital an X-Ray was done. Then it was known. So then in the Government Hospital they said I had TB. They told us to go to this TB hospital for medicines.*

So you did not have to take any private medicines?

*No, first Mummy thought that the private medicines will be better. See there were problems with my throat – there was swelling, difficulty in swallowing, no appetite – so we also had it seen from a private doctor in Mayur Vihar [an upper-middle-class neighbourhood] but there the doctor said, don't worry – it is just a cold, you will get okay – so he gave some medicine but it was very expensive and anyway there was no improvement.*

In the next segment of the interview she described how some people said that it was magic or sorcery and they should have it blown away through a diviner or a healer, and how others recommended other private doctors.

*Then my Mummy said that I would just take her to the sarkari hospital – the TB hospital where they had told us to go. She said that she would not listen to anyone.*

*You mean you decided to go to the TB hospital – the one where doctors from the hospital where your daughter was born asked you to go?*

*Yes, that is the one. People said go here, go there, but Mummy said whatever anyone says – I will take her to that government hospital.*

*What happened there? Did you get medicines? X-Ray?*

*Yes, they gave medicine – two tablets a day. The doctor there said that the medicines must be taken. He said you can forget to eat your food but you cannot forget to take your medicine. So my husband did not have time to take me there to get medicines – so I stayed with Mummy.*

As the interview progressed Sangeeta described how she managed to overcome the obstacles in the treatment process and completed her therapeutic course.

Towards the end of the interview Rajan asked, almost as a matter of courtesy, "So your daughter who was born at the time that your TB was discovered – is she okay?" *No, she died when she was two years old. Everyone said I should not feed her my milk – she became weak. She hardly spoke. See, you have to listen when people say things. I became pregnant again and had a son but he too could not survive.*

Did the doctors in the TB hospital advise you not to feed your daughter breast milk – did they tell you anything about what to do when you became pregnant?

*No, the doctors did not tell me anything but everyone said that my milk was not good because of the disease.*

We can see that the outside space of therapy in this story was made up of a criss-crossing of possibilities. Suggestions and counter-suggestions came from all directions – you did not know who to trust. And though Sangeeta managed to complete the anti-TB regime of medication, she could not ignore the advice to withhold milk from her newborn child. The deaths of her two children did not seem to belong to the narrative of TB; which is not to suggest that she did not mourn for her dead children. Yet the overall effect of the story was about the care she received from her mother and the success of the therapy. For Sangeeta, the positive effect came from the fact that she experienced her social relations to have endured through the course of the illness. Such is the face of success.

There were other cases in which though the illness was cured, social relations were not. This entanglement of illness and experiments with forms of sociality are testimony that the relations of an individual to her kinship network, her community or her neighbourhood is not one in which one can be said to belong as, let us say, water belongs to the bottle or clothes belong to the wardrobe. If Seneca's experience with the cultivation of the self, as Foucault records, was through forms of letter-writing that authorised one's relation to oneself in the gaze of the other, the biggest difference in the stories we encountered was in the nature of this gaze. Whether in the embodiment of the state in clinical encounters or in the community whose voices figure so prominently in Sangeeta's story, the gaze of the other is either inverted or punitive – surveying you but always failing to acknowledge you. The dominant metaphor is not of seeing but of hearing. *Vahan hamari sunvai nahin thi* (We

were not heard) appears to be the opposite of *Mummy ne kaha main kisi ki nahin sunungi* (Mummy said I will not listen to anyone). But both these forms of attesting to the mode of the everyday show that crises do not lie outside the horizon of the everyday – buried in the everyday they constitutes its eventedness. Such are the stories of hope and despair that line everyday life, within which the subject as a point of contact between the self and the world is forged.

## NOTES

1. Foucault, Michel (Paul Rabinow ed.) *Ethics: Subjectivity and Truth* (The New Press, 1997, New York).
2. This study is being conducted by the Institute of Socio-Economic Research in Development and Democracy (ISERDD). I am grateful to the entire ISERDD team for the stupendous efforts they have put into this research, and to Johns Hopkins University for financial support. Most of all, I would like to thank the members of the 300 households who have made us welcome in their homes every week for at least four months of the year, for the last three years.
3. The density of practitioners in these areas can be gauged from the fact that there were 263 practitioners in the four low-income localities in our sample, within 15-minute radii of the sample households, which are clustered in neighbouring streets in the locality.
4. The term 'private' was used in English – the *sarkari*-private dichotomy was used frequently to refer to various kinds of services ranging from health services, schools, transport to liquor shops.
5. The normal charge for both consultation and medication in the area, regardless of the qualifications of the practitioner, ranges from Rs. 15 to Rs. 30. The normal practice is to dispense medications for one or two days and ask the patient to report again. In those cases when symptoms have persisted or there appears to be a life-threatening condition, the practitioner may prescribe medicines to be bought from the pharmacist or he may advise the patient to go to a more qualified practitioner, or to a hospital.
6. For a detailed examination of this question see Das, Veena and Ranendra K. Das "Pharmaceuticals in urban ecologies: The register of the local" (*ISERDD Occasional Paper Series* January 2003).
7. Anyone who has worked in institutions in India will recognise that the subordinate staff invariably create narratives in which one is cast in the role of a patron and, depending upon temperament, one ends up lending money to deal with an emergency, negotiating admissions in schools and being pushed towards using one's 'influence' to get jobs for relatives. The boundaries between the formal organisation and its environment run through the organisation like rivers running through a territory.
8. Important evidence of the lethal character of these relationships is to be found in the accusations of magic or sorcery, and in the work of the diviners and healers who deal with the occult. For reasons of space I am unable to take this point for discussion here.
9. Literally "*mera time aa gaya tha*" (My time had come).