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PRESIDENTIAL ADDRESS

OF

Shri Dalit Ezhilmalai

Union Minister of State for Health and Family Welfare
Government of India

At the

Western Regional
Health Minister's Conference
22-23, September, 1998

AHMEDABAD

PRESIDENTIAL ADDRESS OF SHRI DALIT EZHILMALAI, HON'BLE UNION MINISTER OF STATE FOR HEALTH & FAMILY WELFARE AT THE WESTERN REGIONAL HEALTH MINISTERS' CONFERENCE

AT

AHEMDABAD ON SEPTEMBER 22-23, 1998

Hon'ble Health Ministers, Union Secretaries of Health, Family Welfare and Indian Systems of Medicine and Homeopathy, State Health Secretaries, Officers and friends.

It gives me great pleasure to be amongst you at the Western Regional Health Ministers' Conference being held here to deliberate on issues relating to health care in this region. We have already held three such regional conferences for the southern, north eastern and northen regions. I am glad to state that we had meaningful discussions at these Conferences on vital issues concerning health, family welfare and ISM&H sectors which have helped us to arrive at a consensus on matters relating to the implementation of various national programmes.

Western Region has two industrially advanced States of Maharashtra and Gujarat and at the same time there are States like Madhya Pradesh and Rajasthan with a pre-ponderence of rural areas. Gujarat and Goa have reduced their annual exponential growth rate of population. Gujarat, Maharashtra, Goa and Daman & Diu have female literacy rate higher than the national average. The Crude Death Rate (CDR) is highest in

Madhya Pradesh followed by Dadra & Nagar Haveli, Rajasthan and Daman & Diu. In this Region Goa has achieved the lowest CDR. Again in the case of Infant Mortality Rate, while Goa's performance is excellent, Madhya Pradesh has the highest IMR as compared to the national average. All the States and UTs of the Region have an adverse sex ratio.

As you are aware, the Government of India had adopted the National Health Policy in 1983 which sought to provide universal, comprehensive, public health services focusing on nutrition, supply of quality food and drugs, occupational health services, potable water supply and sanitation. While we were able to make progress in some of these sectors, due to various reasons we were not able to achieve the NHP targets fully and a lot more remains to be done. Wide disparities across states, between rural and urban, developed and backward areas continue to persist. Unless we substantially reduce these disparities, we will not be able to build up the health of the country in the ensuing millennium. Therefore the major challenge before us today, as policy makers, is to reduce these disparities, improve access and ensure greater equity amongst and within States. This will not be possible unless we formulate policies and implement programmes that specifically address the problems being faced by the people particularly those living in remote and far flung areas where transport and communication bottlenecks exist making the delivery of health services more difficult.

Over the last 15 years since the National Health Policy was adopted, there have been fresh developments

in the health sector, global as well as national, giving rise to new priorities and concerns necessitating attention. A note on the agenda has already been circulated for initiating discussions on those vital issues which would help us to formulate a revised National Health Policy. I am sure that the deliberations in this conference would bring forth innovative and positive ideas based on the ground realities and inter-State priorities.

Population containment is a major thrust area in our programmes. The National Health Policy has set the goal of achieving a birth rate of 21 per thousand, death rate of 9 per thousand and infant mortality rate of less than 60 per thousand live births by the year 2000 A.D. The performance in these three crucial variables shows a mixed picture in this region. The birth rate ranges from 14.4 in Goa to 32.40 in Rajasthan. The infant mortality rate ranges from 15 in Goa to 97 in Madhya Pradesh. The States like Gujarat with a birth rate of 25.7, Maharashtra with 23.4 and Daman & Diu with 21.6 are very close to achieving the goal which we have set before us. However, Madhya Pradesh and Rajasthan have to go a long way in reaching the set level. I would urge the Health Ministers of these States to vigorously pursue the population control programme so that the people of these States could be benefited from the various developmental programmes.

Another programme which is important is the Universal Immunisation Programme which we have been implementing for more than a decade. I am happy to note that in the area of immunisation, the States in this Region have implemented the

Pulse-Polio Programme very efficiently. However, the coverage is still less than 100% of the target group. In terms of absolute numbers about 80 lakh children have been left uncovered. I urge the State Health Ministers of this Region to identify pockets and communities of low coverage in their States and intensify efforts to achieve 100% coverage. We are also concerned about the reported decline in the coverage of routine immunisations in the States of this Region. There has been a decline in some States of this Region in the coverage of DPT, OPV and Measles Immunization in recent years. I would like to request the State Health Ministers and Secretaries to take note of this decline and take remedial action.

Hon'ble Health Ministers are aware that the focus of the Family Welfare Programme has now shifted from quantity to quality of services. It is our firm belief that improvement in quality will lead to greater acceptance of Family Planning. The Reproductive and Child Health Programme launched recently has an ambitious agenda. The success of the RCH would greatly depend on local planning of service requirements. We expect the States to come up with specific schemes as per guidelines. Preparation of such specific schemes would require serious involvement of service delivery personnel. They would also require consultation with community leaders. Effective implementation of the RCH schemes would not only improve the availability of services, but increase access to facilities like essential and emergency obstetric care, screening of RTI/STD etc. Particular stress also needs to be given for evolving efficient logistic system for storing and reaching various medicines and contraceptives supplied by the Government of India.

You are aware about the efforts being made by the Department of Health to improve the efficacy and coverage of various National Health Programmes for combating communicable and non-communicable diseases. Tuberculosis is a major problem in Western States and about 9.03 lakh cases of T.B. are detected and put on treatment every year under the National Tuberculosis Control Programme. The threat of HIV-T.B. co-infection and the emergence of drug resistance had added a sense of urgency necessitating vigorous implementation of the T.B. Programmes. The funding pattern of T.B. drugs to the States has now been changed from 50:50 to 100% Central funding. To achieve a cure rate of 85%, the revised National Tuberculosis Control Programme with World Bank Assistance is being implemented in 102 districts in a phased manner. These include 19 districts in Gujarat, 4 in Rajasthan and 5 Districts in Madhya Pradesh. Since the States are now not required to spend for purchase of anti-TB drugs, I urge upon the State Health Ministers of this Region to establish TB centres in all Districts of their States and also strengthen infrastructure so that the benefits of the programme would be available to the whole population of the Region.

Incidence of Leprosy has already come down from 57 per ten thousand in 1981 to 5.3 in 1998. In the Western Region about 45041 confirmed cases have been identified. Out of these, over 46% of the cases are in Maharashtra followed by over 45% in Madhya Pradesh. In this Region, the Modified Leprosy Eradication Campaign is being implemented in all the States except in Rajasthan. Funds have been sanctioned to Rajasthan for implementation of the programme in the State. Most of the

States in the Western Region are not submitting to the Ministry the necessary utilisation certificates and other audited statements of expenditure. Unless these certificates are received, we may not be in a position to release the grants in time. I would therefore request the State Governments to furnish these certificates to the Centre in time. I would also suggest that the programme should be reviewed at the Secretary level once in three months and at the District level each month.

There were major outbreaks of malaria in Gujarat and Goa recently. The malaria situation in Goa is heading from epidemic to hyperendemic levels. This should serve as a warning to other States as uncontrolled urbanisation/ developmental projects with large population movements is likely to create malariogenic conditions which may take epidemic proportions. Such problems can be solved by having in-built anti-malaria components within the developmental projects and enforcing appropriate bye-laws. Of late outbreaks of Dengue/DHF have been reported in several parts of the country. Like Delhi, the states of Maharashtra and Rajasthan also recorded cases and deaths due to dengue. The State Health Authorities are, therefore, requested to prepare a contingency plan to face any outbreak situations of Dengue/DHF. In view of the similarity in ecological, meteorological and epidemiological conditions pertaining to the transmission and also due to the frequent inter-State population movements, there is a need for frequent exchange of information on malaria and other vector borne diseases in border areas of the concerned States and exchange visits of State Programme Officers which will help in coordinating the anti- vector borne disease activities.

It is also important to carry out spray operations along the inter-state borders in the concerned States. Gujarat, Madhya Pradesh, Maharashtra and Rajashtan are included under the Enhanced Malaria Control Project with World Bank assistance. Under this Project hard core tribal dominated districts and towns have been targetted and 58 districts and 9 towns fall in this region. Additional inputs will be given to these project areas for intensification of anti-malaria activities. The concerned States should formulate or revise their District Implementation Plan in time so as to facilitate effective implementation of the project.

The review of the epidemiological situation of the disease in the Western States reveals that there is an increasing trend of HIV infection in all the States and UTs but in Maharashtra and Gujarat a sharp increase has been observed. The recently conducted National Sentinel Surveillance report indicates that HIV prevalence among STD clinic attenders is as high as 26.8% in Maharashtra, 15.7% in Goa and 12.3% in Gujarat. It reflects not only the rising trend of infection in high risks groups but also percolation of infection into low risk groups like mothers attending ante-natal clinics. The rates are highest in Maharashtra (2.4%) followed by Goa (0.68%) and Gujarat (0.52%). Thus there is a need for expeditious and concerted efforts to slow down the transmission of HIV infection in high risk groups as well as in general population. Some of the key areas which require special attention relate to expansion of coverage of activities, directing programme resources to those who are most vulnerable to HIV infection, inter-sectoral collaboration, enlisting the participation of NGOs, the private sectors, the community and individuals, social mobilisation in

the field of blood donation, training of all categories of health workers, treatment of HIV related illnesses without stigma and discrimination, registration of State AIDS Societies for expeditious flow of funds to the States and District Units and above all creating an enabling environment for treatment of AIDS and related illnesses are all important facets of the programme which are being given a thrust. I urge the States to give the necessary impetus to all these strategies.

Prevalence of cataract blindness is relatively lower in the States of Maharashtra and Gujarat than the national average. It is a matter of concern in case of Rajasthan which has much higher rate of prevalence of 2.24% against the national average of 1.49%. Madhya Pradesh and Goa also have higher prevalence rates. In this region nearly 4.12 million people are estimated to be blind and nearly 4.6 lakh people need cataract operations. Maharashtra, Rajasthan and Madhya Pradesh have been included in the World Bank Assisted Cataract Blindness Control Project as these States have prevalence rates higher than the National average. There is a need to enhance eye surgeries in fixed facilities rather than through surgical eye camps as fixed facilities provide better quality of services and help establish institutional system for eye care for ensuring sustainability. District level action plans need to be drawn up so that the State Governments, NGOs and private sectors co- ordinate and co-operate at all levels and help enhance coverage and provide comprehensive eye care to the affected people. Further, the programmes need to be systematically monitored to ensure quality control.

The National Iodine Deficiency Disorder Control Programme is another important programme initiated by the Central Government with a view to bring down the prevalence of IDD below 10% in endemic districts of the country by 2000 A.D. and to prevent iodine deficiency disorders. IDD monitoring laboratories should be set up by the State Governments of Goa, Madhya Pradesh, Rajasthan and UT of Dadra & Nagar Haveli. Monthly progress reports on IDD Programme activities including salt analysis results should be submitted to the Centre regularly by the State Governments of Goa, Madhya Pradesh, Rajasthan and UT of Daman & Diu. I would like to appeal to all the States in the region to promote the use of iodated salt to create awareness about the importance of consumption of iodated salt particularly in remote rural areas and urban slums.

In the field of Medical Education it is seen that mere increase in the number of medical colleges has not helped in achieving the desired goals. Efforts made by the State Governments all over the country in making rural services compulsory for Government doctors have yielded mixed results. We need to ensure continuous availability of graduate doctors and specialists in rural areas for which an appropriate mechanism needs to be built in the scheme of Medical Education. It is Imperative that we ensure that the doctors who have received subsidised medical education are made to serve for a few years in the rural and remote areas where large segments of our rural people reside. Intensified efforts are called for to have an adequate number of doctors and paramedics so that necessary health care and

and

referral services could be provided to the people in close proximity.

India is one of the few countries fortunate to have its own indigenous systems of medicine, established thousands of years ago. Today we have about 6.00 lakh practitioners of Indian Systems of Medicines & Homeopathy with a fairly good network of dispensaries, hospitals, teaching institutions and drug manufacturers. While there are enough educational institutions, they are lacking in basic infrastructure and manpower facilities. Their standards are grossly below acceptable level. These institutions have remained underprovided. The Central Government has a scheme to provide grant-in-aid for the development of under-graduate and post-graduate colleges. The State Governments need to provide bigger contribution in providing funds to these colleges so as to bring them to the minimum level laid down by the Central Council of Indian Medicine. The State Governments may take initiatives to set up model regional institutions in these systems which will act as centres of excellence in teaching and research.

The other major problem being faced by these systems is the shortage of raw material used in the manufacturing of their drugs. Shortage of some of the medicinal plants has led to unhealthy practices of substitution leading to the production of substandard drugs. There is an urgent need for large scale cultivation of medicinal plants and herbs and to standardise agro-techniques for growing these plants. The State Governments need to take an initiative in establishing large

'Vanaspati Van' in denuded forest areas for cultivation of medicinal plants. There is also need for in situ conservation of medicinal plants by setting apart large forest areas where extraction of medicinal plants are not permitted.

I am constrained to state that the primary health care infrastructure continues to be a weak link in the health care delivery system of the Western Region. The major problems in this regard are the large vacancies in the posts of Male Health Workers, Lab-technicians and non-availability of doctors in the PHCs and the short fall in the number of sub-centres, PHCs and CHCs as per the population norms. Rajasthan tops in respect of vacancy of MHW which is currently estimated to be 5865 followed by Gujarat with 3019. The situation in Madhya Pradesh and Maharashtra is also not satisfactory. There are big short falls of laboratory technicians and nurses/mid-wives in the case of Gujarat, Madhya Pradesh, Maharashtra and Rajasthan. As regards the short fall in the health infrastructure, Maharashtra is still short of 808 Sub-Centres, 61 PHCs and 135 CHCs. In the case of Madhya Pradesh, the short fall in respect of Sub-Centre is estimated to be 184, PHCs 206 and CHCs 307. In view of the problems of infrastructual gaps the Government of India has converted the earlier Minimum Needs Programme into the Basic Minimum Needs Programme under which additional Central assistance would be available for implementation of several basic minimum services including Primary Health Care. I appeal to all the States in this region to utilise this opportunity to invest additional resources for bridging the infrastructural gaps in the primary health care network.

Objectives

The basic objectives of "HealthWatch" are:

1. To translate the ICPD Programme of Action for the national context by defining priorities for public policies and action, and the mechanisms for their implementation;

2. To engage in a process of constructive but critical dialogue with the government at multiple levels; and to lobby for a shift in the government's Family Welfare Programmes from provider-driven to people-based programmes;

3. To explore mechanisms to link reproductive health services to strengthen public and primary health care, and related aspects of development, especially education and women's economic, political and social empowerment; in particular to advocate restructuring government programmes based on the vibrant NGO experiences in this area;

4. To provide a forum for effective networking among like-minded NGO's to make progress on the above objectives;

5. To provide a forum for continuous exchange of information and sharing of ideas and experiences among NGOs themselves.

For further information or any comments and suggestions, please write to:

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HealthWatch,
a Network for Action and Research on Women's Health

At a meeting of NGO s, held in Ahmedabad on December 1-2, 1994, it was decided to form a network to explore the feasible approaches to move forward from the Programme of Action adopted at the International Conference on Population and Development (ICPD) in Cairo in September 1994. We visualized "HealthWatch" as a vehicle to increase the attention paid to women's health needs and concerns in public debate and national policy. In fact, a series of meetings and workshops which had begun during the preparations for ICPD focussed on defining and clarifying women's health issues, particularly reproductive health and rights, had prepared the basis on which like-minded NGOs can work together, and begin a process of constructive dialogue with the government on policy and programme directions.

Background

Our Constitution guarantees each citizen the right to life which includes effective provision for work, food security; protecting access of poor people to resources such as land, forests, and water; safe, green, pollution-free environment; safe drinking water and adequate sanitation; adequate shelter and the right to health. The state must allocate adequate resources and design supportive policies to provide these basic needs to all people.

The Constitution also guarantees non-discrimination on the grounds of sex; yet biases against women are rampant in every aspect and stratum of society. It is therefore the responsibility of the state, as articulated in the Directive Principles, to undertake strong measures to remove all forms of discrimination against women, and protect their human rights.

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The Status of Rural Women in Karnataka Study

A Summary Report of the Preliminary Findings

September 1997

Women's Policy Research and Advocacy Unit
National Institute of Advanced Studies
Indian Institute of Science Campus
Bangalore - 560 012

The National Institute of Advanced Studies

The National Institute of Advanced Studies (NIAS) was the brain child of the late Mr. J.R.D. Tata. It was established in 1988 with Dr. Raja Ramanna (former head of the Atomic Energy Department and the Bhabha Atomic Research Centre) as the Founder Director. Dr. Roddam Narasimha is the current director of NIAS.

The philosophy behind the establishment of the Institute was that in an age of scientific renaissance, with the explosion of information in all fields of knowledge, there is a need to integrate this information and examine the challenges posed to the nation by the historical, social, cultural, political and economic context in which these changes are occurring. There is a need for multi-disciplinary approaches to the critical issues confronting the country, to inform both policy and action.

The Women's Policy Research and Advocacy Unit

As an institution committed to examining some of the critical development issues of the country, NIAS realised the need to include gender issues as one of its major areas of inquiry. Thus, the Women's Policy Research and Advocacy (WOPRA) Unit was set up by NIAS in August 1994, with an initial grant from the Ford Foundation. The first major project that WOPRA has undertaken, is the Status of Rural Women in Karnataka (SWRK) project. Prof. M. N. Srinivas and Prof. Ravi. I. Kapur, senior professors of NIAS are consultants to the project. Maj. Gen. Paul (Retd), the Controller of NIAS, provides administrative support to the Unit. The primary objectives of the Unit are

- To study the impact of public policies and programmes aimed at gender justice, particularly the rights guaranteed to women through the Indian Constitution and the international human rights conventions and other agreements to which India is a signatory, and

- To advocate changes in policy and implementation to facilitate the assertion of the rights of women, particularly from the poorest sections.

WOPRA initiated a large scale study of rural women in Karnataka in August 1994. In addition to the research study, the WOPRA team has been actively engaged in advocacy for women's rights at, local, national, and international levels. We have pursued our advocacy objectives through five strategies:

- Training and gender sensitization of grassroots activists/NGOs and bureaucrats;
- Membership of advisory groups and expert committees;
- Participation in workshops, conferences, meetings, collaborations;
- Participation in and supporting the work of various networks and organisations addressing the needs of women;
- Research and writing on gender issues to generate debate, disseminate information, and promote gender justice.

A Study of the Status of Rural Women in Karnataka

Why the Study

The WOPRA Unit was conceived to do advocacy for bringing about positive changes in women's lives based on a systematic study of women. Today, advocacy for changes - in law, government policy, etc. - has acquired the status of an art and a skill. Often, the experiences of individual NGOs / grassroots groups are dismissed as "exceptions" and are not given due weightage in the making of plans or policies. It is being realised that one of the most important requirements for effective advocacy, is actual data or information collected and compiled systematically. It is against this background that WOPRA undertook a study of the status of women, in rural Karnataka (hereafter, SRWK). The broad objectives of the study were as follows:

- Study the status of women in Karnataka,
- Focus mainly on those areas where not much is known, and even less, is systematically documented,
- Use the study as an advocacy tool to change policy, provide information to panchayats for their planning, help NGOs evolve new strategies etc.,

Who did the Study

The study is an outcome of the partnership between the WOPRA Unit[1] and non-governmental organisations[2] from representative regions of Karnataka. We feel, in retrospect, that the partnership was successful in generating quality data despite the large scale of the study. It has also strengthened the much needed links between research and field insights.

Scope of the Study

The process of the study took around three years from September 1994 to July 1997. It included a review of existing literature, developing a conceptual framework, formulating a sensitive tool that could capture gaps identified in existing research and designing an innovative methodology for collecting data and preparation of the preliminary report. Given the limitation of time, money and human resources (the team consisted of 4 women only), it was felt that we should focus initially on the needs and problems of rural women. Also, we realised that the conceptual framework and the questionnaire, we had developed, were inadequate to meaningfully capture the status of urban women.

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[1] The team that did the SRWK Study comprised Srilatha Batliwala, Fellow of NIAS; Anita Gurumurthy and Anitha B K, Research Associates at the WOPRA Unit, and Chandana Wali, the Project Assistant.

[2] WOPRA collaborated with GRAMA from Chitradurga; Gram Vikas and REACH from Kolar, and Mahila Samakhya - a quasi- government programme, in Bijapur and Raichur.

The study restricted its focus to a sample of ever-married women in the reproductive age group, that is, between 18 to 40 years of age. Women in this age group have the least autonomy and face the greatest constraints in securing their rights and so become most relevant to a study on status.

Rather than doing a systematic sampling of women from different strata scattered throughout a district, we selected either one large or two small villages, which mirror the socio-economic and demographic profile of the district, and carried out a complete village census.

Data was collected from 6 representative districts - Kolar, Chitradurga, Bijapur, Raichur, Dakshina Kannada and Kodagu, and approximately 200 households in each district. In each household, one ever-married woman and her husband was interviewed. Where the husband was absent, either the brother, father, brother-in-law, or the father-in-law, who the woman identified as the key male member, became the male respondent for that household. A total 1171 households were canvassed. Adult male members were not present in 68 households. Therefore, there were 1171 women respondents and 1103 male respondents in the study.

Key female member (instrumental autonomy restricted)

The study used the interview method for data collection. The questionnaire used for the interview was comprehensive and included data on the various dimensions of status. Questions were designed to elicit both factual and opinion-based information. All questions were pre-coded to ensure data validity. Data on 200 items was collected.

Copy of Questionnaire

↑ Validity of Formulation? Retesting

Defining Status : The Conceptual Framework

While trying to unpack the notion of status, we encountered one central problem: conventional research, including women's studies research does not appear to have clearly defined or disaggregated the term "status". Like the term empowerment, it is one of those rather vague, loosely used terms.

Further, most of the analyses of women's status based on official data are limited by the inherent gender blindness of formal information systems - for instance, official data on work participation is useful to determine the number of women in the labour force, but tells us nothing about the control women from the labour force have, over their income. Also, official sources often tend to conflate women's status with their education and health status, which although fundamental, are not sufficient indicators of women's status. Healthy, educated and even earning women, are not necessarily free from gender discrimination and subordination.

A framework to study women's status has to follow from a clear understanding of gender equality. Studying women's status means a sensitive diagnosis of the nature of gender subordination through the study of gender relations in a specific context. It also means the application of measures derived from a clearly articulated goal of equality, to that context.

We understand that women's powerlessness stems from the lack of resources - human, material, and intangible[3]. When we examine gender relations as power relations[4], it is evident that men are favoured by the rules of the institutions within which gender relations occur and that they enjoy and exercise power in commanding these resources. Gender inequality is therefore an outcome of asymmetry in power; where men are in a position of privilege and women of subordination.

For women, the absence of power has meant the lack of access to and control over resources, a coercive gender division of labour, a devaluation of their work, lack of control over their own self - skills, labour, mobility, sexuality, time, and fertility. Their powerlessness is expressed in male violence against women, sexual exploitation that erodes all human dignity and a very acute experience of vulnerability.

The transformation for gender equality based on the human rights framework requires the redistribution of power for promoting women's strategic gender interests. Such a transformation involves a set of enabling policies and conditions created by the state that facilitate the reallocation and redistribution of resources. It focuses on increasing women's access to and control over the entire gamut of resources that confer power at individual, household and societal levels. It entails the loss of men's traditional power no doubt, but it certainly does not envisage the abnegation of men's autonomy.

Thus, the study of women's relative access to and control over resources is a useful method of comparing women's position with that of men, and is also a reflection of changes in both ideology and the institutions and structures which mediate such access and control. As indices of gender equality, the terms 'access' and 'control' serve as sensitive indices to capture women's autonomy and status.

But what do 'access' and 'control' mean? In the context of material, human and intangible resources, access refers to the opportunity or the de facto rights available to use the resource. For instance, do women get an opportunity to take a loan or go to a health centre for treatment? If they do, they can be said to have access to these resources. Control is a much more complex term and needs to be understood within the notion of shared power and on-going negotiation. Control over a resource is the bargaining power to define or determine the use of that resource.

The WOPRA Unit based the SRWK framework, on a model developed by a researcher, Ranjani Murthy, which examines women's status through the prism of access and control.

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[3] See Kabeer, Naila and Subrahmanian Ramya, "Institutions, Relations and Outcomes: Framework and Tools for Gender-Aware Planning", Discussion Paper 357, Institute of Development Studies, University of Sussex, Brighton, September 1996.

[4] Ibid

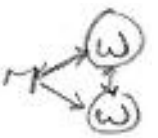
The modified framework uses the following components as benchmarks to study women's status vis-à-vis men's:

- Access to and control over private assets and resources
- Access to public resources
- Control over labour and income
- Control over their body - sexuality, reproduction, and physical security
- Control over physical mobility
- Access to and control over political spaces
- Access to and control over intangible resources - information, influence, political clout etc.
- Position in law and their access to legal structures and redressal.

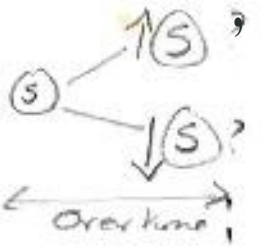
Education
- Household decision making

We realise that in reality, women's actual experiences cannot be compartmentalised. Therefore, no single index can be construed as being independent of the other.

(1) Problem of Formulation



(2) Problem of Cross sectional method



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Highlights of the Study *

Demographic Profile of Households

The households covered by the SRWK study shows the increasing nuclearisation of rural families. The average household size in the study was 6.4 and the mean number of children was 3 per household . All women in the sample were in the reproductive age-group, that is, between 18 to 40 years. The majority of the men, about 70%, were in the 31 to 50 age group. The distribution of surveyed respondents by religion mirrors the distribution for the state. Over 90% of the respondents were Hindus (including scheduled castes and tribes), about 7% Muslims, and just under 2% Christians. Reporting of annual household income indicates that more than 50% of the households were below the current poverty line of Rs. 11,800. Moreover, around 25% of the households reported Rs. 5000 or less as their annual income which places them in acute poverty. The data on caste distribution was still being compiled during the preparation of this document and is hence not available at this stage.

The following are some of the key findings of the study, presented under the different indices discussed earlier.

Access to and Control over Private Assets and Resources

Land

- 71% of the households surveyed in the study, reported owning land.
- In 81% of these households owning land, the title deeds were in the names of men. In contrast, only 12% of the land was owned by women.
- A disaggregation by type of land shows that the proportion of barren land held by women, is more than double the proportion of any other type of land owned. The study shows that as much as 27 % of barren land while only 11% of all rainfed land, 11% of plantation and 10% of irrigated land, are owned by women.

Method used? T le?

Housing

- 88% of the households reported owning a house. An overwhelming 885, that is, 80.38% of the 1101 houses owned belong to men and just 158, that is, 14.38%, to women members of the family (? in presence or absence of men)

* The WOPRA team is thankful to Dr. A.R. Vasavi, Fellow, Sociology Unit, and Head-in-charge, WOPRA, NIAS, for her suggestions and editorial comments in preparing this document.

Perceived Control over Household Assets

- A relatively small proportion of men (27 % for land and 18% for houses) and women (4 % for land and 3 % for houses) respondents reported that they can independently pledge or sell immovable assets such as land and house. However, of those who feel they can, men clearly predominate.
- A higher percentage of male respondents (41%) as compared to female respondents (17 %) feel that they can independently dispose livestock. Interestingly, the proportion of men claiming the right to liquidate "wife's jewellery" is almost equal to that of women reporting such independence with respect to their own jewellery.

Food

- Nearly three-fourth of the study population do not experience insecurity, in relation to food, despite the poverty of at least half of the surveyed households. A large majority, over 80% reported consuming at least three meals a day. Given conditions of overall adequacy of household food supply, there does not appear to be a strong bias against women's access to food, in terms of number of meals consumed per day.

- Gender differences appear in the consumption of more expensive or luxury food items like fruit, eggs, meat, poultry and fish where more men report weekly consumption. Under each of these items, there were 7% more men than women, who reported weekly consumption.

- Sharp differences appear in the reporting of person/s sacrificing in the event of a food crisis. While 79% women respondents report taking exclusive responsibility during such food shortages, only 12% of the male respondents say that they singularly absorb the crisis

- A majority of men and women are of the opinion that men require more food Further, more women (71%) than men (54%) endorse this view. Such a bias reflects the greater internalisation by women of the ideology of women's subordination.

- 24% women and 15% men reported that obtaining two square meals a day was difficult when they did not have work. The difference in reporting suggests that in a quarter of all households, it is women's income that takes care of the family food needs.

- The absence of employment security affects the food security of at least one-fourth of the women in the sample. Coupled with women's internalisation of the belief that men need more food, the non-availability of wage labour is likely to severely affect at least a quarter of the women.

Access to Public Resources

Survival Needs

- 86% women reported that their water source is located within the village. Although this figure indicates that access to water per se may not be a serious problem for a majority of the women, 22% reported that the source they access for drinking water is an open well, river or stream - sources that are relatively unsafe.

- Only 18% of the households, probably from higher income categories, have control over their water source. 28 % report having to depend on sources owned by landlords or private sources, and the rest on sources under the control of the government or the gram panchayat. For 8 % of the women, dependence on other sources has meant enduring harassment meted out by the private owners of the water source.

- An intriguing part of the data in this section is the discrepancy in the reporting about who takes responsibility in fetching water for the household. While 54% of the men report that they fetch water everyday, only 2% of the women say their husband does so! On the other hand, only 18% of the men say their wife performs this daily chore, compared to 87 % of women reporting "self". Considering the data from several field studies, and common observation in rural areas, it would appear that the men have quite deliberately over-reported their role and under-reported their wife's role.

Cooking Fuel

- 83% of the households rely on bio-mass cooking fuels like fire-wood, dung-cakes and crop wastes, proven to be hazardous and having a detrimental impact on the health of women, who almost exclusively shoulder the responsibility of cooking.

- Only, 34 (2.9%) of the households reported owning the fuel-efficient and smokeless *"Astra Ole"*, stoves. This finding reveals the complete failure of the government to disseminate basic technology that has the potential to alleviate problems that adversely affect women's health.

Toilets

- Only 16% of all households reported having access to toilets. Of the women respondents who had no access to toilets 73% reported that they would like to have this facility in or near the house, whereas only 59% of the men not having access to a toilet, showed such a preference. The difference, though not dramatic, suggests that women, by virtue of their gender, perceive a greater need for having toilets closer to the house than do men.

Health

Sex Ratio

- The sex-ratio for the entire study population, computed on the basis of the total number of members for all households, is 969:1000, almost identical to the Karnataka state 1991 Census figure. When computed separately for adults and children, the sex ratio reveals a disturbing trend. The adult (aged above 14 years) sex ratio is 1001:1000 but the child sex ratio is a shocking 922:1000. The exact reasons for this phenomenon, has to be determined through further analysis.

Reporting of Illnesses

- Far more women (76 %) than men (51%) reported having suffered any illness, in the previous year.

Treatment Expenditure

- Gender differentials in accessing treatment and in the type of source sought for treatment, are negligible, but surface clearly in treatment expenditure. Across all categories of treatment expenditure - from consultation fees, to medicines, transport, and diet - the number of women reduces more dramatically, as cost increases. For instance, 84 men reported having spent greater than Rs.500 towards medical fees whereas only 49 women report the same.

Reproductive Health

- A shocking 26 % (310) of the women respondents reported suffering from reproductive system ailments. One-fourth of these women, had not taken any treatment.

- Of the 1033 women who had delivered at least one child, around two-thirds (63%) had delivered the last child at home, not assisted by any trained attendant. The high percentage of home-based deliveries, is a reflection of the poor response of health services to women's reproductive health needs.

- An incredible 1 in 5 women reported having lost at least one child before it reached the age of 5.

Education

- Education data shows predictable gender differences and follows trends available in existing literature. 59% of male respondents and 37 % women reported having attended school.

- Contrary to official statistics which claim a gross enrollment ratio of over 100%, the study data for enrollment computed on the basis of all children in the households surveyed, shows that only 69% girls and 74 % boys below age 15 attended school.

- Only a dismal 8 % of the study population - both male and female, reported having attended adult literacy classes.

Aspirations for Children's Education

- An equal percentage (43 %) of male and female respondents agree that girls must complete their matriculation. A large percentage of respondents - 46% women and 36 % men, believe that boys should study "as much as they want". But the most telling gender difference in perceptions of the desirable level of education is that almost twice as many women respondents (25 %) as men (13%) think girls should study "as much as they want". Women reveal greater aspirations for their children's education in general, and for their daughters' education in particular, than do men.

Credit

- One-fifth (249) of the women respondents and nearly half (517) of all male respondents had accessed credit from different sources.

- While men had primarily accessed formal institutions like banks, followed by large farmers, women had depended mainly on NGO based credit programmes, and then on banks.

- Banks and large farmers - sources that require collateral - constituted 70 % of all sources accessed by men, and 41% of all sources that women had approached.

- Banks alone were 42% of all sources that men had accessed and 24% of all sources that women had accessed. But this 24 % for women, must be placed in the context of the fact that these women are likely to have been beneficiaries of government schemes that lend exclusively to women through lead banks and do not require collateral.

Control over Labour and Income

- On an average, the mean number of occupations per respondent, (including home-based productive work - cultivation on own farm and farm-based activities, sheep/goat rearing, poultry, sericulture, traditional family occupation etc.), is just a little over 2 per head.

Cultivation

- An equal number of men and women, around 55%, had been engaged in cultivation. Census data for Karnataka and India, shows greater participation of women in marginal work (less than or equal to 180 days a year),and of men in main work (more than 180 days a year) in cultivation. However, in a significant departure from these statistics, work participation data for cultivation in the study, shows equal participation of men and women, in both main and marginal categories, because the study used a more gender sensitive definition of work and methods of data collection.

Agricultural Wage Labour

- Although only 29% of the study households were landless, 35% of the male and 41% of the female respondents were engaged in agricultural wage labour. This data reinforces the national trend of small and marginal farmers and subsistence cultivators having to supplement their meager income by selling their labour to other farmers.

Dairy

- The study clearly demonstrates the "femaleness" of dairying - 43% of the women, and 31% of the men were engaged in dairying. The qualitative data collected in the study, shows that men were predominantly involved in marketing and women in the day to day work of feeding and caring for animals, and milking, which are an extension of women's domestic work. Data on poultry also reveals the same pattern.

- The proportion of unremunerated production work, including both waged and homestead-based work, was much greater for women than for men. Only 64% of all productive work done by women yielded income, whereas 86% of the productive work done by men yielded income.

Control over Income

- The study generated data on the control over individual and household income. 70% of the earning women in our study reported handing over their wages to another household member, as against 20% of the male earners. 60% of the women, in fact, handed over their earnings to their husband. The right to retain income in one's own hand gives at least a notional or symbolic control over one's earning even if it is going to be largely spent on the family.

- Nearly two-thirds of the male respondents as against one-fifth of the female respondents reported that they participate in the purchasing of household needs, a task that may be said to vest reasonable degree of control over household income.

- Another indicator - retention of own earnings for personal use, also indicates that women have a lesser degree of control over their income 32% of the male earners and double the proportion of female earners, that is, 67 % reported retaining nothing out of their income for personal use.

Control over the Body and Sexuality

Age at Marriage

- 34% of the women in the sample reported being married before menarche, but only a negligible 3% of the women, said they would choose the option of a pre-menarche marriage for their daughter, if left to themselves.

- Although 52 % of the women respondents had married before the age of 16, only 23% opined that they would get their daughters married at this age, an encouraging trend. In fact 30% of the men chose the option of getting their daughters married before age 16.

Why ?

Dowry

- The data strongly supports our initial hypothesis that the custom of dowry has increased over generations, probably penetrating communities that did not practice dowry before.

  -1% of the women reported that dowry had been paid during their mother's marriage - (55% reported that dowry had not been paid, 3% reported bride-price, and 41% said "don't know").

  -17 % reported that dowry had been paid for their own marriage, (83% reported not paying);

  -31% reported having paid dowry for their daughter's marriage and

  -64% said that they anticipate that dowry will have to be paid for the marriage of their unmarried daughter/s!

Problem of Recall

Interesting Trend but interpret with caution

Child-bearing Decision

- Women's participation in decision-making about child-bearing, integral to sexual rights, was much lower than men's. 1001 women and 950 men answered the question pertaining to decision-making about the total number of children they should have. Only a fifth of these women and 61% of these men reported having participated in the decision.

How many Households ?

M+F
(F)
(M)

Contraception and Birth Control

- Awareness about permanent methods of birth control, especially about tubectomy, was higher than about temporary methods. Only 24% women and 38% men were aware of condoms, whereas 80% men and 86 % women were aware of tubectomy and 65% of both men and women, of vasectomy.

- A surprisingly large percentage of respondents, about one-fifth, had heard of injections for birth control, indicating that hormonal contraception, (not considered safe), has probably penetrated rural Karnataka.

- A vast majority of men and women believe that contraception affects men's health and work capacity, a wide-spread myth, that contradicts medical evidence. Such opinions are inimical to women's sexual rights, and women end up having to bear complete responsibility for birth control. 40% of the female respondents in the study had undergone tubectomy; barely 1% men had undergone vasectomy.

Violence

- The total number of instances of violence reported by women was 289, and the total reported by men, 181. This difference is clearly because of the unique experiences of violence and harassment that women endure within the marital family as well as in relation to their gender-specific roles. Out of the 289 instances reported by women, 115 were in relation to quarrels with the husband / his family, dowry demands, suspicion of infidelity, and childlessness.

- With respect to wife-beating, although a majority (70%) of the women, think it is the husband's right, only a minority (27%) reported actually having been beaten by their husband. Interestingly, 381 men acknowledged beating their wife but only 312 women reported being beaten. Going by male reporting, this means about one in every three married women experiences domestic violence at least occasionally.

Control over Mobility

- The data shows that the critical difference between women and men is not so much their right to go freely to places related to their productive or subsistence work, but to those locations and services which determine their access to various public resources.

- For instance, 72% women had never visited the school and 40 % had never visited the panchayat office, whereas the corresponding figures for men is less than half the women's figures, that is, 31% for school and 15% for the panchayat office.

- 25% women reported having visited the panchayat office with a male escort and another 25%, alone. This mobility to the panchayat office is likely to have been induced by the numerous schemes which have beneficiary quotas for women, the reservation of seats for women in panchayats, as well as the presence of NGOs which promote women's interaction with local government bodies.

- That women's mobility is inversely related to distance comes out clearly in the mobility data. 66% of the women had not visited a health clinic (usually located in larger villages), 52% had not been to the taluk headquarters, and 73% had not visited the district headquarters. The corresponding percentages for men were, 14% , 30% and 36% respectively.

Access to and Control over Political Spaces

- Voter participation was high (over 90%) and did not show any gender differentials.

- Data shows clear gender differentials in elections contested; we find women only contested gram panchayat elections (30 men and 15 women), whereas even if an insignificant number, some men in the study sample had contested elections in a range of other bodies such as taluk (3) and zilla (1) panchayats, cooperatives (10) etc. Women are conspicuous by their near absence in higher level political bodies, a sad truth which is valid for the state legislature and the parliament.

- As regards membership and participation in other community organisations with mass base like farmers sanghas, youth groups, caste organisations, we find women largely confined to women's organisations. For example, 26 men reported being members of political parties and 68 of caste or tribal organisations but the respective figures for women's membership were only 3 and 35. 168 women reported being members of mahila sanghas.

Access to Legal Structures and Redressal

- There was a significant gender difference in awareness about the "injustices" faced by women. In fact, this difference could be traced entirely to the gender difference in reporting of women's problems within the "private" sphere. Out of the total 3838 female and 2408 male responses about injustices that women face, 2733 responses of women and 1340 responses of male respondents were about those occurring within the realm of the household, such as dowry harassment, wife beating, bigamy, harassment for childlessness, harassment for not giving birth to a son, etc. There was no gender difference in the awareness about injustices such as eve-teasing, rape, lack of education, etc., that is, injustices occurring in the "public" sphere. Women may have found it easier to recount many more instances of home-based injustices, than those which are systemic and located farther from their immediate reality; men, on the other hand, seem more oblivious to women's problems within the home.

- However, only a minuscule proportion of women respondents (145), reported actually experiencing any injustice. A majority of these women, recounted experiences based within the home . Ironically, most of these women (131) said they had approached family elders for redressal, although it was the family which had been the actual site of violence for a majority. A significant number of women (52), almost a third of the women reporting personal experience of injustice had also approached the nyay panchayat - a public forum. Although the Nyay panchayat may not be the first choice for women, (only 6% of all women in the sample said they would go to the nyay panchayat first in the event of any injustice), when actually confronted with a problem, many had sought "public" redressal. Further analysis will reveal if these women are part of grassroots organisations.

- The data on whom women should approach for redressal also corroborates the reality and clearly upholds the norm that women should seek redressal for their grievances within the family. Not only 78 % of the women but also 56% of the men in the sample endorse this view point. Further, when asked about who they would personally prefer to approach if they faced an injustice, only 25% men chose the family!

- More (61 out of 111) men and fewer (41 out of 145) women respondents had approached the police for redressal. 45 men and 19 women had gone to the court - a costlier option.

Conclusions

At this preliminary stage, we have been able to share only a percentage analysis of the findings. Although preliminary, the findings indicate definite trends about the status of rural women in absolute terms as well as in relation to their men.

In a study like this, there is bound to be a tension between how women, the subjects of the inquiry, perceive their own status; how men define women's status in relation to their own and how the external researcher defines the parameters constituting high or low status. We find a resolution of this definitional tension in the adoption of the human rights framework by feminists in their struggles for equity and justice. Such a framework, not only vests in women, all fundamental rights (thus far denied to them), that must accrue to them as human beings but also, recognises the specific interests of women, arising out of their gender.

This study therefore looked at women's status through the concept of autonomy, and used broad indices concerning access to and control over private and public resources and spaces, and the body as benchmarks. It also examined the mechanisms available to women for seeking justice and how sensitive these structures are to women's interests.

(1) What but not adequate why?

(2) Cross sectional snapshot problem

(3) What indications of process/space that are

The study data shows that women have very little control over private assets - they lack control over immovable assets such as land and house. Laws of inheritance based on patriliny ensure the perpetuation of patriarchy, through the material dependence of women on men. In India, laws do not confer on married women, an equal right of ownership to the matrimonial home. In any case, marriage marks the separation of the woman from the natal home, and cultural norms expect her to relinquish any rights she may have hitherto enjoyed over the assets of the natal home. The absence of material assets converts into a crisis when women are confronted with violence and harassment in the marital home.

87% Who else

157 women in the study, that is, over 13% have identified the husband and his family as the key perpetrators of the violence they have experienced. Obviously, for these women, there is no escaping this violence. Two other findings that concern women's safety, reveal disturbing trends and deserve to be mentioned. One is about the difference in age-specific sex ratio; while the ratio for the adult population (15 years and above) in the study is 1001:1000, for the 0 to14 age group it is a shocking 922:1000. The second finding is about the inter-generational increase in the practice of dowry. The ground reality is thus a sad commentary of the degeneration of women's position which ironically, seems to be a consequence of material development. Both these findings need to be explored further.

Data on perceptions about status shows that most (85%) women in the study believe that men must be treated with more respect than women, an indication of the deep penetration of patriarchal ideology into their consciousness. The higher status that women accord to men is true also within the marital relationship. In fact, this perceived inferiority of women is captured in the responses of the 25% women who report that single women - widows, divorced and separated women - are not "respected by the community". 25% women also feel that their "respect" (a proxy for status) is derived from the status of their men. Out of the total 1171 women, as many as 5.4% women were single. Within patriarchal contexts, assetlessness would aggravate the loss of status suffered by these single women , who may find it difficult to negotiate their position within and outside the household, in the absence of their husband - the reference point of their status and identity.

Data on women's access to public resources such as water, fuel, health, education, and credit reveals the inability of the state in breaking gendered barriers impeding women's access to resources. Our data on gross enrollment contradicts the claims of the state; in the area of rural energy the state's abdication in disseminating women-friendly technology is evident; women's health is a low priority for the state as it is for the household - a shockingly huge percentage of women report having delivered without the assistance of trained personnel; women's access to formal credit is still low and where women have access to schemes that advance credit for livestock or sericulture, research from many states suggests that these schemes end up adding to the already over-burdened work-day of women, all in the guise of adding to family income. The strategies of the state in promoting women's access to public resources requires to be reviewed so that the state can become a true enabler of women's empowerment.

The findings under the section on work and income, indicate high participation of women in productive work, and the mobilisation by the household of women's labour for not only

5. Data on Household work + Child rearing — (M) + (F) role access and involvement

(6) Dynamic interpretation required.

(7) Rural/urban interpretation/ professional/ elitist interpret.

waged work but also home-based productive work that is non-waged - both, indispensable to the survival of the household economy. Such appropriation is obviously not restricted to income generation but is also for unpaid productive work to which income can be imputed, and most importantly, for sustenance, if we assume that domestic work is women's responsibility. Thus, the question of whether women have control over their labour becomes quite misplaced, in an arrangement where women's labour is appropriated by the household.

The indices that measure women's autonomy in relation to their body go closest to the issue of power and gender. The study looked at women's control over their labour, mobility, fertility, and bodily integrity. The findings under each of these areas highlight the powerful role of the strongly internalised belief-systems of a patriarchal culture. They also point to the prominent role played by the family in general, and the husband in particular, in regulating and controlling women's sexuality. The result of such control - reflected clearly in the low percentages of women reporting participation in child-bearing decisions, or visiting the district headquarters and the high percentage of women reporting very low age at marriage and the high percentage of men and women reporting that men have a right to beat their wife, - is women's lack of autonomy in relation to their body and sexuality. The immurement of women through cultural beliefs directly prevents their access to intangible resources, discussed in the section on the conceptual framework of the study.

It follows naturally that when women's reality and rights are mediated by the family, it is the family that they perceive as most appropriate for seeking justice. Women's lack of assets and their restricted mobility also negates the possibility of their pursuing justice through mechanisms that involve money and travel. However, in the final analysis, struggles for real equality in gender relations demand that the private be made public. Interestingly, the higher stakes that women have in social transformation for gender equality is demonstrated by the high proportion of women who have accessed public fora for redressal. Out of the 145 women who had experienced injustices, 52 had approached the nyay panchayat, 41 had gone to the police and 19 to the court for redressal. It is not clear from the analysis at this stage whether all instances where women approached the public fora challenged traditional gender relations. However, the fact that women were able to move beyond the family when faced with a problem, is in itself a positive indicator, given that deep-rooted notions of honour are associated with family affairs.

Women's political participation is critical because, ultimately, the liberation of women from their subordination is a political task, and cannot be truly achieved until women become a force to contend with in the political sphere. It is clear from the data in the study that reservation of seats for women in the state legislature and the parliament will be a good beginning.

A more complex picture of women's status will emerge with a deeper analysis of the data. Cross-tabulations, correlations and factor-analysis will allow for the inter-play of gender with class, caste and region. The broad quantitative data base of this study has to be supported with nuances from qualitative studies.

Law has its limits. So does social policy. Both cannot engineer or alter social structures and cultural phenomena, least of all, gender relations. However, a state committed to gender equality must intervene through policies and laws that can lay the ground for transformatory strategies. Undoubtedly, we have a vibrant and growing women's movement in India. But if this study is any indication of women's or even men's feminist consciousness, the task ahead is formidable. Strategies are needed not only to support those closer to the goal of gender equality, but to carry the vast majority resigned to status quo, towards this elusive goal

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Women's Perspectives on Public Policy

IXth National Conference on Women's Studies

8-11 January, 2000,

NISIET, Hyderabad.

Organised by : The Indian Association for Women's Studies

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IF YOU WOULD LIKE TO PRESENT A PAPER at the conference, please send a **half** page abstract (250 words) of your paper to:

a) The relevant sub-theme coordinator (addresses can be found below each sub-theme abstract)

b) SONIA BATHLA, Centre for Women's Development Studies, 25, Bhai Vir Singh Marg, New Delhi 110 001, Fax: 011 3346044, email: cwdslib@sansad.nic.in

To participate in the Conference you must become a member of IAWS if you are not already one. IAWS Membership Forms can be found in this brochure. These must be duly filled and mailed along with a Demand Draft drawn in favour of "Indian Association for Women's Studies" payable at Mumbai, to Divya Pandey (address on form).

DEADLINE FOR PAPER ABSTRACTS: 15 NOVEMBER, 1999

Completed Conference Registration Forms along with Demand Draft drawn in favour of Indian Association for Women's Studies, payable at Hyderabad to be sent to: KALPANA KANNABIRAN, Organising Secretary, IX NCWS (address on form).

DEADLINE FOR REGISTRATION: 5 DECEMBER, 1999

Registration fee for outstation participants is Rs. 500/-

Registration fee for local participants is Rs. 200/-

Registration fee after Deadline is Rs. 600/-

Please Note:

- Please ensure that all payments are made through Demand Drafts and accompanied by completed forms.
- Accommodation cannot be guaranteed for participants registering on the spot. Limited accommodation will be made available on first-come first-served basis.
- IAWS Membership to be sent to Mumbai.
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THE VENUE:

NISIET is located beside Yousufguda Police Lines about 5-6 kms from the Airport and Begumpet Railway Station. It is easily accessible from Hyderabad and Secunderabad Railway Stations. Participants will be accommodated in Guest Houses within a 5 km radius from NISIET.

Registration Counter at the Conference site will open at 10 A. M. on 7 January, 2000.

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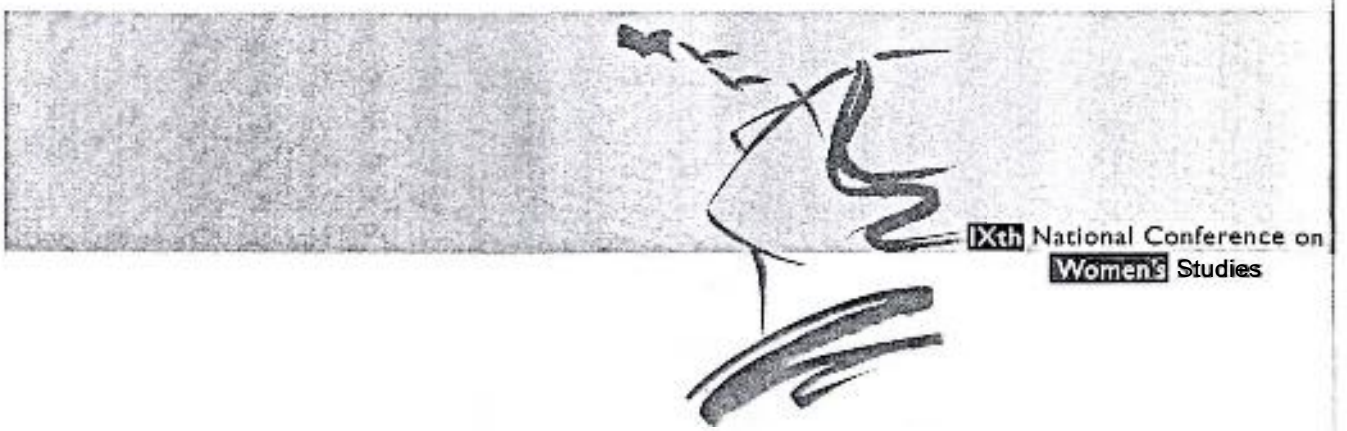

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at
National Institute for Small Industry Extension Training
Yousufguda [beside Police Lines], Hyderabad

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Asmita Resource Centre for Women

IAWS and IX Conference Secretariat

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IXth National Conference on Women's Studies

Contents

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Women's Perspectives on Public Policy

Evolving an Agenda for Action into the Next Millennium

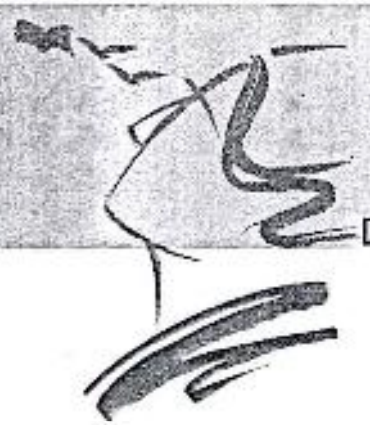
As we step into the next millennium, a much-needed exercise is an assessment of trends in public policies, past and present (continued or changed) and their impact on women across the country.

During the last few decades we have been preoccupied with development and economic policies in view of the deteriorating economic conditions for a major section of women. In the field of laws, personal laws and rape laws have dominated our attention to the exclusion of other aspects of our legal discourse. Public policies on health care and health services have been another area of critical concern. All these have a history behind them. Historically, public policies in India have paid scant attention to regional diversities or regional histories. Be they programmes of poverty alleviation, developmental thrusts, tackling dowry, age at marriage, or violence or scores of other such issues – there are built in biases that demand exposition to uncover their ideological underpinnings.

The primary objective of the IX National Conference is a critical assessment of public policy, historical and contemporary, in shaping women's lives and setting an agenda for the next millennium. The conference will attempt to identify the sectoral priorities that have emerged in each region, their dynamics and their linkages with mainstream priorities viz., employment, health, violence, environment, communalism, family, political representation and right to resources including property. The plenaries and sub themes will explore major shifts in priorities, perspectives and will attempt to understand, and foreground unexplored areas and successful or unsuccessful strategies.

In more recent times, policy initiatives have induced some concrete structural changes. To cite a few: reforms in law and legal processes, institutional reform in policing, constitution of women's commissions at the state and national level and gender sensitizing programmes for policy makers and the bureaucracy. Simultaneously, women's collective action through literacy, self help or anti liquor movements have induced changes in public policy.

The IAWS hopes that the IX National Conference will provide the space for women from different parts of the country to come together and discuss ongoing areas of concern as well as of those that have hitherto been underrepresented or unexplored.



Programme of Plenaries

Invited Speakers

.. Nirmala Buch ..

.. Imrana Qadeer ..

.. Sunila Abeysekera ..

.. Murli Desai ..

.. Nirmala Banerjee ..

.. Jarjum Ete ..

.. Hameeda Hossain ..

.. Mahmood Mamdani ..

.. Kameshwari Jandhyala ..

.. Arundhati Roy ..

.. Anveshi Law Committee ..

.. Manisha Gupte ..

.. Uma Chakravarti ..

.. Sathyamala ..

.. Saheli ..

.. Forum for Women's Health ..

.. Pradnya Lokhande ..

.. Volga ..

.. Mridula Garg ..

.. Veena Shatrughna ..

.. Ritu Menon ..

.. Pushpa Bhave ..

.. Meenakshi Mukherjee ..

.. Maithreyi Krishna Raj ..

IXth National Conference on Women's Studies

Women's Perspectives on Public Policy:

Incomplete or Lost Agenda?

Fifty two years is not a small period for initiating progress. The promises enshrined in the Constitution and the vision of women's full emancipation will not be realised unless once again we gear ourselves to intervene more forcefully in the polity and public policy. By public policy we do not mean only policy documents actually released from time to time by the government in power but by all public agencies in all sectors of life - in institutions and their functioning, in the prioritisation in the allocation of resources, in the modus of implementation in addition to policy directives, explicit or implicit.

Women's concern with the economy has been consistent. Before Independence, the Sub-Committee of the National Committee for Planning had published an exhaustive blue print, radical in thrust for bringing about equality for women in free India entitled 'Women's Role in Planned Economy'. Yet, many indicators including that of the UNDP Gender Development Index demonstrate on many fronts, the jettisoning of these views and the cost to women of this neglect. It took twenty-five years before the shift away from women as 'weaker section' in need of welfare took place. This recognition has been partial with women still seen as merely a segment of the family-household.

In education, instead of strengthening the mainstream system and making it deliver to fulfil its mandate for ensuring full, free, primary education to all, alternate agencies have been mooted. While these are commendable they also raise certain basic questions. Why do girls and women deserve only 'non formal' education with a ragbag of micro programmes? The 1986 New Education Policy raised a lot of hopes for the first time but as yet there is no evidence that this too will not remain on paper. Populist measures like free education till college level for girls in some states make no sense because this kind of across-the-board measure ignores the deep class, caste, regional disparities and the specific hurdles that beset girls' education. The women's movement has not paid enough attention to mainstream education for freeing the curriculum, educational establishments and men students from patriarchal overload.

On the economic front, the first alarm bell was sounded by the NCWS report in 1974, *Towards Equality* that showed women's employment going down in several sectors especially in the manufacturing and mining sectors. There have been several interventions since then by women's movement: the incorporation of a special chapter on women for the first time in the Sixth Plan; identification of intra household inequalities and discriminations through

solid research; exposing the biases in data that make women workers invisible; research documenting the negative or non-effects of many programmes in agriculture and small/ cottage industry; and finally 'Development Alternatives for Women in the 80s' that was produced after national and regional level consultations across the country. The *Shram Shakti: National Report on Self Employed Women* and the report of two labour commissions are confined to the archives. Riding on the back of this severe backlog of neglect, has come 'liberalisation' and the cutting down of public supports for women and opening the gates to competition and international trade. Women's foothold in the organised industry is now even more precarious under flexibilisation and casualisation while their fate in the unorganised sector is worse than before.

The family as a sacrosanct and benign refuge, a basic foundation that glues society, has come under assault with exposure of the less than idyllic picture of the family. Much legal reform has been attempted in this sphere but communalisation of issues has precluded thoroughgoing reform that will grant women true citizen rights and release them from the thrall of personal laws.

This plenary will address all important policy initiatives in the last few decades – population, health, legal reform, labour policy, and others while giving a more detailed treatment to economy, education and family as fundamental structures that need drastic reform. It will evaluate polices as well as women's responses.

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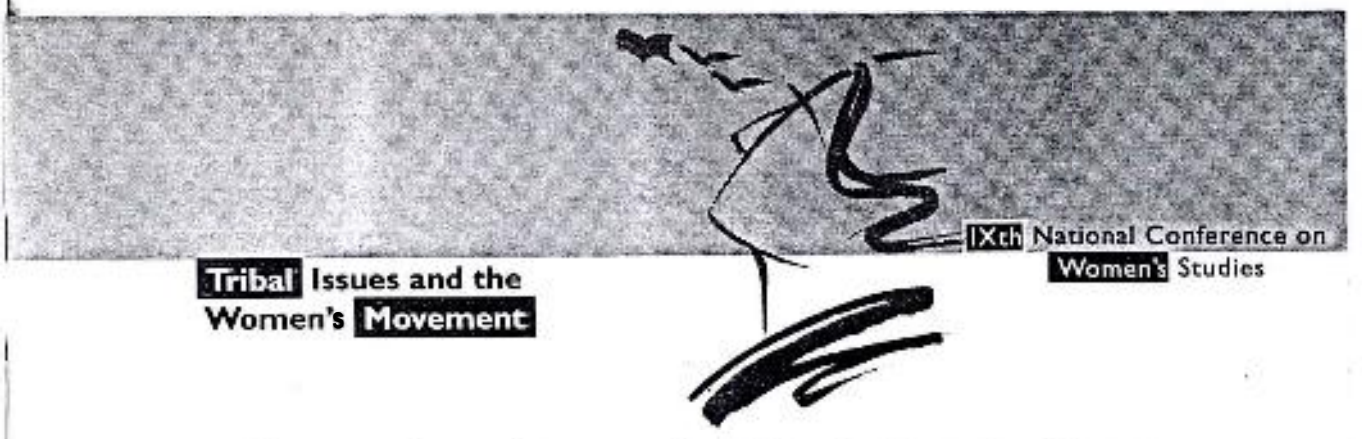

Tribal Issues and the Women's Movement

Class, caste and community are now acknowledged as significant markers for women. However, the issue of tribal identity has not yet impacted on the theorisation undertaken by the women's movement. The category of the tribal is located at a node that is, in ways defined by the state, simultaneously both legitimate and illegitimate. This location in fact throws up a number of questions for the theorisation of gender. We therefore hope that the plenary focus on the tribal issue would reopen for critical evaluation the manner in which the women's movement has thus far conceptualised gender.

While anthropologists, scholars and activist groups have been debating the definition of the "tribe", the "tribal," or the "adivasi" the state has drafted several policies that would impact on them. The seeming clarity of the state's vision in relation to the tribals is in contrast with the analytical confusion faced by theorists as well as activists. We therefore feel that an important outcome of engaging with the tribal policy as formulated by the state would be the recognition of the rationale that the state employs – its ways of identifying, naming and addressing subject populations.

An understanding of the state's rationality is of immense importance to the women's movement, especially since it would enable it to review its position vis-a-vis issues of modernity and development. The face of modernity and development that the tribals have seen has invariably been detrimental to them. The large-scale displacement of the tribals from the site of the Sardar Sarovar Project in Gujarat, the exposure to nuclear radiation due to Uranium mining in Jaduguda in Bihar or the recurrent epidemics of malaria and gastro-enteritis in tribal areas of Andhra Pradesh are some examples that come to mind when one seeks to trace the trajectory of what developmental projects have done for tribals. The question of statist modernisation therefore acquires obviously disturbing dimensions when the issue of tribals is thus centred.

In bringing up these issues, the point being emphasised here is also that tribals have so far been absent from the feminist imaginary. An attention to their situation would necessarily put entirely different light on various issues that are being discussed today within the women's movement. Issues regarded as *ipso facto* progressive or regressive would then need to be re-evaluated. Some of the impasses faced by the women's movement, for instance, in relation to the question of personal laws or in relation to gender representation at different fora, would assume different kinds of significance in the context of how the

notion of gender relations, rights, agency and empowerment is conceived of within these systems. The anthropological discourse around the tribal "customary law" for instance has ranged from representing it on the one hand as most egalitarian to characterising it as immensely oppressive on the other. It therefore becomes important for women's studies to engage with these issues in order to get a more nuanced sense of these concepts which can then be used to influence policy decisions.

Another point of significance in relation to the tribal issues lies in the manner in which they are written into historical narratives. Recent scholarship has shown how the "tribal uprisings" are always treated as adjuncts to the main narrative of Indian nationalism. This in turn has had implications for the manner in which notions of Indian identity and citizenship are predominantly conceived. In its attempt to interrogate hegemonic notions of "national identity" and "Indian identity", the women's movement needs to engage with the situation of the tribals as well.

The plenary will focus on

- anthropological writings on tribal societies and their impact on state initiatives
- customary laws of tribal communities
- tribal identities/national identities: the case of the North-East
- modernisation, the market economy and tribal life
- tribals in India: pre-modern or modern?

Through these broad areas, the plenary will therefore seek to address through the tribal situation issues that are of significance to the women's movement.

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Moving Beyond Wombs:

Foregrounding Women's Health Agenda

The crucial role of public policies in ensuring survival and welfare of people is well recognised. As we await the new millennium, a thorough critique of health and population policies along with many other policies is most appropriate as women face their consequences in a peculiar and gender-specific way. An urgent need for such an exercise emerges in the light of two developments of this decade. Firstly, onslaught of globalisation, best manifested in privatisation, cuts in resources to the social sector, shrinking employment and dwindling food security. Secondly, the much touted 'paradigm shift' in family planning policies wherein 'reproductive health' is fast replacing 'women's health'. Both these developments are hitting women the hardest.

While accepting Bhore Committee's recommendations that health care services be the responsibility of State and comprehensive health care be available to people irrespective of their ability to pay for the same, in reality State health services for poor are dismal. Statistics clearly indicate the urban, anti-poor bias of health care services. The emphasis is on the private health sector that operates without any legal or State control. Women are the worst sufferers due to the prevalent anti-women bias present in private as well as public health sectors. Both these sectors view women only as mothers and therefore consider their health only in terms of their wombs. While the private sector profits on their motherhood, the public health sector's major concern is to prevent women from becoming mothers! Thus, historically, all health programmes designed specifically for women have been related to MCH (maternal and child health), contraception, child survival, safe motherhood etc. Even this narrow approach has failed in providing services related to safe pregnancy, maternity, and contraception to majority women. Little else is available to women to address their general and gender-specific health care needs. This neglect has accentuated the disastrous impact of capitalist patriarchal development process. Various indices underline the poor health status of Indian women. Women suffer in dual ways as they are primary producers of life as well. The basic issue in the present period is one of survival which is under threat. Survival today cannot mean mere biological existence but must also include human dignity and cultural freedoms and accomplishments.

The last few decades have also seen women being targeted for population control. It is important to note that the budgetary financial allocation for family planning programmes is steadily increasing in the last few years even when the government is asked to cut down

expenditure on health by the IMF and the World Bank. The thrust is on the long-acting, provider-controlled, hazardous contraceptives for women. The disturbing trends are trials of contraceptive methods like anti-fertility vaccines and Norplant, a hormonal implant, the permission to market Depo Provera, a hormonal injectible. More and more NGOs are involved in these programmes. This plenary will

- Present a spectrum of macro and micro issues in areas of health and population control
- Provide critique of Health and Population control
- Initiate debate on alternative approaches
- Identify critical issues to set an agenda for action
- Share insights and dilemmas of feminist health initiatives and campaigns.

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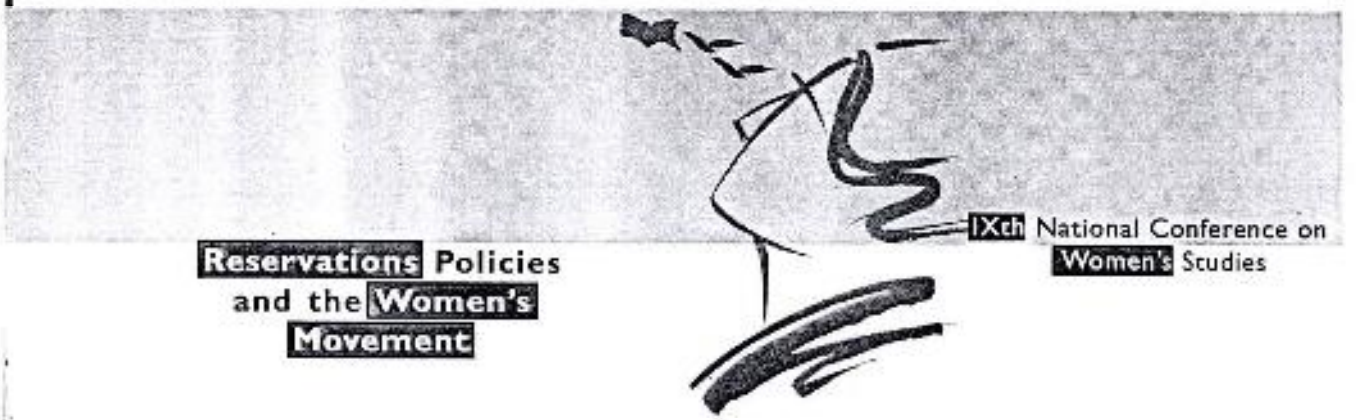

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Reservations Policies and the Women's Movement

The policy of reservations in institutions of the state has invariably and repeatedly been a contentious subject in the political history of twentieth century India. The very recent debates around the demand for the reservation of one-third seats in Parliament and State Assemblies for women is but the most recent illustration of the range of issues that are thrown up at different levels, whenever the need for a policy of reservations has been raised. In spite of this long and conflicted history, however, documentation of earlier controversies (such as the correspondence and debates over reserved seats for women during British colonial rule in the 1920s and 30s) is extremely sparse. The relationships between the demand for women's education as a principal tool of social reform, on the one hand, and the subsequent history of reservations in education (such as the Constitutional guarantee of proportional reservations for Scheduled Castes and Tribes, and reservations for Backward Classes in different regions of the country) has also not received any sustained attention. Even the current debate over the 81st Amendment Bill has been stifled because of the perceived urgency to try and get the Bill passed as quickly as possible.

We therefore view this panel as a valuable opportunity for discussion and awareness-raising for all of us in the field of women's studies. We hope to address some of the major issues involved in this particular policy measure such as:

- The nature of the discrimination and oppression that this policy seeks to redress
- The different spheres of public life where reservation policies have been adopted
- Critical distinctions between colonial and post-independence policies, as well as the distinctiveness of the last decade of the 1990s
- The ambiguous relationship between the women's movement and other social movements over this issue

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Censorship and Silence:

Perspectives on the Freedom of Expression

For the last half century freedom of expression has been a right enshrined in the Indian Constitution, but observed more in the breach. Human rights movements have focussed on the infringements of this right by the state; but civil society institutions have also been sites of censorship and silencing. While people's movements have been vehicles of resistance, they have also tended to subvert women's rights through the patriarchal bias of their politics. In the new millennium women have a pressing need to counter this trend to define and abridge rights and interests according to the political needs of the moment. Issues of censorship in relation to the family, community, violence and peace need to be explored and addressed.

Freedom of expression today is under far more threat than ever before. On the one hand there is the state and its reluctance to provide information, which itself makes for a censorship of thought and discussion. On the other, how does the state intervene and protect the right to freedom of expression when it is curtailed by right-wing or militant groups? What forms of expression does the State protect, and what forms does it deny or worse, allow to be destroyed? To look at the freedoms that different groups of citizens have sought in specific historic contexts and to trace the forces that come into play to promote or prohibit that right, would be useful at this juncture. How do formal and informal, but nonetheless, powerful, censorships come into play with converging or conflicting interests? What is the nature and agenda of gender-based, caste-based and identity-based censorship? How does language itself censor? What are the issues that have been raised through various periods through different movements? How has the state responded in terms of protecting or suppressing human rights in the context of rape, violence, homosexuality, minority and dalit issues? Given the range of concerns that emerge, how do we understand the context, mobilization and responses in terms of policy.

How does freedom of expression operate in relation to the film media? To the electronic media? How does one view the glamorisation of violence and sadomasochistic sex through highly advanced and sophisticated technology that operates at subliminal levels? What does "free choice" imply for a passive audience?

This plenary will attempt to raise these questions and open up these contentious areas for discussion.

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MADHURI SHAH MEMORIAL LECTURE

BY

ARUNDHATI ROY

SOUTH ASIAN PANEL

HAMEEDA HOSSAIN, *Bangladesh*

SUNILA ABEYSEKERA, *Sri Lanka*

SUB THEMES

Mobilizing for Change: Possibilities and Challenges

This sub-theme focuses on the mobilization of marginalised women in urban and rural contexts. Our main aim is to look at innovative strategies for empowerment, development and change through the eyes of the women who are involved in such initiatives. Through this process we try to critically assess the potential of women's collectives to address issues and agenda involved in development and social change.

Of central importance to us are the enabling structure and processes of mobilization, the emerging agendas of women and marginalised groups, and the ability of women's collectives to create an identity and space for themselves which can help sustain action and change.

Among the main concerns addressed by women presenters are: the demand for rights to sustainable livelihood and a healthy and educated life, an end to violence against women and children, the ways and means to influence local self-governance and ensure accountability of governmental systems and services.

As a beginning orientation for our learnings, we will use the experiences of grassroots peoples and the Henry Martyn Institute (HMI), which works with urban woman in the bastis of Hyderabad; Mahila Samakhya, which runs a government-funded initiative to mobilize women for education and empowerment in over seven thousand villages; and Astha, which helps to catalyze and support people's movements in both urban and rural contexts in Rajasthan. Brief presentations on people's initiatives associated with these three organizations will help to highlight both encouraging stories of positive change, as well as challenges inherent in mobilization activities at grassroots levels. We are particularly concerned with organizational and justice issues which arise when working for women's empowerment.

A critical study of women's work as mobilizers and mobilized gives us insights into the invitations, dilemmas and contradictions of practical initiatives for social change. Our collective reflections also provide an occasion to better understand the possibilities and problems of integrating and mainstreaming gender concerns, as well as forming more effective short and long-term public policies.

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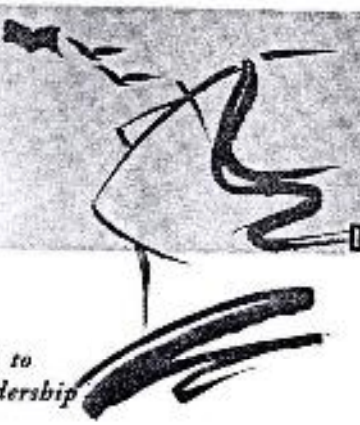
SUB THEMES



Women's Experience in Panchayats

Role of State and Civil Society to Strengthen Women's Emerging Leadership

Rural women have come a long way in their representation in the institutions of local governance since the beginning of this century when even the request for constituting a village panchayat could be made by 20 *adult male* residents. For decades thereafter, they could only have a token presence of one or two coopted/nominated members. The 73rd Constitutional Amendment in 1993 became a watershed when it mandated their one-third minimum representation in these bodies. The elections after this amendment have brought women across caste, tribe, class and regions in critical numbers and, most importantly, not only as members but also as chairpersons. What is the experience of these women? What are their supports and constraints? How has the state supported them in their new public role? What is their impact on these institutions and how has their role impacted on their own aspirations, confidence and attitudes.

Women's entry in panchayats has been preceded and accompained by various myths about their passivity and disinterest in politics, only well to do and upper strata women coming through reservations, their political connectivity – only kinswomen of earlier pradhans and powerful political leaders entering panchayats and, lastly, that all these women are only *proxy, nametake* members.

Data from ongoing studies in different parts of the country question these myths and document women's awareness levels, participation in panchayats, their confidence levels and new political aspirations. Noting the beginnings of the empowering process, it also notes the resistance of patriarchal structures and the back lash and counter forces trying to discredit the experiment.

The sub theme seeks to share women's experiences especially in states which are generally dismissed for exhibiting backwardness on most of the indicators of social development. It also seeks to explore the role of the state and various actors in the civil society in strengthening women's emerging leadership at the grassroots level. It hopes to contribute to the current debate on the need, nature and justification of mandated reservation of women in the political sphere and how best they can use their new political space.

The sub theme will focus on successful and innovative coping strategies and the role played by various social institutions and women's collectives, with special emphasis on

- alternative models of women's coalitions, networks, information systems, which include women in panchayats as well as other women, appropriate for different times and places;
- emerging success cases of the supporting role of the state and other actors in strengthening women's capacities to cope with and build on their new roles.

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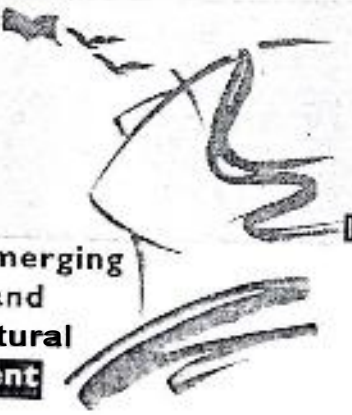
SUB THEMES



Engendering New and Emerging Community Rights and Responsibilities in Natural Resource Management

The interlinkages between gendered power relations and natural resource management have been recognised by activists, researchers and policy-makers, but are as yet insufficiently concretised. This task has become urgent as people's local livelihood strategies and development choices are being swiftly transformed by their own changing perceptions, national policy interventions and global trends. Access to, control and use of natural resources are determined by gender, class, caste, and ethnicity – a dynamic process which is constantly being negotiated and contested. As producers, consumers, conservers and distributors of natural resources, women's rights to resource use and responsibilities for resource management are shrinking in some respects, expanding in others – affected by multifarious factors such as the seasonality, marginality or productivity of the resource; new spaces emerging from social movements for the assertion of community/group rights; the positive/ negative impact of state policies; and the creation of new rights as in wasteland and watershed development programmes. This sub theme, therefore, seeks to focus on key aspects of the new spaces, and emerging community rights and responsibilities, in natural resource management. Location-specific presentations, which document the process of gendered interventions, would be welcome, particularly from the north-eastern, arid and coastal regions of the country, with special emphasis on any or some of the following aspects:

- Establishing the linkages between gender and natural resource management – through empirical case studies of changing livelihood strategies of specific nomadic, hill, forest, wetland, grassland, coastal and island-dwelling groups or communities.
- Integrating gender analysis into community-level natural resource management projects – through documenting recent or on-going field experiences of the problems, conflicts and solutions at the planning, data-gathering, technological intervention, and impact evaluation stages.
- Assessing the impact of changes in resource management policies and practices on gender relations – through analyses related to the procurement, use, conservation and development of natural resources (such as non-timber forest produce, aquatic-marine resources), at both the household and the community levels.
- Identifying customary and new institutional and legal mechanisms for gendered benefit-sharing – through examples relating to the use of natural resources, both within households, and between communities and local and outside institutions/agencies.
- It is expected that the exchange of experiences through the presentations and discussions would help to refine field-level methodologies and to suggest critical action points for policy interventions, at the local, State or central levels.

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SUB THEMES

Meeting the Evolutionary, Cultural and Ethical Needs of Communities

A Feminist Critique of the Gap between Food and Nutrition

This sub theme will seek to critique the current food policies arising out of economic liberalization from the standpoint of women. It is premised on the belief that women in traditional societies had a close relationship with food and were involved in its various stages of growth (from sowing food crops to its harvesting, threshing, storing and preservation), and its preparation for consumption. The growing commercialization of food, promoted by the government food policies, are not only usurping women's traditional areas of control, but are also alienating communities from their cultural moorings.

The roots of this alienation can be traced to the reductionist world-view, which since the 16th century, has coloured the growth of scientific and technological knowledge. The corollary of such a world-view is the prevailing conceptual dualism of mind/body, nature/culture and man/woman in scientific knowledge. Feminist scholarship has increasingly questioned this mechanistic construction of the human body (seen as comprising, like the automobile, various body parts) and the separation of the human physical self from his/her mental, emotional, cultural and spiritual potential and needs. They contend that this model of the human body has generated a fractured image of food and nutrition, which has led to short-sighted food policies. The much celebrated Green Revolution, has failed to wipe out hunger and has threatened the future food security of the world. An equally dangerous fall-out of the use of hybrid seeds, pesticides and artificial fertilizers/feeds as well as irradiation of fruits and vegetables (supposedly to increase shelf life of foods) is their impact on the nutrition. The recent outbreak of the Mad Cow disease in Great Britain is only one manifestation of the reductionist view of food and nutrition.

In the current climate of global economics motivated by the profits that would accrue to them, supranational corporations are promoting foods that, on the one hand, have no nutritional content, and on the other are alien to indigenous cultures. The process, not only fails to meet the evolutionary and cultural needs of the people, but is also robbing women of their access to and control over foods. Deprived of their productive roles, women are increasingly undervalued and objectified. The trend is also exacerbated through the promotion of crop mono-culture and controls over food resources through the patenting of seeds and other natural resources.

From a holistic understanding of the human identity (i.e., an understanding of the human being as being closely connected with his/her environment) this sub theme questions the very premise on which the current food policies are built. It also highlights the politics of knowledge generation and the process which suppresses research findings that contradict the generally accepted paradigms of scientific knowledge.

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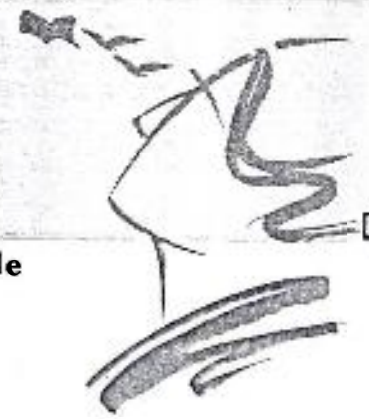
SUB-THEMES

Public Policy and People in Prostitution and Sex Work



The concept of the debauched, debased and deviant woman has always governed public opinion on women in prostitution. Women have therefore been policed, coerced and raided, to be rescued, reformed and rehabilitated by a society that would "like to order and control their life styles", regulate or abolish prostitution. In recent years, the discourse around prostitution has changed and is now couched in the language of human rights. Feminists, theorists and prostitutes' rights activists are involved in unraveling the complex and complicated world of sexual autonomy, free choice, sexual exploitation and the agency versus victim debates. This discourse has helped in that it has shifted the focus from blaming the woman and her sexual preference to a continuum ranging from the 'beneficial exploitation of the institution of prostitution' to the 'inherent victimisation of the woman in prostitution'.

It is apparent that while the "prostitution question" will continue to be debated and arguments for and against, whether voluntary/forced, 'agency'/victim, trafficked/socialised, legal/criminal, sexual slavery/ sexual autonomy, exploited/liberated, will continue to occupy theorists, activists, and governments, prostitution as experienced by the women themselves is not given the kind of recognition it deserves in these debates.

The discourse unfortunately does not recognise the day-to-day struggles much less the strength of a minority community comprising mainly of women who face the brutal and criminalised world they inhabit. It is a struggle that is fortified by a socialisation that encourages and strengthens their ability to deal with a hostile and violent environment. A community that has repeatedly scorned the attempts of mainstream patriarchal society to control, regulate and abolish the institution of prostitution. It is a community that is fighting for a voice in all the debates. In India, as in most countries of South Asia, legislation on prostitution connects prostitution with trafficking. The Immoral Trafficking Prevention Act, 1986 believes that women in prostitution and sex work, are victims of pimps, brothel owners and madams and therefore need to be rescued and prostitution regulated. Prostitution is believed to be 'commercialised vice' and is viewed as synonymous to 'immoral trafficking'. In fact that prostitution is but one site for trafficking is not acknowledged. All women trafficked are not only for 'the purpose of prostitution', and not all women in prostitution and sex work are in the trade due to being trafficked into it. There is a need to define trafficking as separate from prostitution and sex work. Women in prostitution and sex work constitute a community that bears and will continue to bear the greatest impact of the HIV epidemic in India. Communities of women in prostitution and sex work continue to suffer high levels of infection and re-infection. HIV may infect the children they bear. Apart from the stigma already attached to their work, society has further marginalised them as core transmitters of HIV infection. It fails to recognise that they are but links in the broad networks of heterosexual transmission of HIV.

The sub- theme will cover various issues concerning prostitution and sex work and will address the problem from the standpoint of • Laws that affect people in prostitution and sex work. • Trafficking as separate from prostitution and sex work. • HIV/ AIDS and women in prostitution and sex work.

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SUB THEMES

Gender, Conflict and Political Violence

The point of departure for this discussion is the increasing conflict and violence that women have had to face in India - and indeed in South Asia -in recent years. This has important implications both for public policy and development because its impact can be felt in economic, political and social structures and on questions of governance. India is not a region of conflict in the same way as countries like Guatemala, Liberia, Kosovo might be said to be. However, the increasing instances of conflict that have taken place in the country in the past several years are disturbing enough to warrant serious attention. They draw our attention to several important aspects: we can no longer be complacent about the general "non-violence" and "peaceableness" of India; we must face up to the very real possibility of the increase and escalation of the kinds of conflict we have been seeing; we need to carefully examine the increasing militarization of our society, and how this both creates and results in further conflict. The question of gender is central to all these discussions.

The kinds of conflicts we plan to focus on in these discussions include: political and military conflict such as we see in Kashmir and the North East and most recently in Kargil; ethnic/religious/ communal conflict such as has been visible in different parts of India in recent years; ongoing caste conflict and persistent attacks on dalits and minority groups. Our attempt in the discussions will be to examine the complexity of violence that marks our society today and to examine also the continuum of violence whereby political violence can escalate into armed conflict and vice versa. Further, to ask how these affect the daily lives of ordinary people, and particularly the most vulnerable sections of society such as women and children. The vast amount of work on political violence has mainly focused on violence and conflict as primarily male domains, and has seen it as being carried out by men on male armed forces, guerrillas and other perpetrators of violence.

These discussions will therefore examine the following questions: How do women in particular experience different kinds of conflict ? How do women participate in and internalise the ideologies of conflict ? What are the State's responses to women's needs in times of conflict – e.g. what is the law on compensation, on loss of life and limb, on damage to women's health etc in times of conflict ? What are the implications of increasing militarization for women? What are the implications of increasing militancy for women - how do women get drawn into the ideologies of militants, of the right wing, or the private armies and of "military" like groups such as the Bajrang Dal and others. How do they come to serve as couriers/ messengers etc for the army and security forces in times of conflict. What are the circumstances that push women to these steps, and what is it that draws them to such ideologies; what, in addition, are the implications of such involvement for their lives.

The sub theme will focus not only on women as victims of conflict but also as its agents, and to look at the role women have played as peace makers, as well as examine the quality of that peace, its sustainability, its fragility and its importance for women.

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SUB THEMES

Women in Business

The slow but steady increase in the position of women in Small Scale Sector in the Indian economy would be attributed to policy initiatives taken by the Government. It is increasingly being realised by decision-makers that wide spread poverty and stunted development cannot be tackled without providing adequate opportunities for productive employment of women. The Government conferring statutory status to the National Commission on Women, the reservation of a certain percentage of seats for women in local self government bodies and institutions of higher learning create avenues for bringing women into the mainstream.

During the Seventh Five Year plan an integrated multidisciplinary approach was adopted covering employment, education, health and other related aspects on areas of interest to women.

The Government as part of its planning policy from the Fifth Plan period onwards has been giving preferential treatment to women in finding them employment in the organised sector as also in encouraging, equipping and facilitating them to become entrepreneurs. The measures taken include announcing special schemes for women entrepreneurs, preference in allocation of sheds in industrial estates, financial assistance, exclusive industrial estates for women and encouraging them through the institution of awards for entrepreneurs. Financial institutions and other development agencies have taken a cue from the Government and are supplementing their efforts.

Despite the encouragement given by Government and other developmental agencies the progress of entrepreneurship development among women in India has not been satisfactory. There is no dearth of programmes favouring women but unfortunately the policies could not integrate women into the mainstream of society mainly because of lacunae in the implementation process. In recent years it has become increasingly evident that women still lag behind a great deal both in availing of the benefits of developmental programmes due to several socio-cultural political blocks and the impassivity of the implementing system.

This sub theme will examine policy initiatives, entrepreneurship modules and the organisational support available in fostering women empowerment through enterprise development, while focussing on the role of governmental and non governmental agencies in strengthening women.

Coordinator: C. Rani, National Institute of Small Industry Extension Training, Yousufguda Hyderabad-500 045, Phone: 040 3608577, Fax: 3608547, email: nisiet@hdl.vsnl.net.in

SUB THEMES

Violence Against Women

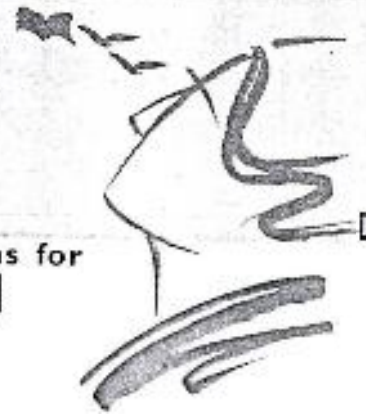
Violence against women is today, as a direct result of the Beijing Conference, assuming centre-stage as a serious development and human rights issue within the national and international arenas. The need to develop new and innovative strategies to ensure the elimination of violence in the new millennium, is being recognised increasingly. In India, the women's movement has been able to consistently push the issue of violence on the national agenda. The activism of women's organizations has been instrumental in both enhancing the understanding of violence against women and in generating innovative responses to the issue. This in turn has not only resulted in amendments in law, setting up of shelter homes and counseling services, but also community responses such as neighborhood watches, women's courts and social boycotts. Although much ground has been covered, we need to take a reflective look at existing data sets on violence, what has been accomplished and what more needs to be done to achieve the elimination of violence against women.

This sub-theme aims to address some critical concerns, like the cultural and regional variations in violence against women, if any, norms of acceptable behaviour in public and private spheres, the relationship between domestic and state violence to state a few.

The documentation of violence by institutional systems like police, courts, hospitals and NGOs is very important. This sub theme proposes to pinpoint the specific problems faced in this area. These responses of the state and NGOs to the issue of violence have to be evaluated in terms of their strength and lacunae. Our focus has to be on strengthening the legal responses alongwith seeking community participation. Since violence is a critical development issue, the sub theme plans to highlight the interconnections between violence and development and the impact of economic restructuring on violence against women.

Finally the sub theme will also raise the question of how violence against women is being re-viewed as a human rights violation within India, the issues around sexual exploitation of girl children with respect to trafficking and trends pertinent to South Asia.

Coordinators: Nata Duvvury, Anuradha Rajan and Seema Sakhare, International Centre for Research on Women, F 81 East of Kailash, New Delhi 110 065, Telefax: 011 6285933, email: icrw@ndf.vsnl.net.in



PRE CONFERENCE WORKSHOP

Information Dimensions for Women's Studies

An Agenda For The Future
7th January, 2000, Hyderabad

IXth National Conference on Women's Studies

The Centre for Women's Development Studies in collaboration with the Indian Association for Women's Studies is organizing a one day workshop on "Information Dimensions for Women's Studies: An agenda for the future" to be held on 7th January 2000 at Hyderabad. The workshop will be a pre-conference feature to the IX National Conference of Women's Studies organised by IAWS from 8-11th January 2000.

There is growing recognition at the international, regional and national levels of the critical role of information for women's studies research, action, advocacy and policy planning. Such information is being generated continuously from a variety of sources. There is constant flow of information coming out from various levels of intra-governmental and governmental agencies, research and academic institutions, women's organizations and also a number of commercial publishing houses.

The task of collecting, preserving, processing and disseminating this plethora of information in its myriad forms is undertaken by Libraries, Information and Documentation Centres, Archives and Museums. The inter disciplinary and cross sectoral nature of women's studies, the varying needs of user groups in different environment, the diffused nature of information available, the multiplicity of format in which it is found makes the task of these agencies a difficult and complex one.

The one day workshop aims to highlight the role of Libraries/ Information/ Documentation Centres/ Archives and Museums in providing information inputs for women's studies. The workshop will also focus on the role of information nerworks and the use of traditional and new information technologies for collecting, processing and disseminating the information. It would also try to assess what has been achieved in the last few decades, analyzing the gaps and planning future strategies to ensure equity of access to information.

The workshop provides an ideal opportunity to bring together on one platform the diverse perspectives from women's libraries, archives, museums and information and documentation centres to strengthen our understanding of this highly evolving area of women's studies information.

The workshop will consist of panel discussion invited talks and paper presentations. It would be limited to 30-35 participants. Papers are invited on the above mentioned issues. Only selected papers will be presented at the workshop due to time constraint. However, the Centre plans to bring out the proceedings of this workshop where the other papers would be incorporated.

Last date for receiving the abstract (250 words) is 7th October 1999. Final papers are to be sent by 30th November 1999. Travel grants will be made available to the paper presenters.

Coordinator: Anju Vyas, Centre for Women's Development Studies, 25, Bhai Vir Singh Marg, Gole Market, New Delhi 110 001, Phone 011 3366930, Fax: 91-11-3346044 email: cwdslib@alpha.nic.in

Stri Vividha

IXth National Conference on Women's Studies

Countless groups across the country are working to enhance the lives of women. Some of these efforts are experimental, some quite fully viable and now working their way into mainstream. Some of these activities concern themselves with education and communication, others seek means of livelihood for women; but all work within a framework of participative, sustainable and equitable ways of living.

At the 9th National Conference of Women's Studies to be held in Hyderabad in January 2000 we will have a development resource fair called Stri Vividha celebrating the vitality of such alternative efforts centred around women. While the conference would concentrate on academic discourses and debates around the theme of women's perspectives on public policy, Stri Vividha could bring these issues into the public arena by making a popular event of it. In other words, the fair hopes to be a bridge between the city of Hyderabad and the Conference, a unique cultural event attracting a section of people who would not otherwise attend the conference.

Proposed features of the event

- a mela, an open platform exhibiting and selling women's literature and products made by them. (As important as the display of the exhibits would be the interaction between visitors and participants which would forge new partnerships, encourage alternatives to prevalent forms of marketing, give craft producers an insight into buyers' demands and stimulate creative exchanges);
- a photo-documentary exhibition on women workers;
- a festival of documentary films on women's issues;
- a platform cafTheta - an interactive refreshment corner which would encourage interaction between the conference delegates, fair participants and the people of the city. It could provide informal space for book launches, debates and impromptu cultural shows by fair participants;
- a publication/a handbook on laws concerning women workers. This could include programmes and policies on women workers as well as a directory of agencies and government schemes applicable to women workers.

Those of you who had been to Pune in 1998 would remember our previous Stri Vividha. We would like to have your suggestions on organisations which could be invited to participate in the fair. Both producers of literature and other resource materials and producers of craft and food items are welcome.

We would also invite your suggestions for the festival of documentary films on women's issues. A selection committee for these films is being formed, and after inviting entries, they will review the films and put the programme together. If you are planning book launches, public debates, press statements or would like to put on informal cultural shows during the conference, do remember you have a stage at the Platform CafTheta. Please book with us in advance, for we would seek press coverage of your event. The cafTheta would expect heavy traffic between 6 and 8 p.m. daily. January 8-11 comes within Ramzan, so a daily iftar spread of fruit chaats, halim, kebabs and so on would be an added attraction.

As with all such events, regrettably, space is limited, and we will have to select a representative list out of your suggestions. The final list of invitees should represent both a regional balance as well as a range of activities and products. Please write with your suggestions to Devasmita Menon at Comet Media Foundation, Topiwala Lane School, Lamington Road, Mumbai 400 007, Phone: 022 3869052, Fax: 022 3870901, email: admin@comet.dbom.ernet.in giving names and addresses of likely organisations, and the names of key persons there.

Conference Schedule

IXth National Conference on Women's Studies

Day I	:	**8 January, 2000**
9.30 – 10.15	:	Welcome Address
	:	Vasanth Kannabiran, Asmita Resource Centre for Women
	:	Vina Mazumdar, President Indian Association for Women's Studies
10.30 – 1.30	:	Panel I: Women's Perspectives on Public Policy
2.30 – 5.30	:	Sub Themes I
Day II	:	**9 January, 2000**
9.30 – 12.30	:	Panel II: Tribal Issues and the Women's Movement
2.00 – 5.00	:	Panel III: Moving Beyond Wombs
Day III	:	**10 January, 2000**
9.30 - 12.30	:	Panel IV: Reservations Policies and the Women's Movement
2.00 - 5.00	:	Sub Themes II
5.40 - 7.30	:	Annual General Body Meeting of the Indian Association for Women's Studies
Day IV	:	**11 January, 2000**
9.30 - 12.30	:	Panel V: Censorship and Silence
1.30 – 2.30	:	Madhuri Shah Memorial Lecture
2.30 – 4.00	:	South Asian Panel
4.30 – 5.30	:	Sub Theme Reports
	:	Vote of Thanks

Indian Association for Women's Studies

Executive Committee 1998-2000

Vina Mazumdar	.....	President
Rama Melkote	.....	Vice President
Kalpana Kannabiran	.....	General Secretary
Divya Pandey	.....	Treasurer
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- Nandini Upreti
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- Pam Rajput
- Rohini Gawankar
- Seema Sakhare
- Vatika Sibal

WH-19;9.5

"Towards Comprehensive Women's Health Policies and Programmes"
Workshop 6-9, October, 1998 at ECC, Bangalore

Dr. Sr. Eliza Kuppozhackel
Medical Mission Sisters, USHUS
Collectorate P.O.
Kottayam – 686002
Kerala

T.S.M. CAN BE CLASSIFIED AS :-

- Drug Therapy
- Drugless Therapy

DRUG THERAPY

Drugs are used for Treatment

eg:

- Alopathy
- Ayurveda
- Unani
- Siddha
- Homoeopathy

DRUGLESS THERAPIES

No Drug but use Touch / Pressure and other gadgets for Healing.

Some of the Therapies practised in India are:

Accupressure
Accupunture
Belly Pressure
Diet Therapy
Hand & Food Reflexology
Heat Therapy
Herbal Medicine
ICN/SPS
Jin shindo
Kalari
Magneto Therapy
Marma Chikilsa
Massage
Moksa
Naturopathy
Oriental Medicine
Polarity Therapy
Pranic Healing
Reiki
Sujok
Yoga Therapy
Zone Therapy
etc.,etc

Herbs for Morning sickness

1. Corrianda - Soak 1/2 tsp in 1/2 glass water overnight and drink that water in the morning.

2. Lemon Seeds - Grind and mix with water or honey and take.

3. Tamarind a) Tender leaves dried in the shade - powder and keep

Take one pinch when ever nausea or vomiting sensation occurs.

b)Tender leaves can be eaten fresh.

India has rich variety of herbal home remedies. Tribal medicine has effective remedies for birth control, fertility & General health. These need to be identified, learned and promoted in health care approach.

Herbal Medicine	- Herbs used as food and medicine.
Grandma's Remedies	- Traditional single therapy for various ailments.
Diet Therapy	- Special herbs traditionally proven for its effectiveness available for women and Health.

Examples :

1. Hibiscus Flower - (red-Five petal flower) rich in iron and B complex	For general Health, Anemia, Uterine problems , Fertility, Menustral pain , Irregularity etc. (not to be used during pregnancy)
2. Goosberry Tonic -	good for anemia. good tonic for pregnant women.

DRUGLESS THERAPIES

Basic Principle : Body has its own healing power.

Healing happens from within.

A holistic approach to the whole person.

Vital energy/life force -
Balancing / Harmonising -
for total health - well being.

Yin & Yang Balance

Less side effects.

Leads to promotion of health.

Works on 3 levels :
Cure -Prevention -Promotion .

Drugless Therapy Types

- Using Touch /Pressure
- No touch - works on energy level,
  Bio plasmic body / Aura

  eg:- Pranic Healing

Drugless Therapy : Application in W & H.

- Can be learned by anyone with average intelligence
- Can be practised in simple settings -
  Home , Community centre, Clinic
- It requires no technology
- Can be made easily available in the villages and rural areas
- Practitioners can be trained by NGO's having knowledge & experience
- In Kerala 10000 people trained in Pranic Healing
- 75 Pranic Healing clinics all over Kerala
- More than 20 trainers available for training
- One year Diploma course conducted for training healers
- These can be employed in W & H programmes.
- In schools teachers trained in P.H.treat children/girls for Head ache,giddiness, stomach problem, cold & cough,fever,dysmenorhea,fainting etc.
- If more lady teachers are trained in this they can heal the health problems related to adolescent girls in the school.

PRANIC HEALING

Pranic Healing Foundation of Kerala has experience of training people at all levels irrespective of caste, creed and class. It has appeal to all classes – high, middle and poor. Majority use it for self healing and healing their immediate family. Therefore, dependency on drugs for even simple ailments is brought down.

People in office, work place, neighbourhood are helped by service minded people sharing their gift of healing.

In one village health workers and other selected men and women from the village were given training. Some of them became experts and were called even at night to help relieve asthma attacks and so on.

The training given to one tribal group proved very effective and hey became good healers.

There are successful stories by healers of treating several chronic ailments like Asthma, Artheritis, skin diseases, heart problem, diabetes, infertility, menstrual problems and disorders, urinary tract infection, eye problem, hearing problem etc. etc.

It has also been successfully applied in several cases of cuts, wounds, burns, bleeding, insect-bites and even snake bites.

Illness in children can be easily be treated by Pranic Healing.

21st century is said to be the era of energy medicine and healing, women's total well-being and RCH to be holistic and effective . We cannot ignore these energy healing techniques which are becoming popular. At the same time we need to work out mechanisims for supervision and effective training so that all can learn and use it for self help and helping others.

S

FOOD SECURITY AND WOMEN'S NUTRITIONAL STATUS"- HAS IT BEEN ADDRESSED BY OUR NATIONAL POLICY ON AGRICULTURE AND NUTRITION?

Vanaja Ramprasad

I have taken the liberty of reframing the topic as above. If we are looking for a candid answer to the above question, we have to redefine the concept of "Food security" and admit the fact that policy interventions most often have addressed the problem of women's nutritional status only at the periphery and at that too reducing the definition of women to "Pregnant and lactating mothers". Whenever malnutrition or under nutrition of vulnerable groups is referred to, it invariably includes pregnant and lactating mothers. On the other hand there is enough evidence to show that starting with discrimination in intra -household distribution of food to various circumstantial and environmental factors contribute to the poor nutritional status of women in the deprived sections of the population.

Taking stock of the current situation on nutritional problems in the country, it is true that there has been a reduction in acute large scale famines, florid clinal forms of under nutrition like kwashiorkor, nutritional blindness and other vitamin deficiencies. These achievements as we know today have barely touched the fringe of the problem. From the review of programme interventions it is clear that there have been vertical programmes at the national level to contain the problems of iodine deficiency, anemia and Hypovitaminosis. Besides, there have been efforts to promote midday meal schemes, supplementary nutrition programmes that have served as a band aid.

However the challenges to address the issue of food security and the nutritional status of women in the deprived sections still remain. the challenges can be distinctly described as arising out of two set of conditions. In the first set of conditions the challenges spring from poverty, landlessness, poor living conditions of the urban crowded dwellings and the like. The second set of challenges have been perpetuated by the very process of development. The modern paradigm of "development" has by and large been anti-women besides also being anti-poor and anti-environment. Food security at the household level and nutritional status are two sides of the same coin. A broad definition of food security will include not merely consumption of food but food production as a source of livelihood and a balance between market forces and public policy. Further food security means

- protecting the natural resources that contribute to the production of food.
- protecting the environment from destruction and degradation.
- Protecting the link between livestock, agriculture and agroforestry that are the basis of people's' livelihood and allowing space for regeneration of all natural resources like land water and biodiversity that fulfill the basic needs of people-

FOOD SECURITY- PRIMARY AND SECONDARY

Food security has been identified as primary and secondary (Amitava, M.) The definition of primary food security conforms to the idea that has gained wide acceptance in recent years that food security is determined by "food entitlement" and not by food availability alone. (Sen 1981) Amitava makes a distinction here to define food in primary food security as food which is grown by the application of technology in the economic sense. A further distinction is made between the concept of primary food security and secondary food security, where apart from food available from the application of technology there is a whole range of different sources to which people have access such as the forests, common property resources and other micro environments for their food needs.

It has been estimated in absolute terms that the quantities of food culled out of the forests and common property resources is upto 30% or so of the total food consumed by the poor rural households. It is also well known that apart from traditional roles, forest foods are extensively used to provide food covered during periods of extreme stress and at times of temporary scarcity over certain parts of the year. Amitava designates this as bridging "Hunger period" when stored food supplies are dwindling and the next harvest is yet unavailable.

It is in the midst of no employment and receding stocks of food, women, children and men continue to get their reserve of food from other sources of existing biodiversity. While land based foods like cereals and pulses are available from the time of harvest (January - July), the diversity of food is available in the form of greens, in the ensuring period. Many perennials start yielding during the rains. The dependence on tubers is relevant during the seasons when cereals reserve is low. The neighbouring forests areas also prove to be a source of food like potatoes, sweet potatoes and bamboo shoots. It is apparent that what the market has to offer them by way of food is very little and that too only for a few months in a year. Thus it is more than obvious that women's role in ensuring food security is crucial and the key to it lies in the conservation of common property resources.

THE ECONOMICS OF FOOD PRODUCTION – A POST LIBERATION SCENARIO

India's impressive food grain production and its growing population below the poverty line have evoked a long standing debate on the economics of over population on the one hand and people's lack of purchasing power on the other.

To combat the food deficit in the country after independence the problems was turned into a technological intervention in food production creating an impression that the new technology of miracle seeds would solve the food problems of not only India but most of the Asian countries. Though evidence exists to show that growth in food production has out paced the growth in population, at the cost of creating several environmental hazards, the fact cannot be denied that average per capita consumption figures or global figure disguise the existence of pockets of under nutrition and hunger.

Adding with this a very large number of developing countries have in the last decade and a half incurred heavy international indebtedness owing to balance of payments problems and have been obliged to implement the Structural Adjustment Programs.
According to Utsa Patnaik there are major contradictions in the IMF / World Bank formula for structural adjustment. For example there is pressure of devaluation, regardless of the fact that it is likely to improve, leave unchanged or deteriorate an indebted developing country's trade balance and hence also the pressure for cuts in public expenditure including capital invested in the agriculture. The fact that agriculture has a special place in today's economy affecting the lives of millions whose livelihood is dependent on it cannot be undermined.

It is more than obvious that the use of all natural resources like land, water and have to be conserved and put to optimal use. The challenge is to ensure that the process of environmental degradation is arrested. Agricultural policy today gives undue importance to productivity and income increase and focuses exclusively on men.

There is much evidence to show that family welfare or nutritional status of women and children decline when control of output or income shifts to men as a result of agricultural modernization. Neglect of women and their contribution to food production leads to the disappearance of food stuffs which are not world trade commodities but which are consumed mainly within the households.

The fact that women and agriculture combine work to earn their income with agricultural work, household work, child care, there are competing demands on the health of the ordinary woman, none which is addressed by the national agricultural policy.

The problem of women and their nutritional status does not end with the rural sector alone. With growing urban population, the challenge to cope with the inadequate water supply, sewage disposal environmental sanitation have to be addressed to meet the basic need of survival and healthy living.

If food security and nutritional status are end products and indicators of development, they cannot be dealt in isolation from other factors. The effect so far to contain the problem of mal nutrition cannot be undermined, but it is necessary to emphasize the fact policy intervention cannot limit itself to a fire fighting approach.

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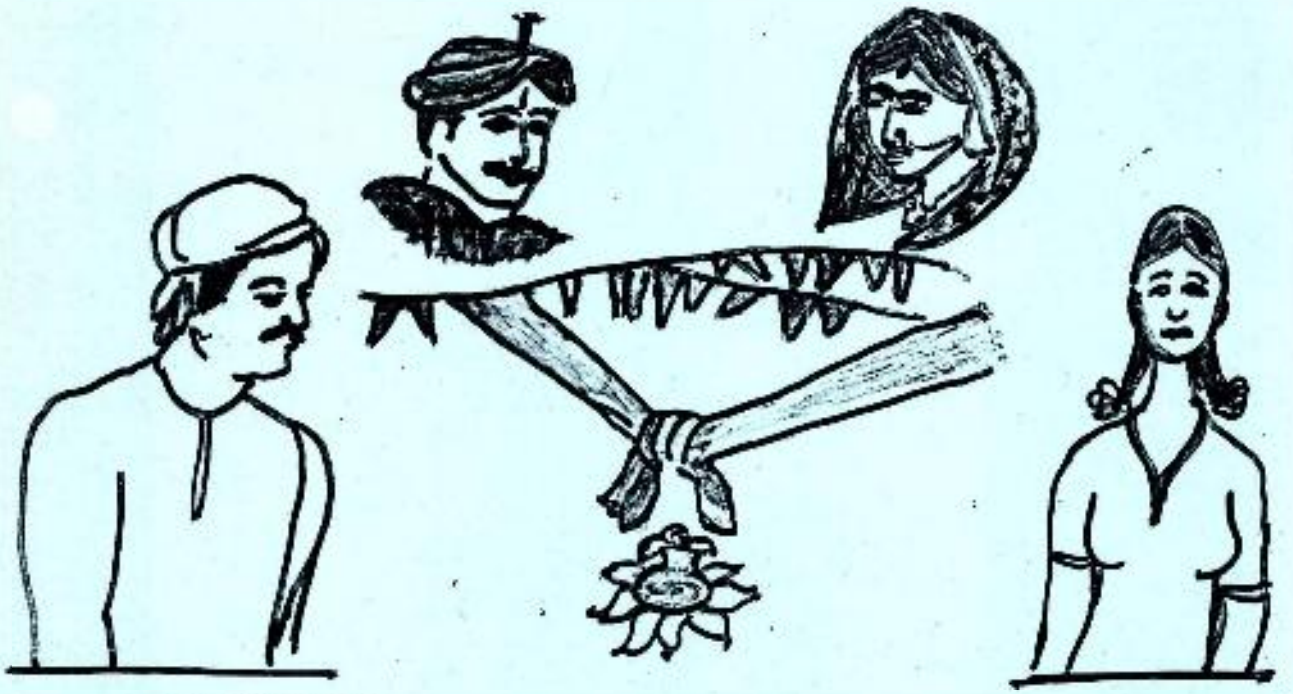
2. Sen Amartya, 1981, Poverty and Famine, an essay on Entitlement and Deprivation, (Oxford).

HEALTH STATUS OF WOMEN IN BIHAR.

W/SHtR.

REASONS RESPONSIBLE FOR POOR HEALTH STATUS OF WOMEN IN BIHAR

1. EARLY MARRIAGE



CAUSES

DOWRY SYSTEM

TRADITION & CUSTOM

ILLITERACY

FEAR OF DOCOITS

RESULT

EARLY PREGNANCY

NUMBER OF CHILDREN

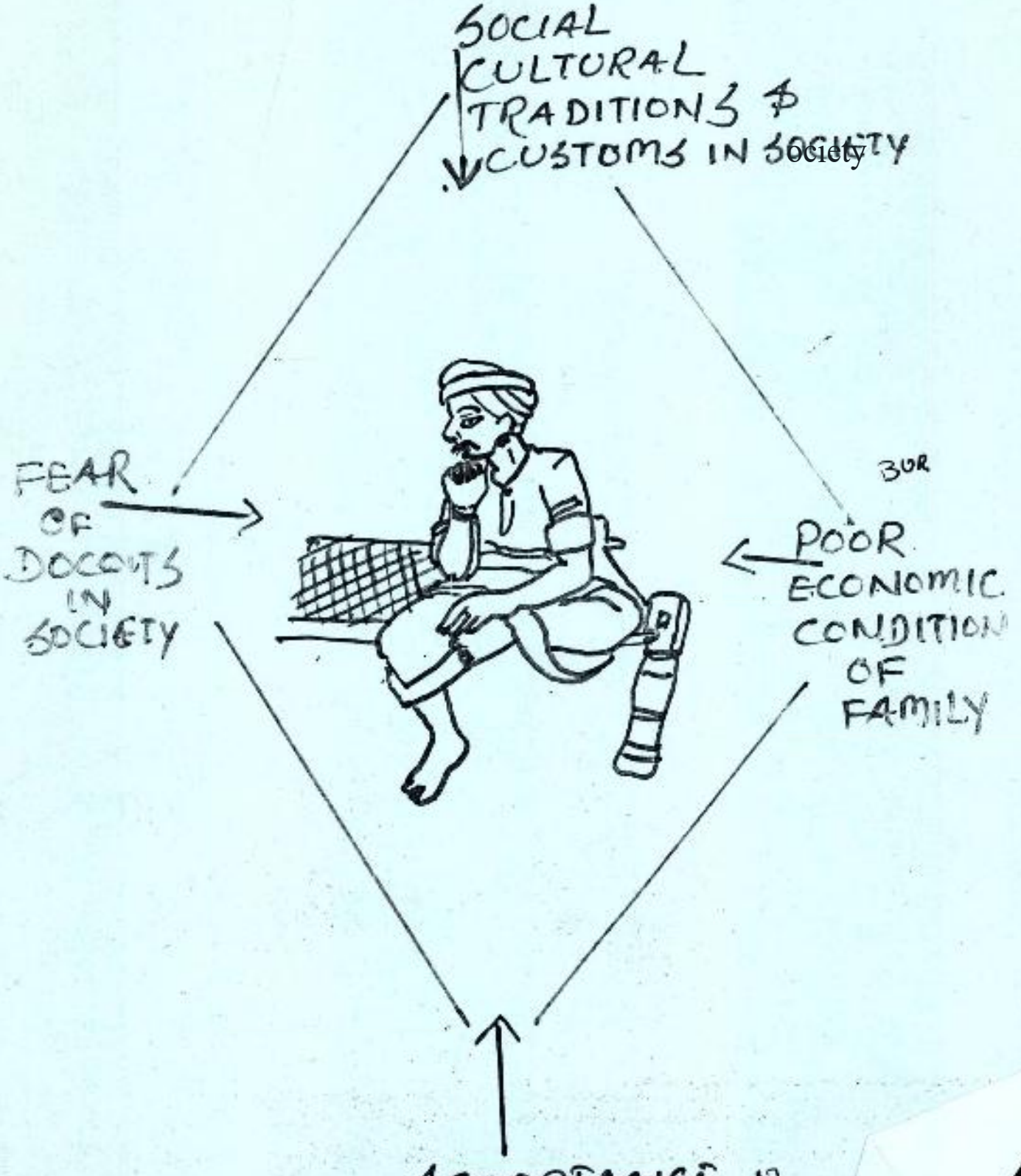
ANAMIC

MATERNAL DEATH

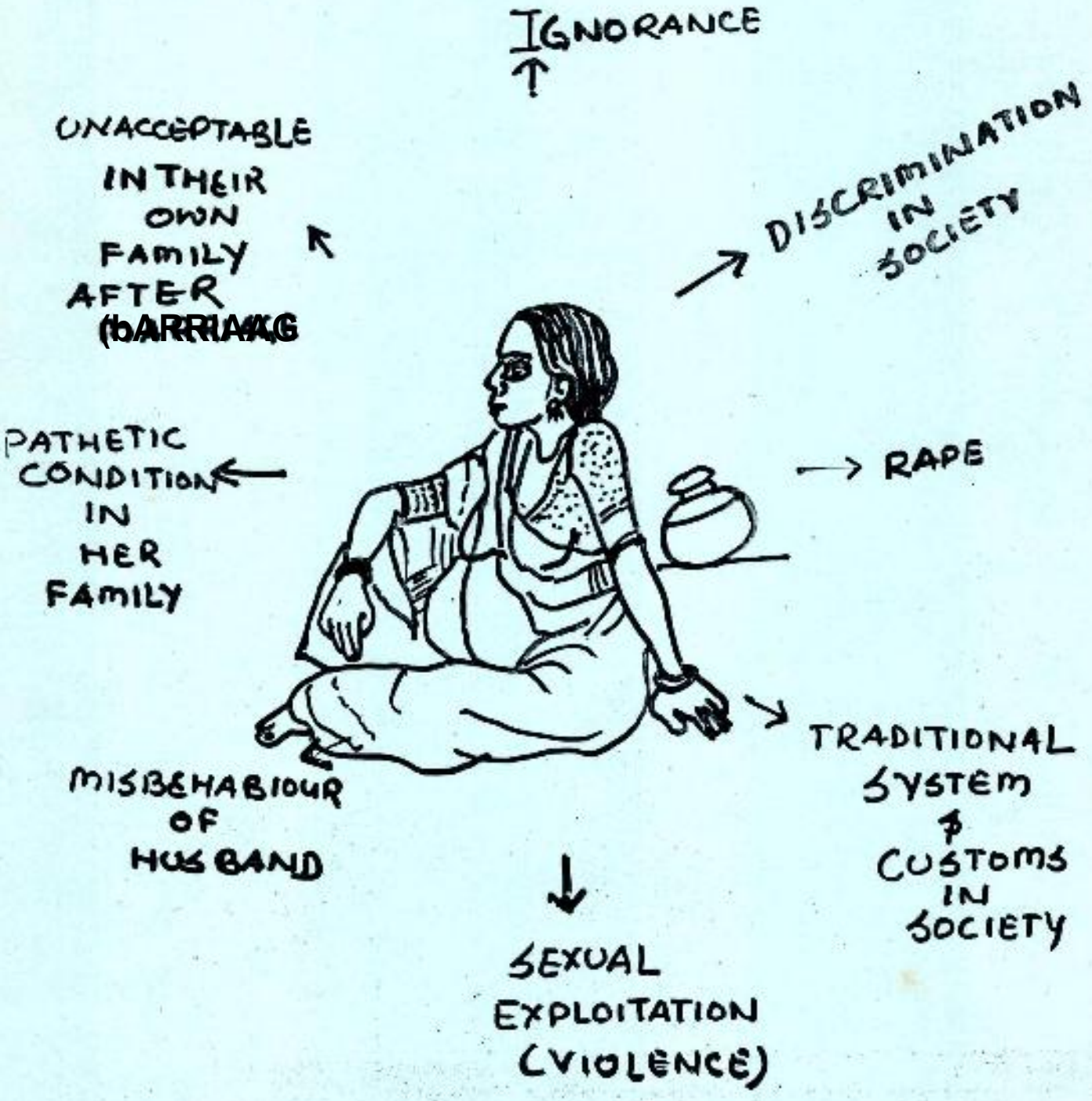
PSYCOSIS

REASONS BEHIND CHILD MARRIAGE

CONDITION OF PARENTS



2. PSYCHO SOMATIC (DISEASE)



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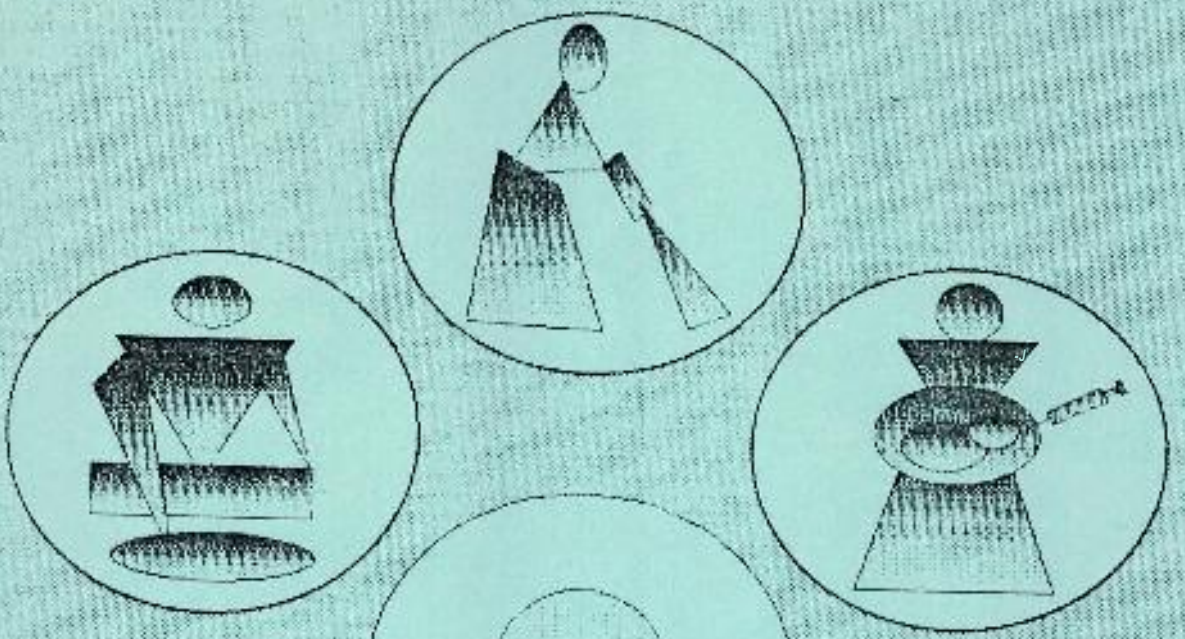


WOMENS HEALTH

AND GENDER CONCERNS

October-1998

CHETNA Women's Health and Development Resource Centre Chaitanya

CHETNA

"WOMEN'S HEALTH AND GENDER CONCERNS:" CHETNA's Prospects, Policies and Programmes

Ms, Jyoti Gade and CHETNA Team

OCTOBER, 1998

Paper presented during a workshop on "Towards Comprehensive Women's Health Policies and Programmes" held between October 6-9, 1998 in Banglore, India, organised by Volantary Health Association of India (VHAI), New Delhi & Women And Health (WAH!) network, Sponsored by The German Foundation for International Development (DSE), Germany.

CHETNA

WOMEN'S HEALTH AND GENDER CONCERNS:"
CHETNA's Prospects, Policies & Programmes

ABOUT CHETNA:

CHETNA, which means 'awareness' in several Indian languages is an acronym for Center for Health Education, Training and Nutrition Awareness. CHETNA was established in 1980 as a project to improve the impact of supplementary feeding programmes for women and children, in the state of Gujarat, India. Since then, CHETNA has been actively involved in addressing women's health and development concerns through a life cycle approach particularly in the states of Gujarat and Rajasthan.

CHETNA's mission is to contribute towards the empowerment of disadvantaged women and children, so that they become capable of gaining control over their own, their families and communities health.

Early in the process of implementing its health and development programmes, CHETNA recognised that gender discrimination is one of the important determinants of women's low health status. Therefore, understanding and addressing the implications of gender relations and enlisting the participation of men and the community, is central to its efforts in enhancing women's health and development.

Presently in its analysis and approach, CHETNA considers the totality of the political, economic and social factors that shape women's enviornment particularly, which affect women's ability to control and improve their health status.

2. NEED FOR GENDER INTEGRATION IN WOMEN AND HEALTH PROGRAMMES OF CHETNA.

Historical Perspective:

Integrated Nutrition and Health Action Programme (INHAP): 1980-84

CHETNA started its activities with a project entitled INHAP in 1980 whose purpose was to improve and assess the impact of supplementary feeding programmes in 100 villages all over in Gujarat the project was managed by Government of Gujarat with support from CARE. This was project aimed at pregnant women and children under six years of age through the Supplementary Nutrition Programme (SNP). The project taught us that the mere provision of supplementary feeding is not enough to improve the nutritional status of pregnant & lactating women and children. Awareness raising of family members and communities along with their active participation was found to be a crucial aspect. The project also illustrated that, the programme should be implemented in an integrated manner including appropriate control of infectious diseases an educational component and other support services such as emergency transportation, and the provision of crèches (for under three) etc. At present these needs such as support services are classified under 'Practical Gender Needs'.

Child Survival Programme : 1984-1990

Based on the above experiences a 'Child survival' programme was planned and implemented. In this programme local women (most of them non-literate and semi-literate daughter-in-law's) were trained as health workers with the help of local NGOs. The aim of the programme was to empower local health workers (from village families) to enhance access and control of primary health care and promotion of nutrition and health education at the village level in order to improve the health status of women and children.

During the trainings within a short period, we realised that the training of local women as health workers alone may not be adequate because they do not have decision making power at the family nor at the community level. Therefore, the messages given by them are not considered for implementation. For e.g. during pregnancy, a mother-in-law decides what and how much should be eaten by the daughter-in-law who does not have any say in such aspects. Similarly at the village level most of the families are extended families, where the final decision is made by mother-in-laws and men of the families. Therefore, the participation of all family members particularly the decision makers is very important for effective results. Also the importance of enhancing

health worker's confidence and status to have decision making power in their own lives and have equal partnership in family decisions was realised.

During the trainings it was also recognised that severe anemia and complications during pregnancy is not merely due to pregnancy but she is already anemic since childhood and severity become more during pregnancy due to the increased need for iron. And it is a result of compounded discrimination of girl child from birth to adulthood. therefore when an undernourished and anemic girl becomes pregnant, she becomes severely anemic and hence complications arise due to this situation. Therefore taking action only during pregnancy will not solve the problems. therefore health services (both preventive and curative) should be provided from birth onwards in all the stages of life cycle.

Age specific mortality is higher among girls compared to boys up to the age thirty: Registrar General India, Sample Registration System, 1992.
In India eighty eight percent of pregnant women aged 15-49 are anemic: Human Development Report, UNDP, 1995

This and several such incidences inspired us to seriously consider including socio-cultural aspects, apart from technical issues related to nutrition in our programmes and trainings. We initiated a discussion on the impact of socio-cultural factors on women's health in CHETNA's activities, which are now well accepted in the name of **'GENDER'.**

3. WEAVING GENDER INTO WOMEN AND HEALTH 'ROGRAMMES OF CHETNA:

After realising the need for gender integration to improve women's health, efforts were made at different levels and in different ways. Capacity building of our own team on conceptual clarity and strategies to integrate gender in ongoing programmes was the beginning of this effort.

3.1 Initiation of Women's Awareness Generation Camps:

To strengthen socio- cultural and economic aspects of women CHETNA organised several 'Women's Awareness Generation Camps' during the course of the programme.

Other issues that were discussed included information and linkages for income generation activities, Issues such as 'Dakan'[1] (witch) were addressed.
Meetings with men and mother-in-laws were conducted in addition elder women were encouraged to become presidents of Mahila Mandals, so that health and gender messages could be accepted and implemented for pregnant women.

Based on the success of these camps, several demands were received for their replication. However, due to the constraint of not being able to reach out to each village of project areas, CHETNA initiated 'Organisers Training' where health workers were trained to broaden their role enabling them to organise such camps and effectively follow-up on the same in their respective areas.

3.2 Organisational evaluation:

In 1990, CHETNA underwent an organisational evaluation facilitated by the Society for Participatory Research in Asia (PRIA), New Delhi. Based on the lessons learned from this CHETNA shifted their approach from ' **MOTHER** AND CHILD HEALTH ' to '**WOMEN** AND CHILD HEALTH' (in the life cycle) .

3.3 Capacity Building of CHETNA team on Gender Concept:

Meanwhile at CHETNA, clarity on gender concepts and planning was built including its practical implication at the community level on various aspects of women's health. As a result, CHETNA trainers own capacities were developed on gender issues including concepts, analysis, planning, monitoring (gender indicators), and evaluation. One of the teams senior members was also specially deputed to a master's degree course in Women and Development at the Institute of Social Studies, The Hague,

[1] Dakan: Generally in villages widows and infertile women are considered bad women and blamed as 'Dakan'. They are not allowed to go to any celebrations. ?It is also considered that her evil eye is bad/harmful for infants and young children and therefore she is not allowed to visit in any family of the village. Even her own family members disregard her. In extreme cases village leaders throw her out of the village and claims her property. (eg. agriculture land

Netherlands. Other team members also participated in short term courses organised by FAO/Jagori, New Delhi and other workshops organised for experience sharing.

3.4 Building of CHETNA's Vision, Mission, strategy, activities:

CHETNA's gender integrated vision and mission for women's health and development was developed by the team members.

Vision: CHETNA envisages an egalitarian and just society where empowered women and children live healthy and happy lives.

Mission/ Goal: To enhance women's health status by empowering them to gain control over their own health and development.

Strategy: To support GOs, NGOs and other autonomous agencies that work in the states of Gujarat, Rajasthan and Madhya Pradesh (M. P), India, by strengthening their capacities to implement and manage effective health and development programmes for women and children.

Activities: Activities focus on awareness raising and sensitising, capacity building of organisations, documenting experiences, developing/disseminating education/ training material, networking and advocating on issues concerning children and women.

T ay gender is weaved in all our activities.

3.4 Gender training plays and important role: Gender training at various levels is an important aspect in order to integrate gender at the programme level. CHETNA builds capacities of middle level workers including supervisors. However for training to lead to change, it has been realised that if leaders must be sensitised to gender concepts, so that middle level workers can understand and implement the concepts in their own organisations or at the community level.

Gender Sensitisation Trainings for Leaders:

CHETNA builds capacities of middle level workers including supervisors, however it has been realised that if leaders are not sensitised to gender concepts, middle level workers can not implement the concept and understanding at their own organisation/community level. Two days module has been developed for leaders which

starts from a macro perspective and moves to the micro level. Status of women, men in Rajasthan, Gujarat, India, It's reasons, concept of gender, patriarchy, importance of gender planning and action from self, organisation and community at large.

Gender Development Training for Second Line Leaders and Middle Level Workers:

Middle level workers from the same NGOs are trained and equipped to plan health programmes from a gender perspective. Some of CHETNA's training reports give an in depth discussion on this. The basic aim is towards building an egalitarian society where both women and men have equal opportunities, power -sharing and choices in life. However women are more discriminated against in the Indian patriarchal society, therefore most efforts and activities are aimed to empower women in order to inere their bargaining power. A six to eight day module has been developed. The module starts with self reflection of gender and moves to gender concepts and relations, patriarchal structure, empowerment and planning of health programmes with a gender perspective. Gender sensitive women's health planning is done in of life cycle approach (before birth, childhood, adolescent, adult and after 45 years of age) .One example is given from a planning framework developed by CHETNA team members and participants..

The following issues are taken into consideration while planning. Gender issues, concerns and reasons, area of action (self/family, community, own organisation, media, education and government/politics level), desired outcome from strategic planning, priority actions to be taken and resources required for implementation. Generally changes (gender integration) are suggested within existing/ongoing program.

Desired outcome priority actions : Gender sensitisation for decision makers of GO/NGO, media, educational institutions, doctors, etc. Strict legal action against dowry, e.g. socially bycot such families and legal punishment, all senior citizens to get a pension.
After this planning feasibility, resources required, skill and time required discusses in detail.

Gender sensitisation training for middle level workers and their family members:

As already mentioned gender change has to start from one self. CHETNA team also realised the need to have common understanding family members to facilitate this process of change. These families can act as role models for their own organisations and communities. Therefore a workshop with significant family members was organised.

3.5 Participation as Resource Persons and Experience Sharing:

CHETNA frequently participates in seminars, workshops, meeting to share its gender and women's health training experiences and its ideology at the state, national and international level.

Resource person to develop Gender and Health Module: Orissa has one of the highest rates of infant morbidity and mortality. OXFAM is actively collaborating with GOs/ NGOs to enhance women's health status. In this regard during December 1993, a workshop was organised by OXFAM to develop a strategy for identifying and addressing women's health concerns, collectively seek solutions for the same and finally to formulate a gender based action plan and modules for capacity building of workers. CHETNA team member was one of the resource persons who integrated the gender component in the women's health module for further trainings.

Similarly OXFAM, U.K. had organised the third regional meeting at Bangladesh. The aim of this meeting was to initiate action to enhance women's full participation in the process of strenthening gender strategies, build gender awareness, facilitate sharing of efforts for communication on gender and consolidate understanding on current priority issues as seen by development practitioners. A CHETNA team member actively participated in this meeting to share views on 'Gender Strategy' through health education.

Before birth of a girl child:

Gender issue: Sex determination (if foetus is female, it being aborted)
Health Concerns due to above gender issue: Lower sex ratio of women, violation of human rights, complications may arise due to abortion, unsafe abortions and emotional stress to women due to abortion.
Reasons for practising the gender issue: Lower social status of female, social practices such as dowry, parents cannot stay at daughters home in old age (patrilocal and patriarchal families), myths such as if last rites are performed by a son person goes to heaven, son continues family line.
Who perpatuate these practices: Mother-in-laws, husbands, mothers themselves, religious leaders.
Who perform sex determination test and abortions: Doctors, nurses, Traditional Birth Attendant
Area of Action:

Self	Family	Community
Even if I already have a daughter I will not go for sex determination testing during next pregnancy	I will try to convince and influence family members to stop this practice. Try to create awareness among them	Awareness of legal strategy for ban of sex determination. Punishement if this practise is followed including for TBA.

Changes in attitudes/practices are needed in the following institutions/peoples:
Doctors/Nurses: Enhance awareness of existing legal bill against sex determination. Social awareness to discourage this practice.
Media : Information on sex determination bill, programmes which enhance women status and equality, articles in newspapers.
Education : Text books emphasizing equal importance of girl and boy, status of girl child and women.
Government/ Political parties : State security for old people, awareness campain to enhance women's status and existing of legal bill against sex determination.

CHETNA was an active team member for developing a Resource Kit on Women-centered and Gender- sensitive Experiences: Changing our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific it was specifically aimed to share experiences, lessons learned and contained practical tools on the "how" aspects of changing population, health and family planning policies and programmes to become more women-centered and gender sensitive and to encourage the full implementation of the International Conference on Population and Development (ICPD) Programme of Action (POA), Cairo 1994 and the fourth World Conference on Women (FWCW), Platform for Action (PFA) Beijing, 1995.

3 Documentation and Dissemination of Experience: CHETNA conducts training mainly in the states of Gujarat and Rajasthan and some international invitations are also accepted. In order to share CHETNA's experiences, learning and ideas widely, CHETNA document and disseminates experiences in regional (Gujarati), national (Hindi) and English language. Recently CHETNA 's documentation centre has been reclassified by the 'Akshara System' a feminist system of classification appropriate for women needs.

Reports: Gender concerns and planning reports have been documented and widely circulated. CHETNA has a documentation center and separate classification on gender. Bibliography of reference material on gender is also available.

3.7 Reference material: CHETNA is actively involved in the preparation of reference material especially in the regional language. At present most of the gender material is available in English. CHETNA adopts the same in regional languages. A status paper on women and men (Gujarat, Rajasthan, India), A status paper on women and men (South Asia), and a Gender and Development manual are some of the examples.

A manual on gender sensitive indicators is developed for reproductive health programmes in India. This manual has been developed to assist the health functionaries, including programme manager, health policy makers and those influencing health policy and programmes, in measuring how well gender concerns are being integrated into their health programmes.

3.8 Publications: CHETNA tries to integrate gender aspects in all its publications. There are some publications specifically emphasizing on gender aspects. Some of the material developed were, ' A set of gender and health pamphlets', Poster on the eve of International Women's day, a set of flash cards.

3.9 Research: CHETNA has recently undertaken to conduct a research study in Women and Health (WAH!) training.

3.10 Collaboration with Other Organisations and Networks: It is necessary to work with networks for the broader impact. CHETNA was active team member to develop a Resource Kit on women- centered and Gender sensitive experiences: Changing our perspective, policies and programmes on women's health in Asia and the Pacific specifically aimed to share experiences, lessons learned ..id containing practical tools on the "how" aspect of changing population, health and family planning policies and programmes to become more women-centered and gender sensitive

CHETNA is also an active member of 'Health Watch' whose aim is to promote and advocate gender sensitive women's health policies particularly reproductive health.

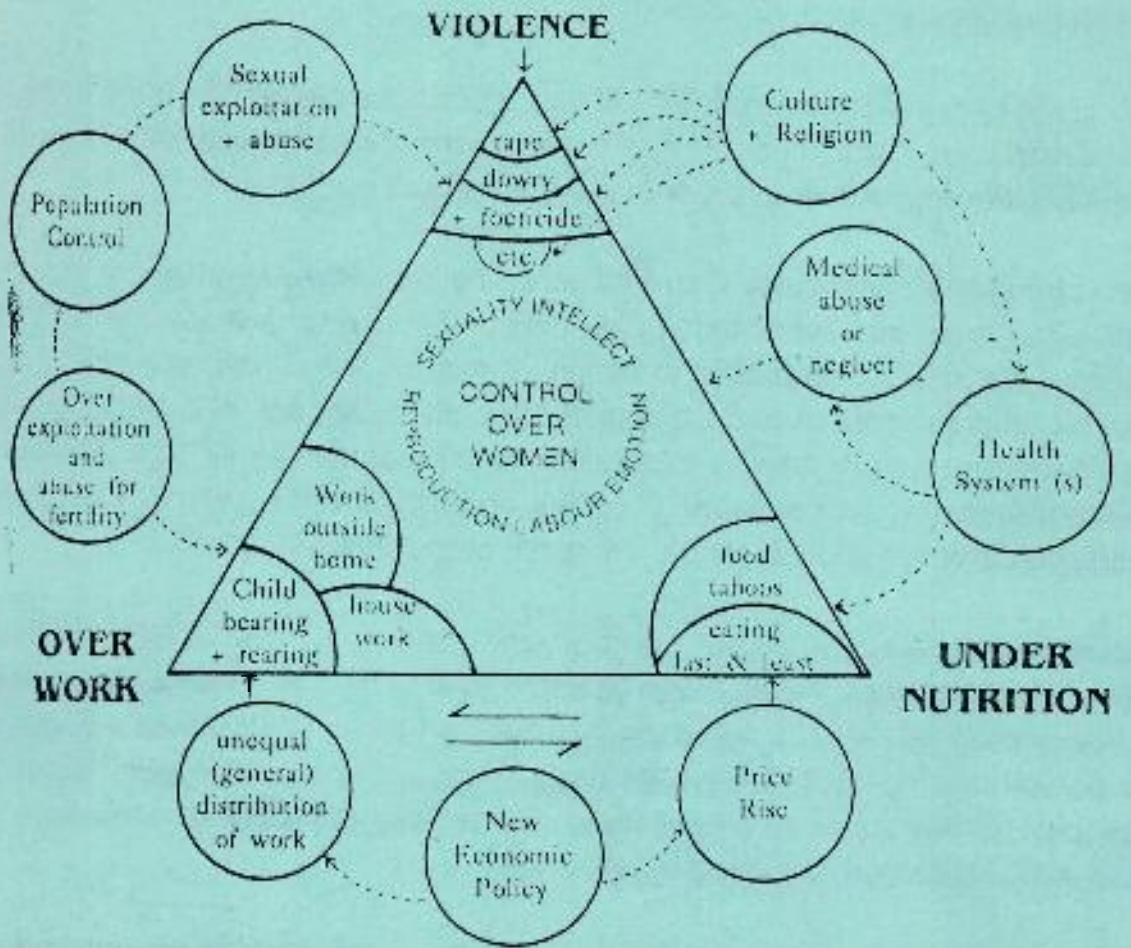
3.11 Advocacy: CHETNA is actively involved at the policy level to advocate gender issues. For e. g. CHETNA is involved at NGO level to recommend and include women's concerns for a draft policy on women's empowerment. Also CHETNA participated in pre-Beijing meetings in an NGO forum to draft a United Nations Platform for Action. In various workshops and forums CHETNA makes special efforts to advocate women's health from a gender, holistic, integrated and realistic perspective.

3.12 Special Efforts: Convention for Elimination of discrimination Against Women (CEDAW) is a United Nations forum where efforts wree made to eliminate all discrimination against women legally and socially. The Indian Government has also ratified the CEDAW. However not much active action has been taken as yet on the same. Indian NGOs decided to prepare an alternative report to highlight discrimination against women in all spheres of women's lives. CHETNA was actively involved in compilation of Discrimination in Primary Health Care (Article 12).

4. SYNTHESIZING CHETNA' s LEARNING THROUGH WAH! TRIANGLE:

Over the years CHETNA team members have made efforts to develop a gender and health perspective. Which would be more clear with this figure which was developed by WAH! network members. CHETNA is a active member of this network and secretariat for the western region of India.

WAH! triangle



WAH! stands for Women and Health which is a multi-national programme for comprehensive, gender sensitive, sustainable primary health care for all with special emphasis on women and girl children and all other disadvantaged persons, throughout the life-cycle. Gender is one of the key components of the WAH! training.

5. LEARNINGS:

To emphasize learning from gender integration efforts is a key issue recommended for gender sensitive women's health policies.

Gender relations can not be seen in isolation: Gender differences varies according to class, caste, age of women, marital status, single women, widow, non-fertile women, mother of a son, position of women such as mother-in-law and daughter-in-law etc. religion, geographical region, generations etc. Therefore centralised strategies may not be effective. Specific strategies for the specific condition/situation will have to be developed and implemented.

Life Cycle Approach: Gender inequalities regarding a girl child starts even befoi birth and continues throughout the life cycle. Therefore it is necessary to address the women's health programme using a life cycle approach.

Gender change is a process: Gender cannot be implemented in one's personal life through a single event workshop or training. It needs self modeling and time to internalise learning. Frequent orientation is required for it to become a practice.. Programme implementation and training is only an intervention to start the thinking process which may provocative participants to take action for change to achieve the objective of humanity and equality. Frequent orientation through workshops, trainings, seminars, conferences and educational material may enhance this process.

It is a slow process : Some Indian socio-cultural practices which result in unequal power relations particularly related to decision making and resource sharing are deep' rooted in households for many years. Historically not a single example can be seen where power relations are changed within a short duration. Therefore the process to change these power relations among men and women, class, caste, may be very slow and one needs patience to understand this process.

It is a multi dimension process : Questioning of self is very important and frequent orientation through workshops, trainings, seminars, conferences, educational material means integration is necessary by various ways to enhance this process.

Starting from self : The experiences of CHETNA team members for more than a decade of integrating gender, clearly indicates that since gender is a socio-culture construct it should start from one self and one's family. This is the most difficult aspect to put into practice.

Strategic Involvement of men: Gender applies to both women and men .
At present, decisions are laying with men and this has direct implication on women's health, for example whom to approach during illness and how many children should be born. Therefore at least at the initial stages it is wise to involve men and other decision makers of the family (mother-in-laws) and community members
(eg. sarpanch) to enlist their support.

Sexual Division of Labour: Gender operates as an organising principle in society through the sexual division of labour, whereby men and women are allocated different es, responsibilities and activities based on societal ideas of capabilities and appropriateness. Although both men and women can be involved in productive and reproductive activities, reproductive or household maintenance activities are largely the responsibility of women. Due to the double burden of work effects can be seen on women's physical and mental health, which we have already seen in the WAH! triangle.

Household as the basic Unit: It was learned that women have less access than men to three key groups of resources - economic, political and time, all of which are required to achieve development. Women also have limited access to the returns and benefits of these resources. This differential access limits women's ability to participate in and benefit from project activity. Access to all three groups of resources must be considered in programmes that aim to involve and benefit women.

osition and Conditions: It is necessary to address both the day-to-day condition of women's lives and this will improve access to health care and enhance women's capacity to make decisions for their own health, reproduction and position .

Needs Patience: Trainers and programme implementers need patience to listen to concerns especially from men they should also have a clear understanding in order to explain reasons to them logically.

Gender is not a blue print concept, it is a social concept where people understand reflect and analyse their experiences of life/work. Therefore during the implementation of a women's health programme the implementors needs patience to listen to concerns, especially from the men of the community. and men involved at the programme level.

6. RECOMMENDATIONS:

To make the women's health programme gender sensitive and more meaningful CHETNA suggests following recommendations from their learning to strengthen existing programmes and to plan new policies and programmes.

Holistic Perspective: Policies and programmes should be implemented in a holistic nature. It should consider the totality of social, economic and political life in analysing the forces which affect women's health. The programmes should examine and addressed social attitudes, behaviour and practices which affect both the productive work and reproductive work of women, less food intake, physical and mental violence and its impact on health conducive work, environment and sharing this work by other family members, provision of support services, empowerment of women.. It should also address the relations of power and dominance at the household, community, organizations.

Addressing Gender Relations: Programmes/Policies should not focus only on women, but on the relationship between women and men, powerful women and powerless women, because understanding this structure and dynamics is crucial for progress. These relations may be different according to region, caste, class, age and marital status of women. Therefore participation of men in women's health programmes is a key component.

Household as the basic unit: The programmes should recognise that the household is the basic unit of social organisation. This would help to clarify gender relations, the sexual division of labour, reproductive and health care decisions. Dynamics and relations within the household have a major impact especially on women's reproductive health.

Women's health programme should be process oriented rather than event oriented: As we have experienced, gender change is a very slow process therefore the programme should be strategically planned and they should be process oriented.

Addressing to various social institutions: Institutions of society such as family, education, knowledge systems, legal systems, media, political and government infrastructures, economics institutions, religions are patriarchal institutions which provoke gender inequalities need to be addressed simaltenously.

For e.g. Media always encourages oral pills rather than condoms. Religion increases the importance of a son which results in too many too close pregnancies which result in poor health. Most government policies and programmes encourage women as 'mothers' 'Single' and 'Non-fertile' women do not have much place in these policies and programmes.

Gender sensitisation of all actors of society: These include →

Programme Level: Starting from policy makers to programme planners, managers, middle level workers to grass root level workers is necessary.

Institutions level: Doctors, religious leaders, advocates, media people, politicians, reaucrats, business men and women, corporate sector, pharmacist, all the functionaries of government departments e.g. health, women, environment, education social development etc.

Community Level: Teacher, Traditional Birth Attendant, witch doctor, sarpanch, and panachyat members, community leaders, Anganwadi Workers, Health Workers, youth/adolescent, children, other influential members of the community.

Family Level: Men (husband, father, brother, brother-in law), Women (wife, mother-in-law, daughter-in-law, sister-in-law, sister), children (daughters, sons).

Active Partnership of GO, NGOs, Corporate sector and Women's Health movement, reserchers, academicians: Since all of these have the same vision and mission of a happy and healthy community, it is necessary to come together to speed up the process of empowerment, so that women can have control on themselves, their families and communities health. Active partnership from planning to implementation, process monitoring and evaluation is needed.

Srategic planning/methods to address gender concerns: As already mentioned,our ultimate goal should be happy and healthy women, men, families and communities. At the initial stage, it may be advisable to start meeting/discussions separately with women, because from our experiences, initially women do not speak in-front of men (they are not even ready to remove their 'Purdah' (veil) especially if older men of the family and community are sitting with them. After raising their confidence, they themselves would be come ready to talk in-front of men.

Effective Information System: For an empowerment process, it is necessary to provide correct information at an appropriate time and in an acceptable manner. For this purpose, information systems should be strengthened so that people can receive the

information in simple/local languages regarding policies/programmes and the procedures of implementation. In addition, the effective channels to communicate gender concerns to programmers and policy makers are needed.

Developing appropriate gender sensitive and need based IEC material and medias: Appropriate need based, and field tested IEC material plays an important role in addressing gender concerns. It was learned that modern technology such as electronics media has not yet reached remote areas, nor are technicians available in case of technical failure. Kits on issues such as anemia, gender and health pamphlets, posters, flash cards are found more useful flexible and effective and people can control their use as well.

Since more than 60 percent women are either non-literate or neo-literate, the educational material should be in clear, simple and locally appropriate illustrations with minimum content in big letter size.

Gender Integration in all Policies/programmes: As we have seen since all social institutions reflect women's health and lives, it is necessary to integrate gender besides health policies, such as policies on agricultural, nutrition, economic, environment etc.

Gender Sensitive Indicators : To monitor gender integration and its impact it is important to develop gender sensitive indicators in programmes.

Decentralised planning and decisions: Since gender is not a blue print and universal all over India, specific differences due to class, caste, age, marital status, mother of a son etc it is necessary to have planning at the panchayat level to address these specific needs.

Conclusion :

Gender construction and relations directly affect women's health. Therefore it is absolutely necessary to have gender sensitive policies and programmes to empower women so that they become capable of gaining control over their own, their families and communities levels.

LINKAGES OF WOMEN'S HEALTH AND GENDER

Age	Gender Issues	Impact on Health	Reasons
Before Birth	Sex determination (If foetus is female it being aborted)	Lower sex ratio Violation of human rights Complication to women due to abortion & mental shock	Lower social status of women Dowery Parents cannot go and stay with daughters in old age If last rights performed by son goes to heaven Son continues family l line
Early Childhood	Discontinuation of breast milk in early months	Lower nutrition status (undernutrition)	If breast milk stopped chances of pregnancy will increased to produce son
Child-Hood (1-15 Years)	Discrimination in food & health care service Responsibility of house hold work & child care	Lower nutrition & health status Complications due to lack of health care services	Secondary status of girl child Socially girls are responsible to help household work Preference to give all the confort food, best health care to son due to patriarchal society.
Adolescent (10-19 age)	No information on menstruation. Early Marrige Lack of decision power to get pregnant Abortion Responsibility of household work	Disturbed mental status. Anemia & weekness. Too early too close pregnancies RTI & prolapse of uterus, STDs	Lack of awareness due to socio-cultural practices & beliefs(about own anatomy & physiology of own body) Lack of control over own body, life. Lack of decision making power Lack of economic empowerment
Adult (20-45 age)	Violence Less access to health care services Overburden of social reproduction & community work Eat last and least Can not talk of own sexuak needs contraception is only women's responsibility	Emotional & Physical distarbance High maternal, Morbidiy, communicable diseases rate Weekness emotional disbalance Lower nutritional status Heavy bleeding, harmonal disturbances & side effects	Poor socio-eonomic status No security Lack of decision power Lack of facilities at household/ work place e.g. Kitchen, toilets In policy/programmes women is seen only; pregnant and lactating mother. Lack of economic, social & political power.

To understand the impact of gender issues on women's health (in a life-cycle). . Such analysis was critically understand and developed among the CHETNA Team.

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WR 11; 9.8

"Towards Comprehensive Women's Health Policies & Programmes"

STATUS OF WOMEN'S HEALTH : BIHAR

Sr. Elise Mary
Sacred Heart – Bettiah
Bihar

From experience of patriarchal family the men are supreme. They may pretend all they like that it is not they who want dowry, it is their wives (the mother-in-law); or that it is they who want to kill the girl babies, it is their wives. But the fact remains that it is the men who have the power, even within the families. If the husband was to say to his mother "my wife should not be ill-treated", there is no way the mother-in-law can continue to subject her to repeated ill-treatment. Similarly if the husband (or the father-in-law) was to say "I don't want my baby daughter (or grand daughter) to be killed", who will dare to kill her ? But in my experience with female infanticide, the men never killed a baby girl themselves. They hide themselves from the crimes !

I think it is time Indian men take a stand on dowry, on female foeticide, on all the violence on women and girl children. It is time to stop to perpetuating the myth "women are women's own enemies". They may appear to be; but there are several reasons for this. The mother-in-law has not had an education, she has no cash in income in her hands, no 'job', her marriage has been bad, she has not had a companionship with her husband; her only real 'meaning' in life is through her son, so she remains very possessive.

In a survey in Bihar of 100 educated and working mothers-in-law (e.g. teachers) and 100 illiterate mothers-in-law had very good relationships with their monther-in-law; 98 of the illiterate mothers-in-law daughters-in-law talked of substantial ill-treatment.

STATUS OF WOMEN

Health status will also depend on the general status of women in the society. They are discriminated in rearing education, employment, wages and health care. Social and sexual violence make them vulnerable. They should be given their share and place in society so that they can make their own decision about family planning choice, health, vocation etc. In Kerala an economically poor state, the status of women and their health is beat due to socio political awareness there.

"Decisions are made on women's health in the patriarchal system and by men in the primary health care delivery system. And women's health depends on girl children's' and adolescent girls' health".

"She becomes adolescent and young woman, she cannot decide how many children she should have without this information and knowledge."

"The next part of the net is poverty; without livelihood skill-training, income generation and employment –generation, poverty leads to malnutrition. Land is not owned by the majority, there is no political will to implement equity considerations. Poverty leads to more ill-health."

EDUCATION

The overall literacy rate of Bihar has increased from 19.9 per cent in 1971 to 25 per cent in 1981 and 38.54 per cent in 1991. Even then it is one of the lowest in the country. Female literacy is far below that of the male.

Education for girls and women has never figured as a priority for many people in the State of Bihar. Overall literacy levels, current enrolment rates and male-female disparities continue at levels far worse than the averages for India. Female rates extremely low.

Literacy (Above 7 years)
Female

	1981	1991
All India	29.8	38.54
Bihar	16.5	23.1

The average female literacy rate is 23.1 per cent in 1991 (GOI, Registrar General, 1991) having increased from 12.2 per cent in 1971 and 17 per cent in 1981. Not only is the literacy level considerably lower in Bihar, but also the pace of change is slower than in the rest of India.

One probable reason particularly for girls not going to school or for their rapid dropout relate to women's overall status in society which allows little value to be attached to educating girls. Socially conservative parents do not want to send their daughters to schools staffed by male teachers and as girls approach menarche they are withdrawn from school and they are married.

The percentage of female teachers in Bihar (18 per cent) is far below the all India figure of 30.56 per cent. The share of teachers belonging to Scheduled Castes and Tribes – in primary and upper primary schools – is also far less than their proportion in the population.

The poor performance in the educational field is partly due to poor allocation of resources to education, which is one of the lowest in the country. Of this about 85 per cent goes to the payment of salaries and allowances; the amount left for development of the quality of education is very little.

"Why should I waste my time and money on sending my daughters to school where she will learn nothing of use? What does the Hindi alphabet mean to her?

Too much of schooling will only give girls big ideas and then they will be beaten up by their husbands or be abused by their in-laws."

SOCIAL FACTORS

One important social factor affecting participation in education is early marriage. Through girls now marry at an average age of 17, pre-pubertal and child marriages are not uncommon.

Parent's willingness to send girls to school depended on whether certain facilities are available such as more girls' school, more women teachers and nearness of schools to their homes, better transport and toilet facilities. While the latest government document states that 95 per cent of the population is within a kilometer of a primary school is concerned, the same document admits the lack of vital facilities in schools such as potable water, buildings, blackboard and so on the document further noted that though the rural sector caters to a much larger segment of the population relatively, expenditure on this sector is comparatively much lower than the money spent on urban schools. The question of facilities acquire particular important in rural areas as it is linked to the urgent need to reach out to village girls.

NUTRITION

Based on the investigators' observation, it is found that the nutritional deprivation suffered by young mothers are acute and range of infancy to pregnancy. The infant mortality rate which is quite high in the study areas conforms that due to nutritional deprivation, female child morbidity is very high.

If we glance at the nutritional programmes, they are aimed at pregnant and lactating women. But what about the nutritional deprivation suffered by girls and women? Undernourishment may not lead to death but there is increasing evidence that undernourished children will grow to adulthood stunted physically and mentally. The undernourished mother will give birth to a premature child in birth weight, length and maturity.

AGE AT MARRIAGE

Marriage is considered an essential requirement of the social and cultural life of an individual in India. Unlike in western societies, where marriage is considered contractual arrangement between husband and wife, in India it is considered to be a sacred life - bond and brings together two families in a close relationship. The marriage of the daughter at young age either immediately before or after menarche is considered an important duty of parents. Child marriages are widely practiced in sizeable numbers in Bihar. As such, age at marriage and percentages married among the different age groups among females influence to a considerable extent the levels and trends of fertility.

The present mean age at marriage is 18.66 years for girls, which is just about the level at which the period of optimum safety for reproductive activity commences; but there is no cause for complacency on this score.

In the state of Bihar proportion of those married in the age group 15-19 remain as high as 64.06 or roughly 2 out of 3 girls in the 15-19 age group. This mean age of marriage in state of Bihar is only 17 per cent. In Bihar it is rate for the girl in her teens to remain unmarried.

Early marriage for girls are sought to preserve the chastity of the girls and secondly to ensure their subordination to the bride-groom's family.

The mean age at marriage for females as per the 1991 census (Bihar) is 17 which is lower than the national average which is 18.32. The study findings also show that adolescent marriages are common in this place. 13.42 per cent of the girls are even before completing 12 years, next 30 per cent are married within the age group of 16-20 years. A big proportion of women in the age group of 12-16 are married and they constitute 55 per cent. The custom of early marriage insured that the girls learned the tradition of the new family, and transferred loyalties to the new home.

AGE OF PREGNANCY

The age at marriage determines the age first pregnancy. The data show that 17.63 per cent get their first pregnancy as early as 16 years. A substantial 60 percent of the women have entered the childbearing role between the age of 17-20 years. The women entering the child bearing role has almost declined as they are entering 26 years and onwards.

The changing patterns of economic development have placed a heavy burden on women which has been reflected in their health status. The marginalisation of farmers, landlessness, forced migration (temporary and permanent) have undoubtedly affected women's health and nutritional status.

Women are working in industries like tobacco, biri-making, textiles, garments, fish processing, agriculture, pesticide application fertilizer application, spice growing and processing, jute growing and processing, seri culture, bambo work, betel leaf growing etc. In all these industries they toil long hours at low-paid, unskilled jobs. Hence there are health problems related to the work-place, hazards of pollutants on women who work during childhood, adolescence, pregnancy and lactation that can be dangerous both to the women and the foetus. There is very little information about the safety levels of these harmful substance and more often the damage done includes TB, allergies, abortion, bronchial disorders, death of unborn child, anaemia, toxicity, disfiguration etc. Hence women have been exposed to new kinds of health hazards.

Women perform a lot of other activities that are energy consuming-cooking, collecting fuel, fetching water, looking after cattle and other animals, unpaid work on the family farm or in family craft and child care. Calorie needs for women are calculated without regard to actual work burdens of women, but even these norms are not generally fulfilled for women and girls as they eat considerably less than their requirements. Malnutrition aggravates diseases, increases risk of infections and reduces resistance to various diseases. Yet ironically women do not ever consider themselves ill.

SON PREFERENCE

On examination as to the sex of the child preferred their strong desire to have at least two to three male children. This further reinstates the fact that rural households child bearing has continued mercilessly until one or two male children are born as per their desire. This means that couples would wait even if they have a string of five, six, even seven or more daughters first. On the other hand to identify even one home which has as many sons and a youngest daughter whose late arrival has been the reason for repeated pregnancies and with those birth child bearing comes to an end.

Number of children desired and their preferred sex composition is a reflection of women's status or the extent of gender inequality. The kinship structure prevalent in this region lays great value on reproduction in general and sons, in particular.

Base line studies in Bihar report family size desires of between 3.5 and 4 children, of these, about 3.5 must be a son.

In the patriarchal family structure of this region an important means through which a young women achieves prestige or recognition in her husband's home is based on her fertility in general and the birth of a son or two in particular. Preference for the male child is not an exception to the state of Bihar. Several studies have come out with findings that almost all societies value sons more than daughters and exhibit son preference or preference for the male child. Son preference is both a cause and a consequence of the low status of women. It is a consequence because it arises as a result of women being considered as playing only unimportant roles and thus being valued less and a cause because this under-valuation in tun has led to lower investment in females as a result of which they are able to play a peripheral role in society-causing a further lowering of their status.

Our study findings clearly show that sons are preferred due to the following reasons.

Religious, economic, old age security and insurance against risk have figured prominently in the demand for children particularly male children. Each of the above reasons can be seen from a conceptual frame work. They theory of demands for children explains that children in general have economic value to the rural households. They serve the households in two ways. One is that they can be directly productive themselves or indirectly contribute to the economic productive process or replace the cost of getting extra domestic help for this economically non-productive work. Children will also have greater economic value in a labour market which is segmented by age and sex. For instance in cultures where women are banned from some kinds of economic activities-the labour of children, especially sons, has an additional value and could theoretically be a motivation for wanting more children. For the country as a whole the level of child labour is high. In principle one would expect the economic contributions of children to be greater in Bihar because child schooling rates are relatively low.

GENDER DISCRIMINATION

In the patrilineal family – a son – is looked upon as the natural successor, supporter and heir of the family. A father is re-lived through his son. Unlike a daughter who is forced to change her loyalties after marriage a son is considered to be a good investment and an insurance for the future. The strong preference for a son has to be understood in terms of three institutions interlinked family – dowry, property and religion.

Gender discrimination has its origin in the socialisation process within the family. This discrimination and sex inequality starts early in a girl's life. Since she has to leave her father's house where she spends a brief spell of her childhood, she was owned by someone and her master controlled her life. Gender discrimination is rooted in the feudal society.

"Girls are not treated equally with boys in the family".

"They are abused and neglected."

"While girls become ill or sick – they are avoided by the family members – doctor and medicines are not given quickly or not given at all."

Girls in our society are considered a liability. So female infanticide and foeticide – barbaric and heinous crimes are on the increase in our society.

MATERNAL MORTALITY (MMR) AND SEX RATIO

The maternal situation in Bihar as well as in India is very gloomy. The MMR which was 400-500 per 1,00,000 live birth in 1976, is still almost the some even after more than two decades. The current MMR of Bihar is 470 against the national average of 453. About 25% of all the death of women in child bearing age in developing countries are due to compilations of pregnancy and delivery in contrast to 1% in USA. About 16000 maternal death occur in Bihar every year, while in India it is 1,25,000. The most common cause of these deaths are : hemorrhage 23%, anaemia 20%, abortion, toxemia and puerperal sepsis. Unless MMR is lowered, their health status can not improve.

In Bihar institutional delivery in rural areas is only 9.5%, though delivery by trained personnel is 13.5%. There is very little facility for referral services to complicated case in Bihar.

Sex ratio is dependent on the health care services, as well as social and cultural factors. The sex ration in Bihar is decling from decade to decade and was 911 in 1991 census, whereas it was 879 in UP, Kerala is only state in the country where it is more than male i.e. 1036.

ANTE NATAL CARE (ANC)

MCH programme was started in the first five year plan for care of maternal and child health. In recent years attention has been focused on them under the UIP,

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CSSM and RCH. Unfortunately, even after four and half decades, there is little improvement in their health, though survival chances of children has much improved due to decline in vaccine preventable diseases. A look at NFHS data reveals that during 1989-90, 62% of pregnant women did not get the ANC services, 17% did not know about availability of such services and 58% did not think it necessary meaning there by 75% of women were not educated about the necessity and availability of these service. How such situation can prevent complication of pregnancy and delivery particularly anaemia, bleeding,toxaemia and even of mother and new born baby,

IMMUNISATION

TT2 immunization in Bihar during 1989-90 to 1993-94 has been only 40-60 though national average have been much higher (70-90%), but according to NFHS it is just 30% in Bihar. The alarming situation is that even this has shown decline in recent years and during 1996-97 it was only 33% after implementation of TFA.

Position of child immunization was better (80-100%) during 1989-90 as per govt. report, by the NFHS report reveal that only 10.7% children got all the vaccine and 53.5% did not get in Bihar. The national average data is much better. However, if we take into account also the potency of vaccine, which is sometime doubtful due to cold chain failure and whether all doses were given in due time, the effective impact may still go down. The performance of 1996-97, has also shown decline (50-top78%) after TFA was introduced.

FAMILY PLANNING

Performance of Bihar has been much lower than the national average, though tubectomy still forms 83-94% of total sterilization. During 1996-97, sterilization declined to lowest of 27-39% and IUD 38-1% Bihar.

UNMET NEEDS

According to NFHS, 25% of currently married women in Bihar had on unmet need for family planning. That is they are not using contraception even though they do not want any more child or they want to wait at least two years before having next issue. On the whole unmet need for spacing 14%) I is slightly higher than unmet need for limiting methods (11%) with the lower performance now, the unmet need is likely to increase.

HOW PRIMARY HEALTH CENTRES ARE FUNCTIONS?

About 2/3rd of total PHC and HSC have no govt. building (1985) in Bihar and are functioning either in private houses or on paper only. During my recent visit to a PHC about 25 km from Patna, it was found that PHC is still functioning in old dilapidated Board building, though a new operation theatre has been added. Only one medical officer was available in OPD out of four Mos, who arrange their OPD on rotation so that others are free on rest of days. Visit to sub centre is occasional. 50% of sub centres are supposed to functions without ANM male Health workers are even much less as state govt. has not sanctioned their post after 1.4.81 In a survey ORG found that in same PHCs MO are available for a few houses only. With such a state of affair of infrastructure and man power functioning hoe quality service can be expected and thus demand generation for quality service appears to be irrelevant. To sum up it will not be exaggeration to say that environment for implementation of RCH is rather lacking in Bihar.

Bihar.

ECC, Bangalore
Oct, 7, 1998

WH-A; 9.9

Annual Report 1997

DSE in Brief

The German Foundation for International Development (DSE) provides a forum for development policy dialogue and offers initial and advanced training of specialists and executive personnel from developing and transitional countries. In addition, it supports experts of German technical and cultural cooperation, and their families, in their preparation for assignments in developing countries (see p. 201), and maintains the largest documentation and information centre on development cooperation issues in Germany (see p. 44).

Conferences, meetings, seminars and training courses support projects which serve economic, social, and ecologically compatible development, thus contributing to an effective, sustainable and wide-ranging development.

The DSE cooperates with partners at home and abroad. A considerable number of the programmes take place in developing and transitional countries, and the rest in Germany. Since 1960 the DSE has given advanced professional training to more than 150,000 decision-makers, specialists and executive personnel from over 150 countries. Every year approximately 10,000 participants take part in the DSE's dialogue and training programmes.

The DSE contributes to development cooperation on the basis of the guidelines of the German Federal Government's development policy. The German Foundation is funded by the Federal Ministry for Economic Cooperation and Development (BMZ). Some of its programmes, however, are financed by other donors (e.g. other Federal ministries, the Federal States, the European Union).

Additionally, the Federal States of Baden-Württemberg, Bavaria, Berlin, North-Rhine/Westphalia, Saxony and Saxony-Anhalt provide conference and training centres and buildings. Since its foundation in 1959 the DSE has been jointly financed by the Federal Government and the Federal States. This corresponds to the German Foundation's decentralized structure with specialized departments (centres) and conference centres in a number of Federal States. The seat of the Foundation is Bonn. The Executive Office, the Development Policy Forum, the Print Media Programme, the Central Administration, and three centres are located in Berlin. Other locations are Bad Honnef, Feldafing, Zschortau, Magdeburg, and Mannheim.

DSE Instruments

The DSE's advanced training events are planned together with partner institutions in the developing and transitional countries and, when they take place on-site, are also implemented with them. The events include:

- **Short-term programmes** lasting up to three months in Germany or abroad, e.g. seminars and training courses for middle management specialists and multipliers, international meetings and expert discussions for high-ranking executives and political decision makers. The programmes also include the secondment of programme officers to support advanced training institutions in developing countries or scholarships for congress trips to take part in the North-South exchange of views.

- **Long-term programmes** lasting between three and 24 months in Germany and developing countries. These programmes with their focus on practical professional advanced training are offered as part of the Federal government's scholarship programme, and in direct agreement with professional institutions of the partner countries, to specialists and executives in the government and non-government sectors.

The short-term and long-term programmes are offered both as project-related and non-project measures.

Combinations of programmes from the short-term and long-term areas, mutually agreed with partner institutions and covering a time-scale of several years, are called **programme packages**. This bundling of different DSE instruments enables a systematic contribution to organizational and human resource development in particular. Programme packages are eminently suitable to support structural change and to achieve the sustainability and broad impact of DSE work. Examples of programme packages are:

- Promotion of local government in Chile and the Philippines
- Training programme for regional planning and project management in Indonesia
- Advanced training of teaching staff for the public health sector in Tanzania

So-called **follow-up contact measures** with former participants of DSE programmes serve the exchange of views and the updating of professional knowledge. The DSE thereby also promotes the sustainability and broad impact of its events.

Public Health Promotion Centre (ZG) – Berlin

The Public Health Promotion Centre (ZG) is the youngest work unit of the German Foundation for International Development (DSE). It was founded in 1991 after the DSE took over the support programmes for scholarship holders from the former GDR.

The ZG collaborates with governmental and non-governmental organizations in the countries of the South in the planning, implementation and evaluation of its programmes. The leading partners are primarily public health services and the training and advanced training institutes used by them. In Germany, the ZG works closely with the Institute of Tropical Hygiene and Public Health (ITHÖG) in Heidelberg, the Health Department of the German Agency for Technical Cooperation (GTZ), the Berlin Senate Health Administration, and the Land Institute of Tropical Medicine in Berlin. Other partners are professional German institutes in the field of public health and/or tropical medicine. At international level the ZG has working contacts with UN agencies and the leading European institutes for public health in the tropics.

The ZG has a harmonized set of programme instruments available for each area of its work. They include:

- Dialogue events
- Training courses
- Long-term scholarships

The notification of ZG events is undertaken by invitations for applications through the German diplomatic missions in the partner countries. The selection of the participants is coordinated with the partner organizations.

Objectives

The work of the ZG is based on the concept of Primary Health Care (PHC) which was formulated at the World Health Conference in Alma Ata in 1978 and adopted by all member states of the World Health Organization (WHO). This concept covers health-promoting services, prevention and rehabilitation and the treatment of diseases.

The objective of ZG work is to assist the developing countries in the implementation of the PHC concept. ZG measures are complementary to the own efforts of the partner countries and the activities undertaken in German and international development cooperation. The following programme approaches are applied to attain the objective:

- Presentation of basic experience and problem-solving approaches in the introduction of the PHC concept. Both South-South dialogue and South-North dialogue are strengthened in conferences and seminars.
- Improvement of the organizational and management skills of leading health officers at district level and other health service providers (e.g. women's organizations) through the development of standardized model training courses which can be tailored to national or regional needs as required.
- Advanced training in basic curative health care techniques (e.g. district surgery), support for effective – in developmental terms – professional integration of medical staff trained in Germany in the health services of the developing countries (physicians programme).
- Promotion of human resource planning, development and management in agencies responsible for health care in the developing countries.

Photos: Andreas Nitsch

The staff of the ZG

Target groups

The advanced training courses of the ZG are particularly addressed to:

- Decision makers in the field of primary health care who

deal with the preparation of basic and wide-ranging concepts (e.g. health ministries, planning ministries, finance ministries, provincial administrations, organizations financing sickness insurance and health care)

- Staff in the technical and administrative departments of training institutes in the health sector
- Members of the district management teams and the structures above them at province level
- Persons responsible for personnel planning and development in health offices and other health care agencies
- Organizations working with municipalities, enterprises, patient and user groups and consumers in issues related to health

In order to improve the contribution of women in keeping with their key role in the health sector, the programme partners are requested to give more consideration to women in the selection of participants and the design of programmes.

Priority work areas

The ZG works in two sections: **Section 81, "Basic issues of health policy"**, organizes seminars and international conferences. It is also responsible for the implementation of the **physicians programme**. The Section has the following work areas:

- Financing of public health, local financing, user participation and health insurance systems
- Drug policy and drug control
- Professional integration through the physicians programme
- Promotion of local experts

Section 82, "Primary health care", deals with the model development and implementation of advanced training schemes at district level. As many countries are introducing decentralization of tasks and decision-making powers in the health sector, personnel management and human resource development are gaining importance. The Section has the following work areas:

- Planning, management and financing of PHC at district level
- Training and advanced training of trainers for medical personnel
- Curative services in the district hospital
- Rehabilitation and orthopaedic techniques
- Reproductive health
- Promotion of non-governmental organizations in health care, particularly women's organizations in the health sector

International Dialogue

on the Financing of Health Care
The Example of Germany

Dr. Walter Seidel, Director of the Public Health Promotion Centre

German public health in the discussion process

There is a widespread malaise in the German public on the situation of the public health system and its reforms. Various catchwords, most of them with a negative connotation, are an expression of this, e.g. cost explosion, lack of efficiency, little transparency, hightech machine-dominated medicine, etc. This basic pessimistic attitude often goes hand in hand with the assumption that little can be learned from the German public health system, and certainly not by developing countries.

In contrast to the criticism voiced by the German public, there is the basically positive assessment by German professionals from highly different circles and disciplines, and the growing interest of international experts. In particular, the more economically advanced developing countries are interested in the experience of how the typical world wide problems of health insurance and health care delivery plus their financing are solved – or not solved – in Germany.

Interest of the developing countries

The interest shown by public health experts and politicians from developing countries in the German public health system touches various aspects:

- The combination of private and public providers which are financed by statutory state-regulated but non-governmental health insurance schemes ("Bismarck model") is an attractive alternative to the purely government-run health care delivery and financing models ("Beveridge-System" in the United Kingdom) and the mostly private delivery and financing models found elsewhere (e.g. USA).

- In a comparison of industrialized countries the German per capita expenditure on public health lies somewhere between that of the USA and the United Kingdom. Foreign observers feel that this could eventually be an acceptable compromise – also in terms of costs – between the two opposite systems.

- The pluralist structure of the German public health system means, on the one hand, that single powerful interest groups cannot get control easily, but it also means that reforms take quite some time. A review of such a system of checks and balances can give ideas and suggestions for alternative structures in the developing countries.

- The development of the rates of contribution for statutory health insurance since 1950 illustrates both the long term rising trends (1950: 6% - 1995: 13.2%) and the efforts to stabilize the level of contribution (whereby the percentage share of health expenditure in the GNP remained constant during this period): Every downturn of the curve or every check in the rise reflects the application of a reform measure.

This type of a permanently ongoing health reform, conducted over decades, can be analyzed in order to identify the successes and failures of the individual measures and to develop assessment elements and criteria for the reform measures to be introduced in a given country.

Necessity for dialogue: central topics

For several years the term "health sector reform" in international debate has contained very different concepts in relation to very different problems:

- Firstly, rigid monopolist state structures have to be broken through the introduction of more *competition* between public and private service providers and more choice for the users.

- Secondly, an attempt is made to influence uncontrolled de facto privatization of collapsed public health services through *regulatory intervention* and the organized efforts of local authorities, and to make them more effective and socially just.

- Additional sources of financing have to be opened through the *introduction of fees* for health services. These fees will be settled either through direct payments by the users or through *newly established health insurance schemes* or a combination of both forms.

- In many reform projects an attempt is made to exploit *rationalization reserves* in the public health sector: some examples are essential drugs policy, evidence based medicine and better links between outpatients and therapy.

- Another internationally often discussed problem for which no satisfactory solutions have been found either in the industrialized nations or in the developing countries, is the participation of the users in the design of the health services. The ways and means of achieving this are the subject of international dialogue on further reform endeavours.

This short outline shows the similarities in the structure of the problems arising in the different health systems – despite all differences in concrete application. Against this background of common denominators and diverse problems, it is useful to conduct an international dialogue which can lead to enhanced knowledge of possible solutions for all concerned.

The Public Health Promotion Centre has developed a type of programme which enables a structured dialogue – with many references to the German situation – between participants from the developing countries and German experts. The participants of the ZG programmes particularly appreciated the critical frankness with which German public health professionals discussed the problems of their system.

As an example of how similar the structures of the problems are, we will – on the basis of reports from ZG-participants – give a brief outline of the situation in two developing countries, Viet Nam and Colombia:

The aim of dialogue and exchange of experience

When assessing reform measures and their momentum, it is relatively easy for experts from developing countries and their German counterparts to get a consensus on their fundamental objectives:

- improvement of the quality of health services (defined as effectiveness and user satisfaction),
- improvement of efficiency, and
- securing socially just access to health services ("equity").

Which insurance system, which payments system, what principle of organizing services and financing, what type of user representation, how much competition and how much regulation or standardization is optimal in the given local and historical situation – the task of finding answers to all these questions is a complex and time-consuming process. The experience gained by the ZG shows that it can be accelerated and intensified through structured exchange of experience and international dialogue – with case studies – between professionals from different continents. All persons involved in this process believe this dialogue is an important contribution to their own knowledge-gathering and decision-making activities.

Viet Nam

Viet Nam, with a per capita GNP of US$ 240 (1995) continues to be one of the least developed countries. Up to 1989 health services were provided through a delivery system financed and organized by the state which envisaged free access for all inhabitants. Later, low user fees were introduced which did not cover the costs, and in 1992 first steps were taken to set up a health insurance system. Already three years after the introduction of this system, this health insurance covered some 7 million persons (equivalent to about 10% of the population). The target is to extend this system to cover the entire population. A special problem arises from the groups of small farmers who make up about 80% of the population of Viet Nam. Some forms of voluntary insurance are being developed in pilot projects for this population (if we recall, the German farmers were fully integrated in the statutory health insurance only in the 1970s, that is, almost a century after the start of the Bismarck reforms). Top-ranking staff members of the Vietnamese Ministry of Health and the health insurance organizations who are familiar with the above-mentioned pilot projects, participated in the ZG's dialogue programmes.

Colombia

Colombia was able to start the reform of its public health system on a considerably better economic basis (per capita GNP in 1995: US$ 1,910). "From subsidization of supply to subsidization of demand" – this was the motto under which the Colombian Parliament adopted a law in 1993 containing the provisions for the introduction of a health insurance system, with fundamental aims similar to those of the Vietnamese reforms. Persons employed in the formal sector are compulsorily insured, those in the informal sector and unemployed persons can, within the framework of the state social welfare system, get themselves classified as needy persons and thus acquire eligibility for state subsidies or a full refund of their health insurance contributions. There are considerable local differences in the insurance protection coverage rate (between 15 and 50%). One must wait and see how long the state can continue paying subsidies at this level, if claims for further subsidies continue to be made at the present rate. Within the framework of its management training the ZG supports the health services in two provinces in their transition from public budget financing to performance-oriented financing via health insurance schemes.

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Draft

Management Constraints for Operationalization of Reproductive Health Programme Interventions in PHC System in India

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After International Conference on Population and Development (ICPD) at Cairo most family planning programmes are moving towards reproductive health approach. A package of reproductive health services has been recommenced for India[1], which is shown in table 1. Government of India is also planning a major project to reorient the family planning programme towards reproductive health under a new programme called Reproductive and Child Health (RCH) programme with the assistance of the World Bank[2]. In India this programme will have to be implemented like other national health programmes through the primary health care (PHC) system. The weaknesses and strengths of the PHC system including the managerial capacity will have important bearing on the degree of success of the programme. For example the Tuberculosis control programme which is integrated in to the PHC system has suffered due to weakness of the PHC system[3].

Strategic management approach mandates that formulation of new strategy should take in to account strength and weakness of the organisation and opportunities and threats in the environment. Hence it is very important to understand the strengths and weaknesses of the PHC system and to design the RCH interventions taking these into consideration. In an earlier paper we have discussed how the strengths and weakness of the PHC system will affect the delivery of Emergency Obstetric Care (EOC) in India, which is a recommended approach for Safe Motherhood component of RCH package[4]. This paper focuses on constraints which may hamper operationalisation of RCH interventions through the PHC system.

Table 1: Recommended Package for Reproductive Health Services for India.

1	Prevention and management of unwanted pregnancy**
2	Services to promote safe motherhood**
3	Services to promote child survival**
4	Nutritional services for vulnerable groups**
5	Prevention and treatment of RTI and STD**
6	Prevention and treatment of Gynaecological problems
7	Screening and treatment for breast cancer
8	Reproductive services for adolescents**
9	Health, sexuality and gender information, education and counselling**
10	Establishment of effective referral system**

** Indicates that these services are part of an minimal or essential Reproductive Services Package.

The PHC system in India has several strengths and advantages which we fully recognise, but these are not discussed here as the central focus of the paper is on constraints of the PHC system. The paper is based on our personal observations of PHCs in some Indian states, in-depth studies of some PHCs which we have done in one state, discussions with PHC and district level staff, reports of other studies in the on PHCs in the country and discussion with other researchers. Given the diversity of India some

of our observations may not be applicable through out the country, but most would represent the reality in many parts of the country with variation in degree from place to place.

Major constraints faced by the RH programme can be classified in to following broad categories.

1. Human Resource Management related problems.
2. Poor access and quality of services
3. Weak support service systems.
4. Weak and centralised monitoring and supervision.
5. Inadequate and in-operational service Infrastructure.
6. Poor demand for services
7. Weak management of services.

We discuss the constraints of the PHC system and suggest some possible solutions below.

1. Human Resource Management related problems

Non-availability of doctors in the new PHCs:

The PHC system is facing shortage of doctors for quite sometime. In Gujarat about 20 % of PHC medical officers posts are vacant at any time[1]. Study from UP shows that in 1990 40% of PHC medical officers' posts and 42% of specialists posts were vacant[5]. The shortage of doctors is likely to be more in states where private practice is not allowed in the government system, making government service much less attractive for the doctors. This problem was exacerbated after mid 1980s when the number of PHCs was increased almost three folds by bringing down the norm for PHCs from 1 for 100,000 population to 1 for 30,000 population, with a view to increase access to health services in rural areas.

Even when the doctor's post is filled at the PHCs in this new set up, they may not be available for about 30-40% of the days in a year due to official leave available to them[2]. There is no provision of having reserve doctors to look after the PHC when PHC doctor is on leave. On top of this doctor may not be available at the PHC for another 10-20% of the time because he is busy with meetings, Sterilisation camps, training, special campaigns and other administrative work. This means that in the new PHC the

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[1] Recent efforst made by Gujarat government to recruit new doctors has decreased the level of vacancies in PHC. But without a long term strategy to combat this problem it is not sure if this improvement will last long or not.

[2] Government doctors in Gujarat get following holidays in one year. 52 Sundays, 18 Government/public holidays, 30 earned leaves, 17 casual leaves, 10 sick leaves. This adds to 127 i.e. 34.8% of days in an year. Saturdays are half days hence to this we should add 26 days which makes it 153 days which is 41.9% of days of the year are holidays.

posted doctor may not be available for almost 50% of the time. This situation is aptly described by one health secretary from a state. She said, " our PHCs are manned by ghosts! The staff is there but not there"[6] Lack of availability of the doctor becomes a major issue in the new PHCs as the new PHCs has only one doctor instead of 2-3 in the old Block level PHCs. Under the old PHC pattern there are 2-3 doctors, hence in spite of lot of officials leaves and holidays the possibility of finding at least one doctor at the PHC at any time was quite high.

The second major factor in the non-availability of the doctors is the fact that in the new PHCs most doctors do not stay at the PHC village. The old PHCs were located at sub-district towns which were somewhat larger and the PHCs had quarters for the doctors to stay, and the village where PHC was located had some basic civic amenities so that doctor's family also can feel comfortable and children's education does not suffer a lot. While the new PHCs, which were opened with a norm of one for 30,000 population are located in very small villages with population of 3-6,000, with very little civic amenities. These PHCs also do not have quarters or if quarters are there they are of very poor quality due to poor quality of construction and lack of maintenance. All these factors lead to the situation where most doctors do not stay at the new PHC or within the new PHC village. In many districts which have large cities in them, PHC doctors prefer to live in the city and commute to and from the PHCs rather than living at the PHC head quarter village. For example out of some 48 PHCs in Ahmedabad district only at 3 PHCs the doctors stay at the PHC village. Even though this may be an extreme case, situation may be similar in districts where cities are located. Recent study by Indian Council of Medical Research (ICMR) covering 23 districts in 14 states showed that only 57% of the doctors of 473 PHCs sampled were staying at the PHC village[7]. When doctors do not stay at the PHC village they have to travel by public transport which is not vary reliable. This makes the availability of the doctor at the PHC very uncertain and limited to only few hours of the day as they have to arrange their schedule depending on the bus timings. Some doctors even do not go to the PHC regularly and still on paper they are posted at the PHC. In extreme case doctors go to the PHC only a few days in a month, while the other PHC staff manages rest of the show on paper.

Lack of Interest in the PHC work by doctors:

The irregularity of doctors is compounded by and is caused by lack of interest in PHC work by the doctors. Many doctors are not interested in PHC as a career they see it as a stepping stone to more lucrative and satisfying private practice or job in a hospital in urban area. Hence they are not eager to develop the activities of the PHC or to do innovative things to improve the PHC functioning. Lack of training and orientation of young doctors towards community medicine, preventive medicine and public health make them less suitable for duty in PHC. Without orientation training or apprenticeship in PHC they feel like fish out of water when they are posted as in charge of the PHC immediately after graduation from an urban medical collage. In the states where private practice is allowed by the government doctors, most of their attention is devoted to their own practice as it directly pays them in addition of the government salary. Such private practice may also reduce the time and attention they give to patients in the PHC. The target oriented Family Planning programme did further damage by evaluating the work of the PHC based on only the number of sterilisations performed. As long as the sterilisation targets were achieve the supervisor did not bother to see what else was happening at the PHC. The PHC supervisors have tolerated less than optimal work by the doctors and hence an

atmosphere of acceptance of poor work culture has developed with in the PHC system thus further supporting such dysfunctional and unaccountable work patterns in the PHCs.

When the doctor is not available the rest of the PHC clinic almost stops functioning as no one else in the PHC including the pharmacist or the trained nurses or ANMs are officially allowed to examine patients independently and prescribe scheduled medicines even for common illnesses. Unofficially they do it, but then they are always afraid that if some thing goes wrong they will be in difficulty.

Non availability of para-medical staff at village level:

Many of the things said regarding doctors also apply to the paramedical staff. Most of them also do not stay at the PHC villages. The ICMR study referred above also showed that 52% of ANMs do not stay at the Sub-Centre village[8]. They have to commute thus their time in the field is very limited. Some studies show that on an average out of the working day of 8 hours paramedical staff of the PHC are available for 3-4 hours at their place of work. On many days the workers do not go to the allotted village due to several reasons. Even when they go to the villages many do not systematically visit all the houses. There is no preplanning of what activities have to be done during the home visiting. Due to this haphazard way of working it is very difficult for community to contact the workers when need arises.

In such situations one cannot expect to treat RCH problems unless availability of doctor is ensured and/or para-medical staff are allowed to use required basic drugs for treating these problems. When the doctor is not regular or not available at the PHC for adequate duration, he looses control and authority over his other staff. Hence such doctor can not get work done from their subordinate staff. The supervision becomes weak and extension activities become irregular and haphazard. In such situation it is difficult to imagine how new RCH interventions will be implemented. Hence regular availability of doctors is essential for success of RCH programme. In area where this is not possible the health workers should be thoroughly trained and empowered to provide a minimum package of RCH services.

Male Doctors at PHCs:

Most PHCs have male doctors. Given the socio-cultural set up in many parts of the country it is difficult to expect that women will come forward for reproductive health problems to a male doctor. One of the important contributing factors to the "culture of silence" regarding reproductive problems among women is lack of availability of gender sensitive health services for women. Currently even males from the community do not seem to be coming to PHCs for STD or RTI or other reproductive problems. This means that even at PHC level a female health provider (generally ANM of Health Visitor) has to be trained to examine and identify RTIs and other reproductive health problems among female clients. And they should be allowed to manage the patient independently or in consultation with the doctor if present. Secondly as far as possible a second doctor who is a female should be appointed at the PHCs. In Sanand Taluka of Ahmedabad district, we have experimented with provision of female gynaecologist once a month at the PHC. This has yield good results in terms of access and utilisation of Reproductive Health services by women. In UP under the USAID project they have made arrangements for a visiting lady doctor every week at each PHC. The response to this seems to be

good. With proper gender sensitive manners, with a female attendant and adequate privacy even a male doctors may be acceptable in many areas for women's examination if arrangements are not possible for women doctors. A well trained nurse as discussed above can also help over come barrier posed by males doctors at PHC level for examination of female clients.

Inadequate Training Management :

Training has never been a priority in the health department. Most state governments did not develop any training infrastructure for in-services training and tended to depend on centrally funded training institutions. For a long time it was assumed that basic training is enough for health workers to do their job effectively. In-service training were only conducted when any new programme was introduced such as immunisation or ORS. Unfortunately there is no systematic periodical appraisal of workers capabilities and skills. Our recent experience in parts of two districts show that workers level of knowledge and skill is very inadequate. Many wrong notions are common in the workers and many a times they don't know the right techniques for various simple clinical procedures such as making ORS, testing urine for protein, diagnosis of ARI.

Given the health department's track record on providing effective training to the health workers for health interventions it is likely that radical reorganisation of the training set up will be required for training health workers for RH problems. Most training in health department has been theoretical and classroom based. For example training done for the Child Survival and Safe Motherhood (CSSM) programme. In this training majority of the time was spent in reading the modules. Secondly this training combined 11 intervention elements into 5 day training thus giving very little time to each topic. After the training the required supplies and drugs did not arrive in the workers hands for 6 to 12 months. As a result of all of this even today many workers we have interviewed are not clear about simple things like management of diarrhoea and pneumonia[9]. Fortunately World Bank assisted India Population Projects and other Area Projects have done many useful things to improve training set up in the government. For the first time State Level Training Institutes are being developed. The training system will have to change from class room lectures by guest faculty to field oriented and clinical training to address reproductive health problems. In-service training for clinical skills have been focused so far on sterilisation. It did not cover basic gynaecological, obstetrical and neonatal health skills. The current pattern of one month's tubal ligation training should be modified to include basic obstetric, gynaecological and neonatal work. This will require at least three to six months time in a high case load situation so that each person get to practice the clinical skills. This could be done by broadening the skills training being planned under the CSSM programme[10] to cover all the RH interventions. Unfortunately in the CSSM programme the clinical skills training was very delayed and perhaps not given high priority, this should be guarded against in the RCH programme. More and more centres at the district level have to be recognised for clinical training besides the Medical collages as in the latter many a times trainees from the PHC system do not get priority as the residents and interns are also sharing the case load.

Second problem of training has been that it has not been linked to the actual work performance of the workers. It is not reinforced by their supervisors in the field and required support materials are not provided to the PHC staff to practice what they have been taught. Many of these things happened in

the immunisation programme but did not happen in the CSSM programme leading to deterioration of skills and knowledge of the workers. The training has to be reinforced periodically by the supervisors and supported by required medicines and supplies. Unless this is done training alone will not produce results. Training has to be followed up with a supervisory system which will ensure positive and negative feedback for the workers so that they are motivated to identify and treat more cases of RH problems. Non-monetary incentive have to be built into practice of what has been learnt in training. Training should be follow up with systems development and problem solving.

Besides training there are several areas of HRM that need to change in the government system. The selection, promotion and transfer policies have to be made more linked to qualification, commitment and performance rather than political connections, ability to pay or caste. Each employee should have reasonable promotional avenues and opportunities for self development. This should be linked to rigorous monitoring of performance in all spheres of work rather than the current system of measuring performance only for sterilisation. Current emphasis on targets for sterilisation must give way to measure work along many dimensions. Rewarding those who perform must be the centre piece of the HRM policy. Unless there changes are made it is unlikely that RH programme can be implemented successfully.

2. Poor Access and Quality of Services:

Worker-Community Contact Weak:

One of the key factors for success of the family planning programme in Bangladesh has been close contact between the FP worker and the community[11]. Unfortunately in spite of substantial FP and health infrastructure in rural areas regular contact between the worker and the community seems to be low. This is due to the fact that most workers are not resident in their area of work, lack of adequate micro-level planing, supervision and monitoring as well as due to over emphasis on sterilisation and immunisation. In most places workers do not seem to visit clients homes regularly. In the hay days of malaria control programme the malaria workers were going house to house according to Time Place Movement (TPM) schedule which was a well worked out system of house visiting on a periodic basis. With Multipurpose Health Worker Scheme starting in mid 1970s and over emphasis on family planning, the TPM schedule got neglected. For the Female workers (ANMs) no such detailed programme of house visiting seem to be in force. They have to visit villages allotted to them on a fixed day of the week. But there is no detailed plan of house visiting. Due to lack of any such plan of activities during the field visit the house visiting by AMNs becomes random and haphazard. Our field observations in a few PHCs indicate the female workers do not visit each household regularly. They spend most of the time in the village at few houses where they have friends or where they get better reception. Because of pressure to get sterilisation cases they do visit house were there are potential sterilisation clients.

Post project studies after the India Population project in UP showed that only 15% of eligible couples were contacted by the health workers[12]. Recent survey done in 11 districts of UP have shown that only 7-16% of couples are visited by health workers in last 3 months[13]. On the other hand 80% of the

households were visited by any health worker in past 3 months as reported in a base line survey in 5 districts of Gujarat[14]. National Family Health Survey data showed that only a small percent of pregnant women got a home visit by any health worker for ANC during the 9 month of pregnancy. Ideally each couple should have been visited by both the male and female workers once in every 15 days i.e. in three months the couple should be visited six times by the male and female workers. During the nine months of pregnancy each women should receive at least 3-4 visit by the ANM. This shows the gap between the planning and what is actually happening in the field and that there are wide variation in coverage of extension work. At such a low level of contact with the community it is very difficult to imagine any rapport building or effective service delivery. In many villages we work in, the people don't know who the male and female health workers for their village are.

Given this scenario of lack of contact and rapport between the government health functionary and the community, the community currently does not see government health worker as a source of treatment for health problems except perhaps for family planning and malaria. In this situation it is difficult to imagine that the community will readily come forward for treatment of reproductive problems from such workers or health centres. The first step will have to be developing close rapport with the community through regular and reliable contact between the community and the health providers at the village level and PHC level.

Deteriorating Technical Competence and Level of Clinical Practice:

The technical competence and clinical practice at PHCs has deteriorated substantially over time. The current practice at PHC is limited only to symptomatic treatment without arriving at a clinical diagnosis based on proper examination. Most doctors in PHCs do not take adequate clinical history and conduct proper physical examination. Our recent visits to PHCs showed that many PHCs even do not have standard set of instruments for basic clinical examination. Simple and essential things like torch, spatula, thermometer, blood pressure measuring instrument, stethoscope are not found in many PHCs. Situational Analysis done in two districts of UP by Population Council showed that 20 to 45% of the PHCs did not have basic instruments such as stethoscope or BP instruments[15]. Situation at the sub-centre level is even worse. Situational analysis study in 2 districts of UP bears this out. Availability of the instruments does not mean that it is used. Many times instruments are available but generally locked up in the cupboards, or are not functioning or of very poor quality. For example the data from ICMR study of 23 districts showed that even when facilities were available woman's weight was taken in 68% of cases, foetal heart sounds were listened in 57% of cases, BP was measured in 37% of cases, urine was examined in 37% of cases and haemoglobin was measured in 31% of cases for pregnant women[16]. In surgical contraceptive procedures as female sterilisation the quality of care is poor as reported by us from Gujarat [17], and by Townsend, Khan and Gupta from UP [18], by Laxmi and Barge from Madhya Pradesh [19].

The clinical knowledge of the doctors also leaves lot to be desired. There is not regular updating of the technical knowledge of the doctors or the health staff. Irrational prescribing is not uncommon. Recent review of drugs procured by one district showed some irrational medications indicating that not much attention is paid to updating the drug list at the district and state level. Currently district or state level supervisors are not taking any interest in the clinical side of the PHC practice. They concentrate their

attention on monitoring of the sterilisation and other targets. In this situation introduction of RCH programme will need thorough reorientation of the doctors and para-medical staff and improvement of their clinical skills and prescribing practices. We feel that each doctor in the PHC system should spend at least 15 days per year in a higher level of facility to update clinical skills and knowledge. Every 5 years each doctor should spend 1-2 months to upgrade the clinical skills and every 10 years each doctor should spend 3-4 months in upgrading clinical skills. Before each promotion each staff member should go for in services training at an appropriate training centre as is the system in the Indian Armed Forces. Besides this supervisors will also have to introduce regular auditing of clinical practice at the PHC level. Only such attention to clinical practice will help implement the RCH programme effectively.

Lack of Privacy and Confidentiality:

In the current PHC set up hardly any attention is given to ensure privacy and confidentiality of the clients. The usual scene at the PHC is that two or three patients are present in the doctors room when he is examining one case. Proper screens are not used to ensure privacy while doing physical examination. At sterilisation camps the level of privacy needed is more as exposure of private parts is required during the preparation and operation. Our observations at the sterilisation camps in Gujarat have highlighted this problem of privacy [20]. Situational Analysis study of PHCs in two districts in UP showed that auditory privacy was available in only 46% of PHCs and visual privacy was available in 64% of PHCs in Sitapur district while both these numbers were 42 % in Agra district[21] . Unfortunately, PHC staff is insensitive to this aspect of quality of care. Confidential counselling hardly ever takes place in the PHC system. One of the important reasons for people to seek private care especially for abortion is due to lack of privacy and confidentiality in the government system [22].

Given such environment maintenance of confidentiality cannot be expected unless special attention is given to it. These factors will act as barriers to the use of RH services at the PHC level as confidentiality and privacy are very important for delivery of RH services which by its nature are sensitive matter in any society. Sincere efforts are needed to sensitise the staff to these issues and systems need to be developed to ensure privacy and confidentiality at each step. Privacy and confidentiality should be incorporated into each training and should be part of supervisory checklists at all levels in RCH programme.

Weak Information, Counselling and Communication process:

At various levels in the PHC system the information giving, counselling and communication process are quite weak. Situational analysis in two districts of UP referred above indicated that information provision to even acceptors of family planning methods is not adequate. Other studies also have pointed out this weakness. For example the four state study by IIPS showed that only 22 to 40% of ANMs reported that they would discuss with the client how to use the oral pill if the client showed willingness to use the pill[23]. NFHS has shown that even in 1992-3 only 58 to 66% of women in reproductive age knew about various spacing methods[24]. Further analysis of the NFHS data showed that only about 45 % know about all the four methods of FP available in Indian programme. This indicates low level of communication even for family planning in the community. This is because communication skills are not taught in the basic training of any category of staff including the doctors.

Secondly the programme does not place importance on this and hence the workers do not think that talking to the patient or client and explaining them the procedures for various services is part of their job. Our participant observations at several PHCs, camps and immunisation or ANC clinics showed that there is hardly any communication with the clients. Communications is limited to the bear minimum necessary related to the services given. Even proper instructions are not given regarding how to take the medicines, when to come back, what is wrong or what is done to the client. Workers and doctors we have talked to do not see any need for such communication! ICMR study in 23 districts showed that only 21% received information about other methods and 26% were told about advantages and disadvantages and 31% received advice on how to use the method at the time of accepting the method [25]. This clearly shows the weakness of information giving process in the FP services.

The family planing programme has used incentives and targets rather than communications to motivate their clients and workers. The Block Extension Educator and the District Extension Educator which are the key posts for ensuring communications have become more of clerks or assistants to the medical officers to do administrative work rather than communication and extension work. Communication work becomes more difficult as the workers timings (8am to 4 pm) coincide with the daily work timings of the community especially the males. There is hardly any communication activities happening late in the evening or night when the community has spare time. Field experience shows that not much regular communication efforts goes on even though on paper reported activities may look impressive. The communication aids used like posters, pamphlets etc. also have several technical problems besides being unattractive and in inadequate in quantity.

As communication and counselling skills play a very important role in RH approach it would be essential that these skills be developed at various levels so that they can support the activities for RH. All the staff including doctors have to be trained and motivated to practice good interpersonal communication and counselling with the clients. This will help improve the image of the PHC to a great extent. This will be a difficult and long term process as teaching communications skills is more difficult than teaching technical skills. Secondly regular field level monitoring will be needed to ensure that communications for RH continue in a systematic way. This can be done if at the state level and district level qualified and dynamic persons are in charge of communication and health education activities. Communication should be integral part of service delivery process and should be included in the quality standards as well as monitoring indicators.

Poor Image of the PHC in the Community and gross under utilisation of PHC services:

Due to over emphasis on preventive programmes, especially family planning, the PHC's curative role has been neglected and weakened. There is no monitoring of how many patients come to the PHC and for what diseases. The health statistics reports published by the ministry do not include these data. Currently PHCs are seen by the community only as a place for sterilisation, immunisation and malaria treatment. Because of various problems in the PHC system including non-availability of doctors and medicines, poor quality of services and indifferent human interaction, they have lost credibility in the community. Baseline surveys from 11 districts in UP show that only 5-27% of the households reported that they always prefer government health services, while 30 to 76% prefer private health care services[26]. There is increasing competition from the private sector in many area of the country. With

improvement in transportation the access to private care in towns and cities has also improved substantially in most part of the country. This has led to further under utilisation of health services especially those not located at strategic locations. Data from baseline surveys done by ORG in 15 PHCs of 5 districts of Gujarat in 1990 showed that on an average each primary health centre clinic treats about 24 cases per day which is a small number given the fact that each case takes only 2-3 minutes. This study also showed poor use of the indoor facilities[27]. Data from all PHCs in Gujarat showed that on an average each PHC treats 20 cases in a day[28].

Recent Multi Indicator Cluster Surveys done by Centre for Operations Research and Training for UNICEF in six districts of Gujarat show that 54-80% of people went to private doctors for treatment of diarrhoea while health worker have treated only 1.6-16% of diarrhoea cases and government doctors have treated 13-39% of cases in different districts[29]. NFHS data shows that substantially small proportion of diarrhoea and cough with fever were treated by government health facility[30]. An all India household survey of medical care done by National Council of Applied Economic Research (NCAER) in 1990 showed that out of all illness episodes where medical care was sought in last two weeks, only 8% went to PHCs, while 28% went to government hospitals and 43% went to private sector[31]. In a baseline survey done by ORG referred above, in Gujarat only 13 % of families reported exclusive dependence on PHC system for treatment. Majority of people tended to seek medical treatment from private sector.

Most sub-centres do not have a building and sub-centres clinics are not held regularly and are not well attended. Data from recent surveys done in UP cited above, show wide variation in percentage of households reporting visit to a PHC or sub-centre in last 3 months. This figure varies from low of 6% to high of 59%. Attendance at sub-centre clinics is also very low. Only small proportion of deliveries are conducted by the para-medical workers. NFHS data shows that only 12.6% of deliveries are conducted by health workers[32]. Most workers do not have training and required equipment and supplies to properly examine a patient and treat common illnesses. For example most ANMs did not have BP instruments till very recently and many still don't have it. On the other hand even when nice equipment are provided they are seldom used by the staff. We have seen several PHCs and CHCs where new equipment are found unopened even after months or years of receipt.

This clearly shows how poor is the contribution of PHC system to curative care. Looking at what kind of cases come to the PHC it is very clear that reproductive problems forms a very small part of it if at all. All this indicates that there is an urgent need to refocus PHC work on curative care and establish its credibility in the community. Only then one can expect that people will come to PHCs for STD/RTI, maternal care and other reproductive diseases.

3. Weak Support Service Systems:

Weak Referral System:

The referral system in the PHC is currently ad hoc and un-systematic. There are no referral slips or records of referred cases. The referral facilities also do not inform the referring PHC about the follow up actions needed in each case. Referred cases do not get any special care or preference at the referral

centre. Each level of the PHC system functions almost independently, even administratively they fall under different set ups. For example in Gujarat the PHCs and Sub-centres are under district Panchayats with Chief District Health Officer and the District Development Officer being in charge, while the Community Health Centre (CHC) and above are under state government with Regional Deputy Director and Additional Director of Medical Services as the administrative heads. The PHCs are under the Director in charge of public health services while the, CHCs are under Director of Medical services and medical collages are under the Director of medical education. Many times the head of these divisions within the health department do not get along well with each other and hence can not forge proper co-ordination and co-operation at the top level which percolates to the lower levels. This situation has added to the deterioration in the image of the PHC system. Many RH services require referral to higher levels, for example surgical treatment, management of infertility etc.

Given the present situation it would be difficult to visualise that for RH problems treatment will be offered through proper referral in the PHC system. The programme will have to develop adequate referral mechanism especially to ensure that contacts of the case are traced and treated simultaneously for STDs and RTIs and higher level of care is available when ever needed. This will mean development of a functioning referral chain. One of the reasons that clients go to private sector is that there the informal referral chains are well developed due to monetary interests. This gives clients faith in the private system.

Weak Laboratory Services at PHC and CHC:

Laboratory services at PHCs are currently very weak, primitive or non-existent. Lab technician's posts are vacant in many PHCs and where filled the scope of their of work is limited only to blood tests for malaria, sputum for TB and urine sugar and albumen and some time routine tests like haemoglobin. Even urine microscopy is not done at many places due to lack of simple instruments like centrifuge. Many PHC laboratories do not have even basic furniture, washing facilities and autoclaving arrangements. The maintenance of laboratory equipment is also lacking and hence instruments once out of order remain unrepaired for many months or years thus making laboratory dysfunctional. Given this situation substantial inputs will be required in the laboratories along with training of laboratory technicians to ensure that basic tests required for RH diagnosis are available at PHC level. Condition of CHC and district hospital labs may not be very different. Generally lab tests needed to diagnose STDs, HIV, cause of infertility and menstrual disturbances, PAP smear for cancer of cervix are not available at most CHC and even at many district level hospitals. People have to go all the way to medical collage for such tests. Hence these labs will also have to be upgraded to do basic and more sophisticated work for detecting RTIs and other RH problems that are referred to higher level.

Poor Epidemiological and Microbiological Services:

As the incidence and prevalence of RTIs and other reproductive problems vary a lot from place to place[33], it is very important to have adequate epidemiological information on these problems at local level. Even now at district and state level epidemiological and microbiological services are very poorly developed. This was highlighted during the recent Plague epidemic[34]. Virological services are almost

non-existent in most parts of the country. The district health organisation has only one post of epidemic health officer who is having only a basic medical qualification without any special training in epidemiology. Even at state level there are very few trained epidemiologist in the health department. As discussed previously the lab services at CHC and district level are weak. In effect district health organisation in most districts do not have any laboratory set up under its control. The district hospital laboratory is only for clinical lab work. Microbiological work or histopathology work is generally not available in the CHC or district level. None of the National Level Research institutions have focused on RH problems with exception of family planning.

Epidemiological and microbiological services are essential for accurate diagnosis of RTIs and for working out their epidemiology of RH problems in the community. Unless these services are improved it would not be possible to direct the RH intervention in a scientifically appropriate way. For example, periodic testing at sensitivity of organisms is essential to provide optimal drug therapy for RTI and STD. Standardised clinical and epidemiological definitions of various RH problems are urgently needed. Using different criteria for diagnosis of various RTI can give wide variation in their prevalence as shown by Bulut et al [35]. Hence local epidemiological understanding of women's health and neonatal health problems is essential to the development of appropriate strategy to tackle them. Building up epidemiological and microbiological services will be important first step in dealing with RH problems. Better linkages of health department and the medical collages where these services are potentially available and could be developed will be useful. Unfortunately no national level thinking seems to be going on in this direction.

4. Weak and centralised monitoring and supervision:

Difficulty in Monitoring RH interventions:

Management of RH programme is difficult as it has many different interventions as shown in table 1 and the demand for RH services will vary from PHC to PHC based on prevalence of various RH problems including RTI/STD and community's health care seeking behaviour. In some RH interventions such as safe motherhood or immunisation one can set a norm for services provision based on estimated birth rate, but for other problems such as RTI/STD or menstrual problems no norms can be set centrally on expected cases to be treated in each PHC. This means that a new monitoring system will have to be developed for measuring the performance for RH interventions at the PHC level. Such monitoring system will have to link up with reward system to ensure that the workers are motivated to take care of RH problems. A target based approach which has been used for family planning programme so far will have to be replaced. At the central government level efforts are on to develop an alternative way to monitor the programme without the use of targets[36]. Unfortunately these systems are yet not tested in the field. Hence urgent efforts are needed to develop and field test feasible approaches to replace target based approaches.

As quality of care including information and client perspective are also important aspect of RH, indicators to measure them will have to be developed and used in monitoring the programme. Secondly given the limited capacity of the health system to collect, analyse and use information in a meaningful way any new system of monitoring will have to be very simple and straight forward. Today's public

health system works under lot of political interference, the new monitoring system will have to circumvent these problems in order to be effective. Developing such a system will be a important managerial challenge for the RH programme.

5. Inadequate and in-operational Service Infrastructure:

Poor buildings, equipment and supplies:

The PHC infrastructure including buildings, equipment, transport and supplies are generally in a poor shape due to lack of maintenance and timely replacements. This is due to inadequate finances, diversion and wastage of available resources and lack of interest and initiative of the PHC medical officers and their higher level managers. An extensive study of PHCs done by ICMR in 1987-89 has showed that PHCs were deficient in many of the basic requirements[37]. Things do not seemed to have changed much since that study except that in some PHCs and CHCs new equipment have been supplied under the CSSM programme and some new buildings are constructed under various Areas Projects which are supported by bilateral donors. Our recent visits to many PHCs showed that the basic equipment at PHC are not available or old, not working and often kept in an unclean condition. Recent situational analysis done by Population council in two districts of UP also show that almost half of the PHCs and SCs do not have basic equipment or equipment are not working[38]. Except for cold chain equipment, no system of repair and maintenance is developed for any other equipment in the PHCs. Non-working equipment provides the unwilling doctors a good excuse for not doing work related to that area of health care and the supervisors also do not take serious notice of such non-functioning equipment or doctors. The audit and accounts system too does not calculate costs of down time of equipment due to non-repair and the consequent indirect cost and suffering imposed on the clients. Purchase of poor quality, substandard and unnecessary equipment due to vested interest and corruption also contributes to this problem.

One of the main problems is that the construction and repair of buildings of the PHC system is under the Public Works Department (PWD) of the state governments which are famous for their inefficiency, poor quality of work and corruption. This affects the quality of PHC building construction and maintenance. Poorly constructed and maintained buildings provide reason for doctors not to stay in them or not to do surgeries and procedure in them.

The situation of supplies of medicines and contraceptives is also a problem. The ICMR study and the situational analysis done by Population Council have shown substantial supply problems at the PHC and SC level. Many PHCs and SCs do not have essential medications for RH problems and contraceptives. Even simple things like Iron and Folic acid tablets are in short supply at times.

Along with shortage of equipment and buildings there are also surplus and unused equipment and buildings bought or constructed under various schemes and donor assisted projects. Each new project adds new set of instruments and at times buildings without assessing the location-specific need and potential for use given the local circumstances. Such facilities and assets are later not used at all or not

fully used. We have seen store rooms of many PHCs which are full of expensive but unused equipment from several projects gathering dust. Many a times location of buildings are not strategically chosen and hence their functionality suffers a lot. It is reported that in Gujarat about 200 PHCs get less than 5 patients per day. Several CHCs are underused because of locational problems. Unused or under used buildings and staff are one of the greatest sources of wastage in the Health department which is not accounted for. There is not "asset-productivity" audit in the health department.

Because of various infrastructural, supply related reasons as well as lack of training and motivation, various levels of the PHC system are not fully functional. For example many SCs and do not provide basic delivery services, many PHCs do not provide sterilisation, MR, MTP and delivery services, many CHCs don't provide Essential Obstetric Care services. Situational Analysis study in Agra and Sitapur districts of UP showed that only 16 and 23% of PHCs offered sterilisation while only 9% and 26% of PHCs offered MTP services. Unfortunately there is no monitoring at district, state or national level of the functional status of the, SCs, PHCs and CHC/FRUs. The most glaring example of this is that even after the completion of the World Bank assisted CSSM project (in which one of the main safe motherhood intervention was to offer Emergency Obstetric services through First Referral Units at CHC level) there is no clear idea about how many planned FRUs are actually functional in the country[39].

Given this situation the RH programme will have to ensure that equipment are properly maintained and infrastructure is in a reasonably functional and in clean condition so that clients would like to come to the health centre. Standards for quality and adequacy of physical facility will have to be developed and adhered to provide good quality RH care. This may mean setting up separate maintenance systems for buildings and equipment. Diverting some funds from construction of new PHC and subcenter buildings to maintenance of existing infrastructure would be more cost effective. Before buying new equipment the existing equipment should be inventoried and repaired and redistributed to make optimal use of it. Only after this the missing equipment should be allowed to be purchased. For this to happen the purchasing has to be done at a local level and has to be tied up with decentralised planning.

6. Poor demand for health services:

Low Community Demand for PHC services :

Given the problems with the PHC system and its poor image the community does not perceive it to be a preferred place for curative care. Hence many people are using private health care providers for treatment of health problems. The overall demand from the community of services of the PHCs is low. Studies done by UNICEF, NCAER and Population Council cited above indicate that majority of the people prefer private care. Secondly many RH problems such as leucorrhea and menstrual problem are seen by women as inevitable and they continue to suffer in silence. The cultural factors also contribute to this low demand for gynaecological health problems. Given this situation lot of effort will have to be devoted to generating community demand and increasing community awareness regarding RH services at PHCs. Unfortunately till the services availability and quality does not improve the demand generation may prove to be counter productive and frustrating to the staff and community alike. Our experience with RH services camps and similar experiences from other NGOs indicate that if

reasonable services are provided for RH problems with proper communication to the community women will come in large numbers to take advantage of these services. Thus supply of gender sensitive and effective services activates potential demand.

7. Weak management of services:

Lack of Commitment and Accountability in the PHC Staff:

Of late the levels of commitment and accountability to work in the PHC has been deteriorating. Many PHCs and SCs do not start working at 8.30 which is the stipulated time, as staff comes late, usually by 1-3 hours, partly because they do not stay in the PHC or SC village and partly because there is no monitoring. Absence from work, not going to the field area, poor quality of services, etc. are quite common in the PHC system. The field work is also not systematically planned and happens in a haphazard way. Bringing cases to sterilisation camps or motivational visit to a potential sterilisation client dominates all other activities and takes precedence on them as well as provides an ready excuse for not following the schedule if work. There are very few individuals in the PHC system who are willing to try out new or innovative activities to improve the services. The common complaint of everybody is that they are over burdened by work even though studies of time use of PHC workers have shown substantial proportion of time is used in unproductive activities such as travel, records and personal work[40, 41]. The work output of the PHC also indicates gross under-utilisation of staff and PHC services at many places. The supervisors are not able to enforce a highly productive work culture and at times encourage the lax attitude and complacency due to their own shortcoming or irregularities. When medical officers are not attending to the PHC regularly on time or if they are doing illegal private practice they loose control over the field level staff. Most supervisory visits and meetings of district level officers are meant to check on the target achievement and to motivate the staff by threatening them if targets are not achieved. They never bother to check or ensure quality of service or solve genuine problems of the workers. Accountability is further weakened because of inability of the district and state levels health managers to take action against erring workers due to their political connections and pressure from local politicians. For example punitive transfers and non-payment of salaries are frequently cancelled under political pressure. It is frequently reported that local politicians often protect erring employees at the expense of damaging the accountability in the whole system and putting the public at risk. This demotivates the few who are committed.

Given the situation one can expect that introduction of RH interventions may meet with substantial resistance and inertia from the staff and supervisors as they will have to change their old ways of working to become more responsive to the need of the clients. Thus changing the work culture must be the first step along with inducing reasonable level of accountability in the system. Community pressure along with administrative accountability will be needed to implement RH programme in its true spirit.

Ineffective and Bureaucratic Management Processes:

Most of the PHC managers including doctors are not at all trained in management. Just one year diploma in Public Health besides basic medical qualification is enough to reach to top position in some of the state health departments in others even that is not required and a clinical specialist can also

become head of the public health services without any further management or public health training. At central level the Director General of Health Services does not require any public health or management training. A pure clinician such as an orthopaedic surgeon can become and has become Director General of Health Services at central level having the responsibility for the whole countries health systems. Secondly the at the central level all the technical positions are staffed only by officers of the Central Government Health Services. Thus these officers do not have first had management experience of any state government run PHC systems. Their only exposure is in the CGHS which only covers the employees of central government and some small union territories. Various government rules and regulations along with centralisation of power in the department limits the scope of effective management at the peripheral levels. Promotion by seniority rather than ability and skills puts the oldest person at the top rather than the most capable or innovative and dynamic persons. All this is compounded by archaic hierarchical style of management where the boss is always right. There is hardly any team spirit. In such environment innovations and participatory management can not be expected. RCH programme focuses on decentralised management which will need substantial change in the way the programmes have been managed so far.

Quality has never been on the agenda of any governmental department in India and health department is no exception. There is no management recognition that quality is important. This can serve as a great barrier to RH approach where quality and client satisfaction are paramount. Supply and logistics an important management function is also weak in the PHC system. Target oriented approach has further damaged the effectiveness of the management. Political interference, corruption, lack of accountability and other social cancers have not spared the management system of the health programmes. In this situation if the RCH programme has to succeed the PHC management has to be rebuild with effective management training, decentralisation and alteration in the monitoring and evaluation as well as the reward systems.

Conclusions and Recommendations:

It is obvious from the discussion above that the PHC system in India is facing may constraints which will limit the effectiveness of the RH interventions. Given these constraints of the PHC system introduction of RH interventions will have to be done very cautiously and after addressing some of the key systemic problems discussed above. We see three broad and interlinked strategies which may be needed to promote RH interventions.

Firstly, improvement of overall management functions to ensure availability of doctors and para-medics and improve their commitment to RH programme. The management intervention should also help reduce the barriers to provision of quality care and support the functionaries. This would mean solving some of the genuine problems of the employees and the system, overcoming infrastructural problems, ensuring supplies and logistics to encourage delivery of quality service.

The second strategy will have to address itself to improving clinic based and community based practice at PHCs and sub-centres. This will include retraining of the staff and motivating as well as monitoring their process of service delivery to ensure compliance with good clinical practice in diagnosing and

treating RH problems as well as effective extension work. For this training and supervision system has to be reworked. Training has to be continuous and skill building type rather than didactic. Super vision has to ensure good clinical and field practice. It is vital to clearly specify what RH service will be offered at which level and further specify the timing and quality of services. And finally set up monitoring system to ensure that the services are accessible and of high quality and are used.

Lastly, adequate efforts will be needed to generate demand in the community so that community members seek treatment from the PHC set up. This should go pari pasu with improving quality of PHC services. The community efforts will also have to be directed to changing behaviour so as to reduce risk of STD/RTI and AIDS and seeking early treatment for various RH problems. The community efforts also should focus on creating pressure for performance on the health system to deliver the services due to the community. For this effective communication using multiple media will be required to reach the community.

Such three pronged strategy will help operationalize the RH interventions through PHC system in India. Unless these changes are made the constraints of the PHC system will grossly limit the effectiveness of the RH interventions, as has happened in the CSSM programme, and the large investments being made in the programme will not yield commensurate results.

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TOWARDS COMPREHENSIVE WOMEN'S HEALTH POLICIES & PROGRAMMES
WORKSHOP 6-9 OCTOBER, 1998 AT E.C.C, BANGALORE.

Health Scenario at the Turn of the Century

Shanti Ghosh

In 1977, the Thirtieth World Healthy Assembly passed a historic resolution committing WHO and its Member States to achieving by the year 2000, a level of health for everyone that would permit them, to lead socially and economically productive lives. Towards achieving that, the declaration of Alma Ata in 1978, called on all governments to formulate national policies, strategies and plans of action, to launch and sustain primary health care, as part of a comprehensive national health system and in coordination with other sectors, leading to Health for All by the year 2000. With only 2 more years to go, the problems of primary health care delivery in India are as formidable as ever. WHO realising the impossibility of achieving this goal, has now shifted it to 2020.

The rural health infrastructure suffers from many inadequacies, which is partly due to poor training, inadequate supervision, and indifferent attitude of the health personnel, and partly due to lack of mobility, inadequate supply of drugs and equipment. Besides there is not enough awareness of preventive and promotive health among the health personnel and the community, with the result that only about 50% women receive any prenatal care or iron tablets for anaemia and 70-80% are delivered at home by unskilled persons, contributing to the high maternal mortality as well as a high neonatal mortality. In a large country like India, there are vast regional differences and the worst scenario is in the large states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. India's maternal mortality estimated around 400-500 per 100,000 live births is fifty times

higher than that of many developed countries and six times higher than that of Sri Lanka. On the whole access of women to health care is poor. This is due to lack of awareness, their poor status in the household, lack of initiative, lack of time and empathy and the working hours of the health services. Besides there are very few women doctors, whom the women would prefer to consult. They mostly suffer from chronic reproductive tract infections, problems associated with pregnancy, anaemia, backache etc.

There is an increasing disenchantment concerning health and health services among all segments of our society. The poor who have so far accepted illness and death are now beginning to demand care during illness. Poorest 40% of rural households spend on an average Rs. 131/- for an illness episode when receiving care from government doctors and Rs. 157/- when purchasing care from private doctors (42nd round of the National Sample Survey (NSS) 1986-87)[1]. Medical care cost is only next to dowry as a cause of rural indebtedness. Several reports have assessed that 7-9% of income is spent on health care, which is often of poor quality, and the "doctors" usually untrained.

Cost and the burden of treatment are closely related to access to health care and are among the highest in those states where public health infrastructure is least developed. This fact applies equally to government and to private institutions. Where public health infrastructure is well developed, not only is treatment cost in government hospitals low but same is true for private hospitals. This is clearly demonstrated by the Kerala situation. In all states with the exclusion of Kerala, rural patients pay more for health care and bear a higher burden for treatment. This is due to sparse distribution of

health care facilities in rural areas. The Kerala situation demonstrates that if primary health care is readily accessible to rural population, then even the cost of out-patient treatment can be minimal. The high out patient treatment cost for the rural population in the backward states clearly indicates the failure to deliver primary health care.

The investment in health is very small. The most persistent declining trend has been on expenditure for hospitals and dispensaries during the last decade, counter balanced by the phenomenal expansion of private hospitals. Health care expenditure has not kept pace with increase in government expenditure. For the eighth five year plan, the total outlay was Rs. 434100 crores of which Rs. 7582 crores was for health and Rs. 6500 crores was for family welfare - total 3.25%. WHO recommends about 5%. The estimates for the Ninth Plan are only marginally higher.

The goals and targets of the eighth plan (1992-97) emphasised the human face of economic reforms. However, social sector expenditure did not reflect this concern. The budgetary allocations for education, public health and water supply family welfare, housing, urban development labour, social security and welfare by the Centre and States together remained almost stable at about 5.8% of GDP and about 21% of total government outlay. Much of this is used up by salaries and buildings, leaving little for new investments, human resource capacity building and other inputs for improving the quality of life.

Mortality Rates

Even though infant mortality rates (IMR) still remain high, these have been steadily falling, but the decline varies greatly from one state to another. IMR which was 110 in 1981 has come down to 72. More than 50% of this takes place in the first month of life (neonatal) which is due to inadequate services for prenatal, natal and neonatal care. Childhood mortality too is declining (1993 figure is 23.7) and here there is considerable disparity between male and female deaths, female mortality being higher from one year onwards. As a matter of fact, female mortality is higher till 35 years of age due to discrimination against the girl child and due to causes related to reproduction.

There are vast urban and rural differences, which are due to poor access to health care, lack of knowledge and information and paucity of economic resources. Age at marriage too is significantly associated with high birth rate and high death rate. According to the National Family Health Survey[2], children born to teenage mothers were 40% more likely to die in their first year than those born to women in their twenties and yet early marriage is a common phenomenon in several states. Four large Indian states, Uttar Pradesh, Madhya Pradesh, Rajasthan and Bihar contribute most to mortality. Table 1, 2 and 3 show the health indicators, death rates by gender and relationship between birth rate, infant mortality rate and age at marriage.

Table 1 : HEALTH INDICATORS			
	1951-61	**1981**	**1996**
Birth rate	41.70	37.20	27.40
Death rate	22.80	15.00	8.90
TFR	5.97	4.50	3.50
IMR	146.00	110.00	72.00
Life expectancy	41.30	50.50	60.00
Source -World Bank, 1995 *SRA - 1996*			

Table 2 : ESTIMATED AGE SPECIFIC DEATH RATE BY GENDER		
Age (years)	**Male**	**Female**
0-4	26	28
5-9	2.4	3.0
10-14	1.4	1.5
15-19	1.7	2.5
20-24	2.4	3.2
25-29	2.7	3.0
30-34	3.2	3.2

Table 3 : RELATION BETWEEN BIRTHRATE, IMR AND AGE AT MARRIAGE			
State	**Mean age at effective marriage**	**IMR**	**BR**
Kerala	22.1	13	17.3
Bihar	19.0	72	32.1
Madhya Pradesh	18.4	97	32.4
Rajasthan	18.3	86	32.3
Uttar Pradesh	19.3	85	34.0
Tamil Nadu	20.3	54	19.2
India	**19.5**	72	27.4
SRS - 1996			

Major causes of deaths

Apart from the high neonatal death rate, the other major causes of deaths are acute respiratory infections (ARI) and diarrhoeal diseases, even through diarrhoea management programme has been in operation for several decades and ARI programme for about two decades. The key message that diarrhoea needs replacement of fluids and not drugs is beginning to be accepted, even though a vast number of anti-diarrhoeal drugs still continue to be prescribed and parents spend a great deal of money buying these.

The standard treatment regime for ARI, Cotrimexazole is also supposed to be available at all outlets of health services - rural as well as urban, and yet due to lack of awareness and lack of timely access, infants and young children continue to die of this condition. The number of deaths due to these two conditions is difficult to assess, but could be around 3 million per year.

Universal immunization programme

One of the more important area of success in health delivery system is the immunization programme which was started in a mission mode by Rajiv Gandhi , the then Prime Minister of India, and where coverage overall had reached almost 80%, even though children with complete immunization with all vaccines are only about 35-40%. Two doses of tetanus toxoid to the pregnant women have helped to reduce the incidence of neonatal tetanus to a much lower level than hitherto. Now India has launched a pulse polio programme for elimination of polio, in which two doses of the vaccine, a month

apart, are given to every child under 3 years (now increased to 5 years) on two fixed days throughout the country. The programme needs an efficient surveillance system, which at present is lacking. For how many years the programme will have to be carried out, is difficult to say even though the slogan adopted is - Polio free India by the 2000. One hundred and forty five countries are polio free according to WHO, 1996. According to government sources, the number of polio cases in 1996 was 1005, compared to 3428 in 1995. However, there are indications that immunization rates for various other vaccines have shown a downward trend, which could have serious consequences.

Child Survival and Safe Motherhood programme covered the whole country during the Eighth Five Year Plan which gave some boost to MCH. Now it has been replaced by Reproductive and Child health (RCH) programme in which women's health gets much more attention. There has been a paradigm shift in the family planning programme also with abolition of targets and the programme emanating from the grassroots and making various contraceptives available for spacing. However, this is easier said than done and needs a tremendous amount of organization, training and supervision. Central to all this is community involvement and participation, so it is not surprising that family planning activities go on much the same as hitherto. The targets are there, the camps are there, but there is a little more client friendly atmosphere and some evidence of spacing methods. The clients are nearly all women. So nothing much seems to have changed.

Too early, too frequent and too many

India's population in 1996 was estimated to be 953 million (1996 UN estimate) which is 16 percent of the world population and has more than doubled in the past three decades. The population had remained stable in the first half of the century, which has been attributed to frequent famines and epidemics. India has a young population - 36.3 percent of the population is between 0-14 years. The mean age at marriage of females is presently 19.6 for India as a whole, but is much lower than that in several states. The reproductive pattern can be summarised as - too early, too frequent, and too many. One third babies have a birth weight less than 2500 g (low birth weight) Early marriage and repeated pregnancies take their toll and about 20,000 deaths are attributed to **abortion** because of lack of access to contraceptives and inadequate facilities for medical termination of pregnancy (MTP) even though the Act came into force in 1971 and was a landmark of social legislation. NFHS has estimated that there is 30% unmet needs for contraception. Sex ratio is unfavourable to females - 927 females per 1000 males (1991) with a higher female mortality from the first month of life till about 35 years of age. This indicates discrimination against the females, and a high death toll because of causes related to reproduction. The maternal mortality rate is estimated to be 437 per 100,000 live births according to NFHS, but in some areas it could be even twice as much.

There is increasing evidence of foetal sex determination with a view to aborting the female foetus inspite of laws against it. A recent report from Haryana highlights the widespread prevalence in that state (Eco. And Political Weekly, 1998). Female

infanticide too is reported from a few states. Son preference is a very deep-rooted phenomenon in most of the country and many rural families would like to have two sons!

Widespread malnutrition

Malnutrition is common among all population groups but is more significant and serious in women of child bearing age and young children. Maximum malnutrition is between 6 months and two years in every state - only the extent varies[2,3,4].

According to the National Nutrition Monitoring Bureau, Hyderabad (1988-90)[5] only 10% children had normal nutrition, while 8.7% were severely malnourished. The situation was a little better than what it was ten years ealier[6]. According to the countrywide National Family Health Survey (1992-93)[2], stunting rates are 52% while wasting rates are 17.5%.

It can be estimated that there are 60 million malnourished children under four, of which nearly 60% live in the five states of Uttar Pradesh, Bihar, West Bengal, Madhya Pradesh and Maharashtra. Two out of three preschoolers are severely or moderately malnourished. Malnutrition is contributory to almost half the deaths under 5 years of age.

The risk of death for common childhood diseases is doubled for a mildly malnourished child, tripled for a moderately malnourished child, and may be as high as eight times for a severely malnourished child[7].

WHO estimates that malnutrition was associated with over half of all deaths in the developing countries in 1995. Besides research indicates a link between malnutrition in early life including the period of fetal growth and the development later in life of chronic conditions like coronary heart disease, diabetes and high blood pressure, giving the countries in which malnutrition is already a major problem new cause for concern[8].

However, there seems to be light at the end of the tunnel. Nutritional status seems to be improving a little and even prevalence of low birth weight babies seems to be declining a little (Sachdev H.P.S., unpublished data).

Reports from Tamil Nadu[9] suggest an improvement in the nutritional level with 51.8% normal, 27.6% stunted and 9.9% wasted, and one should make an indepth study of the contributory factors.

Feeding and Caring

Breastfeeding is a fundamental right of the child. It is the perfect food and even the malnourished mothers are able to produce sufficient amount for the baby. It costs nothing, it is a source of bonding between the mother and the baby and prevents the baby from infections. Several studies have shown a high incidence of diarrhoeal and respiratory infections in non-breastfeeding babies. Exclusive breastfeeding for 5-6 months is what the baby needs before going on to home cooked semisolid foods[10]. The economic value of breast milk has been estimated to be approximately Rs. 6000 crores per year.

However, apart from lack of family support to the breastfeeding young mother in the case of nuclear families, their availability for breastfeeding is also questionable when they are working. They try and cope by breastfeeding in the morning, evenings and through the night. However, the feeding of semi-solid family food is left to someone else, a granny if she is lucky, but often to a young girl who in the bargain misses out on her schooling and a carefree childhood.

How is this young child to be cared for ? A working mother is a reality and a necessity in our socio-economic milieu. A majority, almost 80% are in the un-organized sector and are not entitled to any maternity leave. They do take some time off depending on the needs of the child and their need to earn money to sustain their families. There is very little provision for child care. In this context the traditional custom among some communities of the pregnant woman going to her maternal home towards the end of pregnancy and staying there for a variable period after the birth of the baby is extremely helpful both for the health of the mother and the baby.

For the organized sector, there has been some improvement. Maternity leave has been increased from 3 months to 4-1/2 months (only for two pregnancies) and there is a paternity leave for 15 days as well.

Integrated Child Development Services (ICDS) programme, which will soon cover the whole country, has no provision for child care either. One can consider a

convergence between ICDS and some of the women's development programmes such as DWCRA, TRYSM, Indira Avas Yojana and many others, where women could bring their young children with them and they could be looked after by some of the women who could be trained as child care workers and earn some money. The ICDS programme could provide overall support.

The crèche as it is generally understood is a very expensive venture, and unless managed properly, can lead to infections with further deterioration of the nutritional status. However, with mothers present in the child care centres described above, the situation would be far better and breastfeeding could go on. This will also release the older sibling from child care responsibilities, and she could go to school. ICDS could then become a real nutrition and child development programme as it was envisaged.

At present, there is nothing in it in practical terms for children upto 3 years except some food distribution. For older children there is some provision for child development activities. Some studies have shown better psycho-social development in these children. However, there is ample scope for improving these activities.

Several evaluations have shown no difference between the nutritional status of children in ICDS and non-ICDS blocks[11]. If ICDS has to make a difference to the nutritional status of children, it will have to concentrate on children under 3 years, not at the anganwadi but in their homes. Active participation of the community, which is sorely lacking at present, is of paramount importance. Vibrant women's groups could contribute

a great deal to various activities connected with ICDS and in empowering the community.

ICDS is considered the prestigious child development programme. Out of a budget of Rs. 847 crores for the department of women and child for 1996-97, as much as Rs. 682 crores was allocated for ICDS.

Accesses to adequate food and to health care are among the universally accepted human rights. While infant and under five mortality has registered a considerable fall (72 and 35 respectively) it is still much too high. Several studies have shown a higher prevalence of malnutrition among the girls and higher mortality among them. There is cultural and social bias and their access to healthcare is poorer as compared to the boys. There is discrimination regarding food at the household level. NFHS data shows that a higher proportion of girls are severely malnourished in 11 of the 14 large states.

Shiv Kumar[12] has studied the Gender related Development Index (GDI) in the various states of India. Whereas India as a whole ranks 99th out of 130 countries on the GDI, there are only 13 countries in the world that record a lower GDI than Uttar Pradesh and Bihar. Kerala has done well on the GDI and ranks seventy third in the world along with China. As against an HDI (Human Development Index) value of 0.423 India's GDI value is 0.388. The two would have been the same if there had been perfect equality between women and men in the formation of human capabilities. The extent of disparity varies across the states. The lowest differential is found in Himachal Pradesh,

Maharashtra and Kerala and the highest in Haryana and Punjab, two states noted for their high per capita incomes but extremely adverse female-to-male ratios.

Anaemia is widely prevalent among all age groups and is particularly serious problem among pregnant women. It is responsible for 20% of maternal deaths. Government has had an anaemia management programme for more than twenty years, but it has not made any dent on the problem[13]. The supply of iron tablets is erratic and their consumption by pregnant women is also irregular. Besides, the short period for which a pregnant woman is being treated is not enough to make any impact.

Several studies have now shown a high incidence of anaemia among the adolescent girls[14]. These anemic girls are tomorrow's mothers, and with early marriage and repeated pregnancies, the chances of any improvement in anaemia are practically nil. Anaemic mothers are more likely to give birth to babies under 2.5 kg. In whom the death rates are higher and growth is also compromised.

There are hardly any services aimed at the adolescents - be they related to health, education, awareness etc. Frequent suggestions have been made to include the adolescent girls in the anaemia management group. Various studies have shown that it is possible to do that. Besides for reducing low birth weight, one has to focus on the health and nutrition of young girls before they become pregnant - in other words, health care during adolescence.

Directive Principals of State Policy have wide provisions for women and children. National Policy for Children was pronounced in 1974, which was a follow up on the Directive Principals and the United Nations Declaration of the Rights of the Child, 1959. The National Children's Board was set up in 1974 and reconstituted in 1981 under the Chairmanship of the Prime Minister. However, it has not met for a decade or more. Convention of the Rights of the Child was adopted by the UN General Assembly in 1989. India ratified it in 1992. However, the situation of children leaves much to be desired with poor access to education and to health care not to speak of millions who labour for long hours under difficult and even dangerous environment. This requires not only laws (which are usually flouted) but concern and activism on the part of others, who have all the advantages.

According to Mahatma Gandhi, the test of human rights and human dignity was when the last among the least were empowered to realize them first. Among these the most defenseless and the most voiceless are the children, and even among them, the girl children.

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CONCEPTUAL FRAMEWORK FOR ASSESSING WOMEN'S HEALTH NEEDS

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Introduction

It is now more widely accepted that during the past few decades the health system in India, in its planning and health careservices, has viewed the health needs of women primarily in terms of their child bearing or reproductive function. Most health programmes for women have focussed on family planning and mother and child health services. The main interest seems to have been to evolve methods by which the reproductive function of women could be controlled, so as to serve the needs of the nation, of society, of demography, of the child or perhaps the family. Even child survival strategies were evolved to ensure that the small family norm was acceptable to people. There is probably a consensus among people oriented health workers that this has been a narrow and limited view concerning women's health. It does not take into consideration sufficiently the personhood and the wholeness of women.

There is also a growing and anxious realization that this approach has not even been able to serve the purpose for which it was intended, namely of population control. However in the process of evolving alternative approaches, the basic assumptions concerning the position of women in India society and their resultant health status, on which the earlier approach rested, have not been challenged or questioned by the health system. Therefore, the same philosophy, with the same underlying goals have been repackaged or extended to cover more than just the child bearing age group of women. They now also cover the girl child and the adolescent girl, with the hope that these efforts would bear fruit during the crucial child-bearing or motherhood period. International public health experts and agencies have also floated various package deals like GOBI-FFP and Safe Motherhood, which again are narrower and more verticalised versions of the earlier Mother and Child Health Services.

The other cause for deep concern in India has been the declining sex-ratio as is revealed by the decennial census, ever since the turn of ..2

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the century. Levels of other indicators regarding the health status of women like the Maternal Mortality Rate, levels of anemia and malnutrition etc., are also unacceptably high. This has occured inspite of at least four decades of planned health interventions through an expanding health infrastructure. It has occured even though there has been an overall slow improvement in other health indicators of the population in general. There is therefore, clearly a need for a "rethink" and for evolving new approaches.

Redefining health needs of women

If new policies, strategies and approaches for the improvement of the health of women in India have to be developed, there is a need to understand and define anew what the health needs of women are. A few ideas are being raised in this regard.

A woman is a human person situated in society and her health has to be viewed with an integrated wholistic approach. Several non-medical, societal, socio-economic, political and cultural factors determine her health status. Using the WHO definition of health itself, there is a need to include the physical, social, emotional and intellectual (mental) and spiritual aspects in understanding the health status and needs of women, when evolving health strategies.

When considering physical health, while her reproductive system does influence the functioning of her body and may be a cause for ill health, women also suffer from morbidity and mortality resulting from disease in any or all the other systems as well. Availability and access to good basic and comprehensive health services is therefore essential.

There is also a close interplay of all the aspects of health mentioned in the WHO definition. The most crucial fact, cutting across class lines is that being 'woman' straightaway categorises all women to an inferior, unimportant social status in India. When considering the sizeable proportion of women (30-40% by official estimates) living below the poverty line, their health and social status is far worse than others and would derive from the following life scenario. Being poor they are likely to have a large number of live, stillborn and aborted children. They are also susceptible to a variety of physical sicknesses, most of which are preventable. They undertake exhausting work at home in poor environmental

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conditions. At work too they have the dirtiest, most tiring jobs with inadequate remuneration and rest. They have lower levels of literacy and less access to existing health services. Life in this situation also makes for a poor self-image, low self esteem, lack of self confidence and to unrecognised emotional problems during the several episodes of life crises that are experienced.

Viewing women, particularly poor women, surviving in an inhuman situation, primarily in terms of their reproductive function, therefore does them no justice, and not surprisingly, does not meet the targets set by the health system,, and even much less caters to their total health care needs. There is evidence infact that this targetted approach with the indiscriminate and unscientific use of numerous family planning procedures, are an added iatrogenic cause of ill-health for women living under these iverse circumstances.

Therefore it is imperative that the health needs of women should be viewed from a broader and a more humane perspective.

* Her value as a human person of dignity and worth needs to be emphasised. This is to be de-linked to reproduction or production of any tyre. This crucial aspect is not measurable or quantifiable.
* Her total health needs in the context of her circumstances should be considered.
* Positive indicators of physical, emotional, intellectual and social health need to be used.
* Periods of life crisis in womens' lives are to be recognised. This method can build on the strengths and infrastructure of the MCH approach and extend not only to the girl child and adolescent but also to the postchild bearing period.

Indicators to assess health/disease

The assessment or the measurement of the health status of women is an important yardstick for us to know where we are in our efforts to promote the health of women. It helps us to make a situation analysis, to measure the extent of the problem, and also the effectiveness of strategies used.

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Commonly used health indicators most often give us information about levels of disease and death among the population. These are a result of general living conditions, access to health services etc., which are thus indirectly indicated. The sex specific Crude Death Rates, sex differentials in Infant Mortality Rates, Maternal Mortality Rates etc., based on studies of sample populations, are well known indicators of deaths occuring in different groups of the population. Life expectancy at birth or at 1 year also reflects the overall health status and conditions under which people/ women live. The sex ratio is the number of women per 1000 men and its trend over the decades speaks volumes to us of the situation of women in the country. If one could disaggregate and study these rates by geographical region, by urban/rural/tribal location, and by class and caste, enormous differences would be revealed. It is necessary to do this if the health statusof those in greatest need has to be recognised/assesed and also for the monitoring and evaluation of health and related strategies that are employed.

Inspite of certain limitations and cautions that are necessary when undertaking such an exercise, comparison of rates between Districts, States, South Asian Countries, Asian Countries, developing countries and developed countries are useful. Some indices from South Asian countries are given below to illustrate the differences revealed by such comparison.

Country	Maternal Deaths per 1,00,000 Live Births	Female Life Expectancy (Years)	Proportion of Births Attended by Trained Staff
. Agghanistan	690	42.0	8%
2. Bangladesh	600	50.4	5%
3. Bhutan	1710	47.1	7%
4. India	360	57.9	33%
5. Nepal	830	50.3	6%
6. Maldives	400	61.0	25%
7. Pakistan	400-600	56.5	24%
8. Sri Lanka	60	72.5	87%

Source: 2

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Information regarding sickness (morbidity rates) among women are more hard to come by at the national or State level. This is even more true of community based epidemiological data. Studies of nutritional levels reveal that levels of malnutrition among girls/women continue to be high though there may be a gradually declining trend. Studies by the National Nutrition Monitoring Bureau showed no evidence of improved height and weight among girls from 1955 to 1979. One third of babies born are low birth weight (less than 2.5 KG), which results from poor maternal nutrition. Other studies reveal inadequate calorie and micronutrient intake.

Community based studies by Rani Bang, et al., have found that the prevalence of Reproductive Tract Infections (RTI) are very high. Contraceptive use in the presence of RTIs have been found to aggravate the problem. Occupational or workplace related health problems of women in the tobacco industry, among tea pickers and in a host of cottage industries in the unorganised sector also reveal high sickness rates. Hazardous effect of pollutants on women during childhood, adolescence, pregnancy and lactation also need to be studied. A study by Sathyamala, et al., found that the toxic gases at Bhopal adversely affected reproductive health and reproductive outcome in Bhopal. We have an indication about the extent of violence against women in Indian Society from the media, and from the experience of groups working with women. A few studies regarding mental health indicate a higher proportion of suicides and suicidal attempts among women than among men.

It is necessary to integrate and pool all available data concerning the different aspects of health of women to get a composite understanding of the situation. This needs constant updating and continuing studies. When putting different studies together, it is also important to keep in mind that there may be differences in concepts and definitions used and in the methods employed.

Need for new indicators

While accepting that having some indicators, however imperfect, are better than none, health workers/activists have been feeling the need for indicators that could gauge decision making opportunities and capacities of women, their levels of participation in health and societal life, their

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levels of autonomy, their role in provision of health care in the family, their levels of knowledge and practice of traditional methods and systems of healing among others. There is much scope for further work in this.

Indicators of health related issues

These include figures regarding levels of literacy (formal, non-formal), income/wages, percentage below the poverty line, employment/unemployment, participation in different sectors of the workforce, purchasing capacity, housing, food intake, access to safe water and sanitation. These are also crucial factors that impinge on the health status of women.

Health care indicators

These would indicate access to primary and secondary health care, distance to nearest health facility etc.

tilisation (of services) rates and coverage rates are available for some services eg., immunization coverage and immunization status. The proportion of births attended by trained personnel is also a useful indice.

The need for measurement and assessment of effectiveness and utilisation of services is illustrated by a few examples. A study of in and out-patient records showed that for every 3 men who utilised medical services only 1 woman did so. Male staffing of facilities was a deterrent to utilization (Ref. Health Status of Indian People, 1986., Foundation for Research in Community Health)

Another recent study by the Paediatric Department of Maulana Azad Medical College in 150 slums, covering 22,181 households in the capital city of Delhi found the following:

* 45% mothers did not avail of antenatal services
* 16% had the optimal four antenatal checks
* 12% smoked even during pregnancy
* Awareness regarding health, nutrition, and awareness of possible complications during pregnancy was poor
* 51% received iron and folic acid tablets
* 63% mothers were immunized with tetanus toxoid.
* 82% delivered at home, untrained birth attendants conducted most deliveries.

Source: 3

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Caution in the use of indicators

When using any health indicators, it is important to keep in mind the methods of data collection and quality of data before deriving conclusions from them. Questions should be raised regarding methods of sampling used viz., are they representative of the population. Are findings from one or two studies conducted in relatively defined geographical areas being extrapolated or generalised to the entire population. There is thus a need for a critical appraisal of any data and rates. It is also important to keep in mind that the health situation in the community is dynamic and changes continuously as a result of several factors. It may also not be all that easy to draw cause and effect conclusions from a particular health intervention and possible health outcome. The role of other factors that could cause a bias or be confounding will have to be considered. However, inspite of all the above there is scope to build further and not to just abandon what we already have.

As we look at new perspectives emerging in health, new indicators will need to be developed.

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TOWARDS COMPREHENSIVE WOMEN'S HEALTH POLICIES & PROGRAMMES
WORKSHKOP 6-9 OCTOBER, 1998 AT E.C.C, BANGALORE.

* Role of T.S.M in Women's health with a special reference to R.C H.

Traditional systems of Health Care flow through two distinct but symbiotically nourishing streams, an oral streams and a codefied one.

The local Health traditions or the Lok Swasthya Paramparas are the oral traditions born out of experiences of thousands of communities of different geographical zones and cultural backgrounds over thousands of years. This system is basically eco-system specific and local need based, depending on the immediately available local resources such as flora fauna and minerals.

This is spread across the country over six lakhs of villages carried down by common house wives, village dais bone setters and other local practitioners and some religious institutions and healers.

The codefied streams which are documented in thousands of manuscripts are represented by Ayurveda, Siddha, Unani and Tibetan.

The unifying factor of these written traditions are the underlying unique basic principles and world view which forms the corner stone of this science.

The codefied and oral traditions have been in interaction over the years and many practical aspects of written traditions are drawn out of the experiences of the oral traditions. And the oral traditions when validated can be seen as based on the foundational principle of the written tradition such as Ushna Sheeta Vata etc.

TSM as a whole is basically a science born out of experience and based on universal principles.

The world view of TSM is that the whole world including living beings and inert substances are made of FIVE ELEMENTS which through their infinite and reversible permutation combinations create different objects of diverse characters. Thus we see in everythings which has an existence in consciousness having the presence of these five elements namely

Prithwi (Solidity principle)
AP (Fluidity principle)
Thejas (Heat principle)
Vayu (Principle of movement)
Akash (Ether or principle of space)

In the living beings these principles are further grouped into the three functional units called VHATHA, PITHA AND KAPHA.

VATHA is formed by the predominance of Vayu + Akasha elements with other 3 principles in lesser percentage.

PITHA is formed out of more of Agni + less jala and other 3 elements still in lesser quantity.

KAPHA is formed out of the combinations of Prithvi + jala with other 3 elements with lesser volume. Thus the Panja Mha Boodhas are re-classified in the living being as Vatha, Pitha and Kapha.

The role of the physician or the healer is to observe the changes or vitiation of these 3 e.ements in the body either alone or in combination and provide such materials from the outer universe to the body so as to bring in back the lost equilibrium.

The only contribution of the healer in this action is the processing of such outside substance into an easily assumables form by the body.

To be precise the healer chooses and advises such deeds (Karma) life style (Pathya) and medications (Oushadhi) which can be assumulated by the body when it is in a de-ranged condition.

To bring back its homestatsis or internal environment.

It is with this view point Acharya Vagbhada described everything in the universe as medicinal (Jagathyevamanoushadham Navadyat) so if properly understood in the right perspective TSM can do a great deal in preventive, promotive and curative aspects of health care.

In TSM women's health comes under separate branch along with paediatrics. Women's health is giving so much of importance in TSM that the whole life cycle is very beautifully drawn in the Samhabidas.

BALA, THARUNI, KANYA, YOUVANA, PROUDHA, MATHYAMA AND VRUDHA are the seven stages in chronological order in women's life.

In Bala Avasta also it is further divided into KSHEERADA, KSHEERANNADA and ANNADA, which marks the culmination of infancy.

Women's health in adult life is elaborately dealt along the following lines:

1. Problems of primary and secondary reporductive organs
2. Reproductive tract infection
3. Diseases of uterus during menstrual period and after menopause
4. Elements to be remembered for suitability of bride and bridegrooms
5. Compatability for marriage
6. Methods of making marital life enjoyable by right choice Ahar and Vihar
7. Diet during different age, season and occasion - for example:
    a. during menstruation
    b. during early stages of pregnancy
    c. after delivery
    d. during breast feeding
    e. during menopause AND
    f. during old age

Subtle and detailed descriptions of women's health needs and disease management with minute details are explained in TSM. The whole concept of ante-natal care where the mother is given the utmost importance not only for physical and physiological needs, but for her psychological and spiritual wellbeing is a notable area in Ayurveda.

Apart from the detailed life cycle approach of health and disease, the cosmetology for women is an unexplored area in TSM.

From skin care to hair care, from maintaining the body form and shape to keeping all the organs of the body with optimum functional level is another unique aspect of TSM.

The permutation combination of plants and other materials give infinite choices to the healer . from within or without to chose the appropriate materials at the right time.

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Indian medical professionals have a great deal to contribute to women's health by exploring the fullest potential of TSM. They can bring out effective and safe materials and methods which can be used by our healers and health managers of today so that Traditional wisdom can be rediscovered by rural women who have in recent decades been stripped off all their natural healing powers curiously enough in the name of 'Science and Modernity'.

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Organising Poor Women for Health - A Note

WH-11; 9.14

Mirai Chatterjee
General Secretary, SEWA
October, 1998.

SEWA has been organising poor, Self-employed women for full employment and self reliance for over two decades. In the course ofour work, there have been several experiences concerning poor women's health.

Women often say:

"Our health is our only wealth"

"As long as we are healthy we can work. And as long as we get work we survive".

SEWA Bank's experience and data reveal that mortality and morbidity of a Women and/or Family member is the Number One Stress event in her daily life. It is a major cause for non-payment of installments for loans taken out, and for indebtedness.

In fact, in 1977 when SEWA Bank reviewed the loan performance of its depositors, we found that of 500 women who were defaulters, the major cause was sickness of the loanee, inability to work and earn and hence inability to repay the loan taken. Of these 500 women 20 women had died - the predominant cause of death being childbirth. This finding forced us to start up our work for Maternity Benefits, Safe Child - Birth and Health in general.

Another concern which is uppermost in women's minds vis-a-vis health is the escalating costs of health expenditure. Our members routinely spend between Rs.500/- and Rs.800 on health-related expenditures. The major increase in cost is due to rapidly increasing drug costs. The cost of life-saving Rifampicin, for example, an anti-T.B. drug, went up three times in one year alone (in 1996)!

In sum,we learned that:

a) Women in the informal sector do work that is physically demanding, often with harmful substances. They work long hours in positions that harm various parts of their body. Pregnant and feeding mothers often work in circumstances that lead to miscarraige or affect the health of the child. Occupational health is a major issue for poor women.

b) Their health affects their work. Work in the informal sector is mainly manual, and productivity depends on a body in peak physical condition. Unfortunately, because of poor nutrition, lack of care during pregnancy and childbirth, living in unsanitary conditions and lack of access to health care, most women are in poor physical (and often mental) health. This causes a fall in productivity and income, leading into a vicious cycle of deteriorating health and increasing poverty. Access to Social Security is essential for poor women.

Given the above, then, SEWA developed its health team with the following basic approach:

a)All health services/care should be need-based and demand driven.

b)All health care should strengthen women's quest for Full Employment & Self Reliance (SEWA's goals).

c)A community health/primary health care approach - holistic and integrated both within the health sector and with other economic activities.

d)Women should be developed as health providers, building on their existing knowledge and skills.

e)All health services should be provided in a manner which contributes to long-term self-reliance (both cash and in kind contributions from women are encouraged).

f)Initial curative care to be slowly augmented by health education, and the latter to be emphasized.

g)Strong referral care by coordination and collaboration with both government and pro-poor, affordable private health care.

h)Rational, generic drug therapy.

i)Combine grass roots action with policy action at State, national and international level policy action for more pro-women and pro-poor, appropriate health policies and resources allocations.

Some examples of health action at SEWA

1.Organized local women (from villages and poor urban neighbourhoods), often dais, to be "barefoot doctors" for their own communities. These women then formed their own health workers and dai cooperatives with SEWA's support. 4 such cooperatives are active at present. In an additional two drought - prone districts (Banaskantha and Surendranagar) dais have been organised into exising district - level women's associations which are part of SEWA movement.

Each cooperative has an elected executive committee which run the cooperative and plans and manages all the health activities for the district concerned. They generate revenues in various ways: from women, from employers, from government, through training fees and drugs shops.

2.Health insurance has been organized for SEWA members with the support of SEWA Bank. 32,000 women have paid premium for coverage which includes matenity benefits, reproductive health, occupational health, health problems of older women and for common and serious diseases. Each woman receives coverage upto Rs. 1200 per annum.

3.'Shakti Packet' programme is run by village women and provides foodgrains and essential food items to women in two desert districts at present.

"Shakti Packets" ensure that poor women and their families obtain good quantity and quality food items and hence proper nutrition, and at affordable prices at their very doorsteps.

4)Basic amenities in 11 poor urban neighbourhoods in Ahmedabad have been provided by collaborating with the Ahmedabad Muncipal Corporation (AMC) in a unique joint programme called "Parivartan". Under "Parivartan", AMC local Corporate bodies and poor families themselves contribute towards provision of health-enhancing basic services: water, toilet, gutter connections, garbage disposal, street - lighting, paving roads and by - lanes and lands caping (filling ditches and leveling and growing shade trees). Individual families' finances are managed by SEWA Bank which also provides them with loans and only releases the families ' deposits to the AMC when substantial ground work (laying of pipes etc.) is completed.

5)3 round -the-clock drugs counters have been run by women, providing standard quality and low cost drugs and surgical equipment to poor patients Ahmedabad city. A recent evaluation of this activity found the counters' prices to be the lowest in the market. It has also forced nearby chemist shops to revise their exorbitant rates.

At present, 4 new drugs counters are being developed, one of which will be in a taluka town, serving our rural members.

What we have learned -a summary

1)Women's priority is work security and income security. But without appropriate and affordable health care, they cannot obtain work and income security nor Full Employment and Self-Reliance.

2)When women organize for and obtain some measure of work security, they seek and demand health security and health care.

3)Reproductive health is viewed by women as an integral part of their overall health. Separating this aspect of their health is not useful to women.

4)Occupational health is a very neglected aspect of women's health and yet one where it is difficult to intervene, and have some impact. This is because

a)Women are afraid of losing their employment in a situation where alternative employment is scarce (as in the case of tobacco workers), and hence are not eager to take up occupational health activities.

b)Safe workplaces often require major changes in work processes and substitution of toxic substances which employers do not want to undertake , saying they are 'expensive'. And women have weak bargaining power as few unions exist.

c)Occupational health interventions often need to be technical and scientists with an interest in working with and learning from the poor are hard to come by.

5)There is a tremendous hunger among women and men to learn about their bodies and their health. They are very ready to learn and need simple, understandable and appropriate health information - information that is both useful and empowering.

6)Health care/services can be a source of employment, especially self-employment for poor women. For example, they can become health educators and charge fees they can earn from their midwives services and by sale of drugs.

Cooperatives of health providers like dais can be active and economically viable organisations.

7)Decentralization of health services and delegation of the latter to women's groups and organisations (unions, Manila mandals, cooperatvies and producer's groups) is an effective way to reach health care to the poorest populations. It is the ideal alternative to both government and private health care which are both generally neither pro-poor not women - centred.

8)Combining a strong grass roots base with policy action can help develop health policies and programmes that reflect the health priorities of poor women. Policy action may be undertaken at district, state national and international levels. For example SEWA's long standing demand for identity cards and hence recognition of dais has been accepted by the Gujarat government. Various plans to involve these local women health care -givers in primary health care activities are being worked out.

Perhaps most important what we have learned in all these years is the importance of organising -i.e. when women workers come together in a group around common interests including their own health, they become a powerful force for change. Change in their own lives, their own communities and the world beyond their villages. It is they who will lead to ensure their own and their families overall health and well - being.

WH-11; 9.15

REPRODUCTIVE HEALTH PROMOTION AMONG WOMEN

Paper Presented

By

Mrs.J.P.Saulina Arnold, MA., MSW (USA)
Executive Secretary
Tamil Nadu Voluntary Health Association
18, Appadurai Main Street, Ayanavaram, Chennai - 23.

At the
WORKSHOP

TOWARDS COMPREHENSIVE WOMEN'S HEALTH POLICIES
At
ECC BANGALORE

HEALTH PROMOTION AMONG WOMEN

In this country, which is called Bharath, the Baratha Matha is the mother of all and all important issues is given to goddesses (not god the male) - Education to Saraswathi, wealth to Lakshmi and power to Kali. God created male and female in His Image and left the work of production and rule the world to them says the Bible. Production and protection has been left to Sivan (Male) and Sakti (Female) equally that one cannot exist without the other says Indian religion. But all are only religious attribution and in reality the daughters of mother India lack education - as there are more illiterate (61%) than literate (39%) - women have low status, no rights on wealth or power over their own body leave alone their family. In this situation this paper is to present women's agenda for health. It is not sure if the agenda is for the women to follow, or the policy makers (mostly men) to follow. In this paper the presenter is trying to depict the situation of women, the health status of women, issues blocking their health and development and ways to improve the situation through health promotion activities.

Fifty years after independence it is not sure if the health situation is more improved than science and technology. The population has been doubled, literacy rate has improved and mortality rate reduced considerably. But still the following data show the health situation of people. There are still many illiterate, specially among women, there are about 32 crores living under poverty line.

INDIA - FACT SHEET (1991)

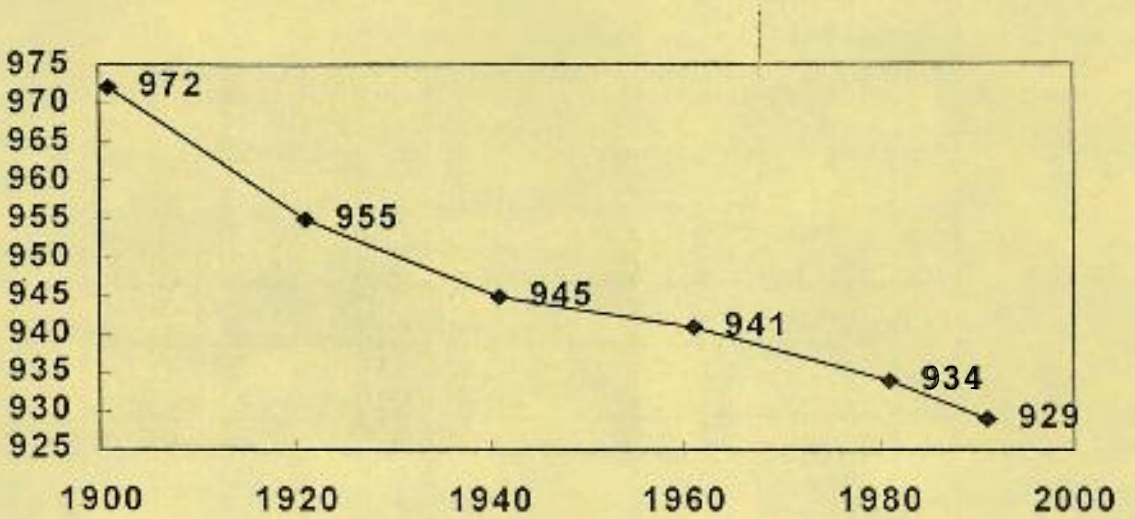
Sl.No.	Particulars	India
I.	Population Total	84.6 Crores
	Sex Ratio per 1000 Male	929
II	Literacy Rate	
	Male	64.13%
	Female	39.29%
III	People living below Poverty line	
	Percentage	35.97
	No. of people	32 Crores
IV	Maternal Mortality Rate	570
V	Infant Mortality Rate	110
VI	Mean age at marriage	15 years

The status and situation of women has to be understood on these issues-declining sex ratio and gender inequality, the burden on women, reproductive health and morbidity, adolescent health, etc.

DECLINING SEX RATIO

India is one of the few countries, where since the turn of century the sex ratio of women to 1000 male is steadily declining from 972 in 1901 to 929 in 1991.

Sex Ratio Tamil Nadu & India



Years	1901	1921	1941	1961	1981	1991
India	972	955	945	941	934	929

This key indicator of the low status of girls and women in the society is further supported by the reversal of the Infant Mortality Rate (IMR) between boys and girls.

1980 -	Male	96	:	Female 90
1986 -	Male	74	:	Female 86

The unfavourable status of women in India affects the health status of women and their girls both directly and indirectly. "Son preference" and gender disparity in household has its own ill effect on the growth of the girl child. Due to these the number of girls outside education system is more, more girls who have to work at home, (and also study if they

are sent to school); Besides girls eat last and least amount of nutritious food; the social norms both in the natal home and in the home where she is given in marriage, gives her least priority for her health or status. This treatment and trend is more now than ever before. Increasing "dowry" problems, ill-treatment and death are seen even among educated. Due to this gender discrimination, violence against women is increasing.

"In India more than 5000 women are killed each year due to dowry"

- UNICEF

Wife beating is very normal, when most of the countries has brought legislation against Domestic Violence, Marital rape, Sexual harassment and female genital mutilation, India has not included these in its legislation. Not that there is no policy or legislation in India. Since British time many legislations were enacted but they have not been implemented due to the strong male dominant world. Women groups need to know about these and try to implement.

Even educated people see only the visible - educated middle class women - and forget about the women. Invisible - 60 - 70% women in rural and urban slums.

HEALTH STATUS

According to the World Bank, about one third of the disease burden in developing country is of women between 15 to 44 years of age. It is linked with pregnancy, child birth, abortion and Reproductive Tract Infection, STDs/HIV/AIDS.

India's maternal mortality ratio is fifty times higher than that of many developed countries and six times higher than that of Sri Lanka. The generally poor nutritional

status of girls and women plays a major role in this. Malnourished women give birth to low-birth weight baby and if it is a girl the vicious cycle continues.

Most of the burden of health care falls on women. Nearly all family planning methods are for women creating more problems. While the data given below shows those recorded there are thousands who do not seek medical help from trained professionals. There are many mis-conceptions that prevent women from seeking health services.

DISEASE DATA

Sl.No.	Particulars	Both	Male	Female
1.	CRUDE DEATH RATE	10	10	10
2.	Life Expectancy at Birth	-	55.4	55.7
3.	DISEASES (in 1000s)	2,87,902	1,42,308	1,45,594
	Tuberculosis	13,794	8,748	5,046
	STDs	5,566	1,871	3,695
	Respiratory Infection	34,251	16,059	18,192
	Maternal conditions	7,409	--	7,409
	- Infection	1,256	-	1,256
	- Abortion	1,600	--	1,600
	- Obstructed labour	1,503	--	1,503
	- Haemorrhage	846	--	846
	Non communicable	83,437	42,071	41,366

-Source - World Bank Publication 1995

BURDEN ON WOMEN

Women who is not given power or education is expected to take care of the whole family, irrespective of whether the husband earns and gives money, whether there is fuel or provisions for the family.

Rural Energy Consumption %

Kerosene	7.1
Log, twigs & charcoal	51.6
Dung	21
Crop waste (Hay)	16

- The Second India - World Resources Institute

These data shows that 89% of energy is non commercial - have to be collected, saved by women. Their time and energy has to be spent for this. These energy, specially with smoke are very hazardous for women. Some studys said a women inhales about 40 cigarettes smoke while working in the kitchen. Kerosene and other commercial energy are not accessible to women. It is also said that with less and less common land for women, to collect twigs and cow dung her task is harder.

Poverty: - in India with less social security the individual households have to look for their own survival - that means all in the family have to work. So no time for education or upgradation. Lack of income produces malnutrition, low productive people and in turn they give birth to similar persons which perpetuate poverty. Inspite of development the people under poverty line remain the same. This cycle has to be broken through education and empowerment. At present urbanisation and urban poverty have increased. There are many cities with more than one lakh population. The local authorities for example, Channai with only 174 Sq.Km has 50 Lakhs population and has a density of

21,111 persons per one Sq. Km. Growth of this scale has put enormous pressure on urban infrastructure and administration. So women are more burdened.

Families have less and less social support and that also is a problem for women. Increase in urban poverty affects mostly women and children. There are not many who work for these groups.

- Poverty with illiteracy, unemployment and low status drive many women to sell sex for survival. This makes them more vulnerable for STDs and even HIV/AIDS.

- Basic amenities-water and sanitation is lacking in many places. That affects the health of women. There is an urgent need to provide these.

ADOLESCENT HEALTH

It is estimated that 19 crore adolescents (aged 10-19) are in India with nearly half of them being girls. Many of them are not studying but working. In India in many states girls are married in this stage. Also women commence sexual activity at an early age and become more vulnerable due to their already under-nourished status. Inspite of conservative attitudes there are more and more unmarried adolescent girls getting pregnant and restore to unethical and dangerous methods to abort the child. Lack of education, sex education, modern mass media all lead to this situation. There are evidences to show that RTIs and STIs are in young girls also. But no measures have been taken to educate them properly. Even the lesson added in 10^{th} standard text is only an academic exercise and makes no change in their lives. There are more semi educated girls now, without jobs, than ever before. That leads to problem. Only planned intervention for them can promote health.

HEALTH SERVICES

One of the most neglected areas for women in India is lack of access to health services. There are blocks at every steps.

- In the family - they have to get permission, money
  - they need a support to go with them
- In the health centre there are not - many Lady Doctors.
  - basic health facilities
  - encouragement
  - besides distance, unsuitable OP timing also contribute to their misery.

Besides these the medical personnel in many places do not understand the plight of women and blame them for the same. Their attitude prevent women from going to treatment.

Creating awareness among health personnel could be one solution for this.

AGENDA FOR WOMEN

In this background if we have to give women's group an agenda to improve women's health, the following steps have to be taken on all the above issues.

a) Awareness for women's group leaders
b) Documentation of information
c) Awareness to women and community
d) Promotion of Reproductive Health
e) Socio-economic programmes

only step by step changes could be brought and little drops of water make an ocean.

a) Awareness for women leaders

The Voluntary organisations and the Government need to plan strategies to equip women leaders with knowledge and skill.

b) Documentation

In India most of the data pertaining to women's development are not available. To create awareness as well as to see the progress in each area, data have to be collected regularly on the following issues:

- no. of women in the area
- no. of women in reproductive age
- no. of girls - adolescent
- their status / health problem, etc.

These data could be used in participatory methods to create awareness.

c) Promotion of Reproductive Health

To reduce Maternal Mortality Rate and Infant Mortality Rate as well as to have healthy life the people in this age group (14-40) need to be concentrated on and, activities to be planned for the improvement of

- Nutritional status of women
- Adolescent girls health - education on sexual health
- Follow-up of Family Planning
- Prevent abortions through education and support
- Education on RTI/STI and prevention methods

- Promote health seeking behaviour and referral
- Promote Breast Feeding through family support
- Education on Sexuality and gender and sexual health
- Community mobilization and education for reproductive health

Provide basic amenities - Toilet / bathroom in public places for women with the help of local Panchayats.

Motivate women groups for action to promote women's status.

d) Socio-economic programme

Women Sangams need to be strengthened to mobilise local resources. There are many schemes by Government for women's group for self employment, cooperatives etc. Women should participate in Panchayat and mobilise resources for their development. Women should be organised to empower them.

ILLITERACY *AMONG WOMEN*

STATE	SEX RATIO 1991	ILLITERACY		
		FEMALE	SCHEDULE CASTE	SCHEDULE TRIB
INDIA	927	60.71	76.24	91.81
DELHI	827	33.01	56.18	-
UP	879	74.69	89.31	80.14
BIHAR	911	77.11	92.93	85.25
MP	931	71.15	81.89	89.27
RAJASTHAN	910	79.56	91.69	95.58
ORISSA	971	65.32	79.26	89.79
KARNATAKA	960	55.66	74.05	76.43
A.P.	972	67.28	79.08	91.32
TAMIL NADU	974	48.67	65.11	79.77
MIZORAM	955	21.04	18.75	21.03
KERALA	1036	13.83	25.69	48.93

FEMALE 'ILLITERACY' BY AGE

AGE	RURAL	URBAN
35+	85.98	53.37
25 - 34	73.45	36.08
20 - 24	66.01	27.05

NEED ADULT LITERACY PROGRAMME & HEALTH EDUCATION ACTIVITIES

PRESENT HEALTH PROMOTION ACTIVITIES

By Govt. / NGO / Health Workers

FOR LITERATE

Poster / Booklets / Handbills

FOR GENERAL

MASS MEDIA - TV - VIDEO - HOW MANY PERCENT ARE COVERED ?

FOLK MEDIA - Through Govt./NGO - **Only in very few selected area**

LITERACY PROGRAMME
IS SUPPOSED TO BE IN ALL AREA -

BUT HOW MANY
ATTEND ?

HOW MANY HAVE TIME TO
REALLY SIT AND LISTEN TO *EDUCATIVE PROGRAMME*

Mostly they want only Entertainment - not Education

WAY OUT

When do women seek advice?

When they have a problem

Whom do they approach?

THE VILLAGE HEALTH INFORMANT

HEALTH WORKERS

HEALTH PROMOTION AMONG WOMEN

HEALTH PROMOTION through

Health Education]
Health activities] Individual / women groups

TNVHA'S EXPERIENCE IN HEALTH PROMOTION AMONG WOMEN

TNVHA had collaborated with Government to promote specific health action among women.

SOME SALIENT FEATURES

1991-97 - PVOH-II USAID Govt. of India, Health & Family Welfare Department

A. PROJECT THROUGH - LAY FIRST AIDERS

COORDINATION BETWEEN

- Govt. - NGO (TNVHA)
- NGO (TNVHA) - NGO (Members)
- NGO (Members) - GRASSROOT LEVEL WORKER (LFAs)

1200 LFAs of 129 NGOs were trained

TWO MONTHS TRAINING ON PRIMARY HEALTH CARE

Follow up 4 years

They were :

⇒ First Health informant

⇒ Counsellors

⇒ Health providers

⇒ Even Researchers

⇒ SOME CONTESTED & WON

Posts in Local Body Election

1996-97 Operational Research on Reproductive Tract Infection (RTI)

These LFAs were involved. Trainings

Health Camps

Focus Group Discussions

Individual Interviews

OUTCOME OF THESE - 'SILENCE OF WOMEN' WAS BROKEN

⇒ WOMEN GOT AWARENESS

⇒ WOMEN TALKED OPENLY

⇒ CLARIFIED DOUBTS ABOUT THEIR REPRODUCTIVE HEALTH

ONLY PROBLEM is for Treatment Not many Health centres were available for women

TRAINING of Girls from SC/Backward community

TN MCH & FIRST AID

TARGET : 30,000 girls

AGE : 15 - 25 years

Girls trained so far 19,000 (app.)

OUTCOME : The girls are active

- ◊ SOME BECAME HEALTH WORKER
- ◊ They have become an informant in their habitat

Plan to make them a link between SC Community and Govt. facilities.

THESE ARE SOME WAYS THE WOMEN COULD BE INVOLVED FOR HEALTH PROMOTION OF WOMEN

CONCLUSION

Women's power need to be re-kindled. Let us to women to show the way for other women. But at the same time men need to extend their support and help in this aspect to have a lasting change in the society. Only health education and health promotion can do this. This can be achieved if all get together and work.

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2. "Improving women's Health in India", World Bank 1996, USA

3. Pachauri, Saroj "Defining A Reproductive Health Package for India" - A proposed Frame Work, 1995. The population council, New Delhi, India

4. Jejeebhoy, Shireen J. "Adolescent Sexual and Reproductive Behaviour", International Centre for Research on Women (ICRW) 1996.

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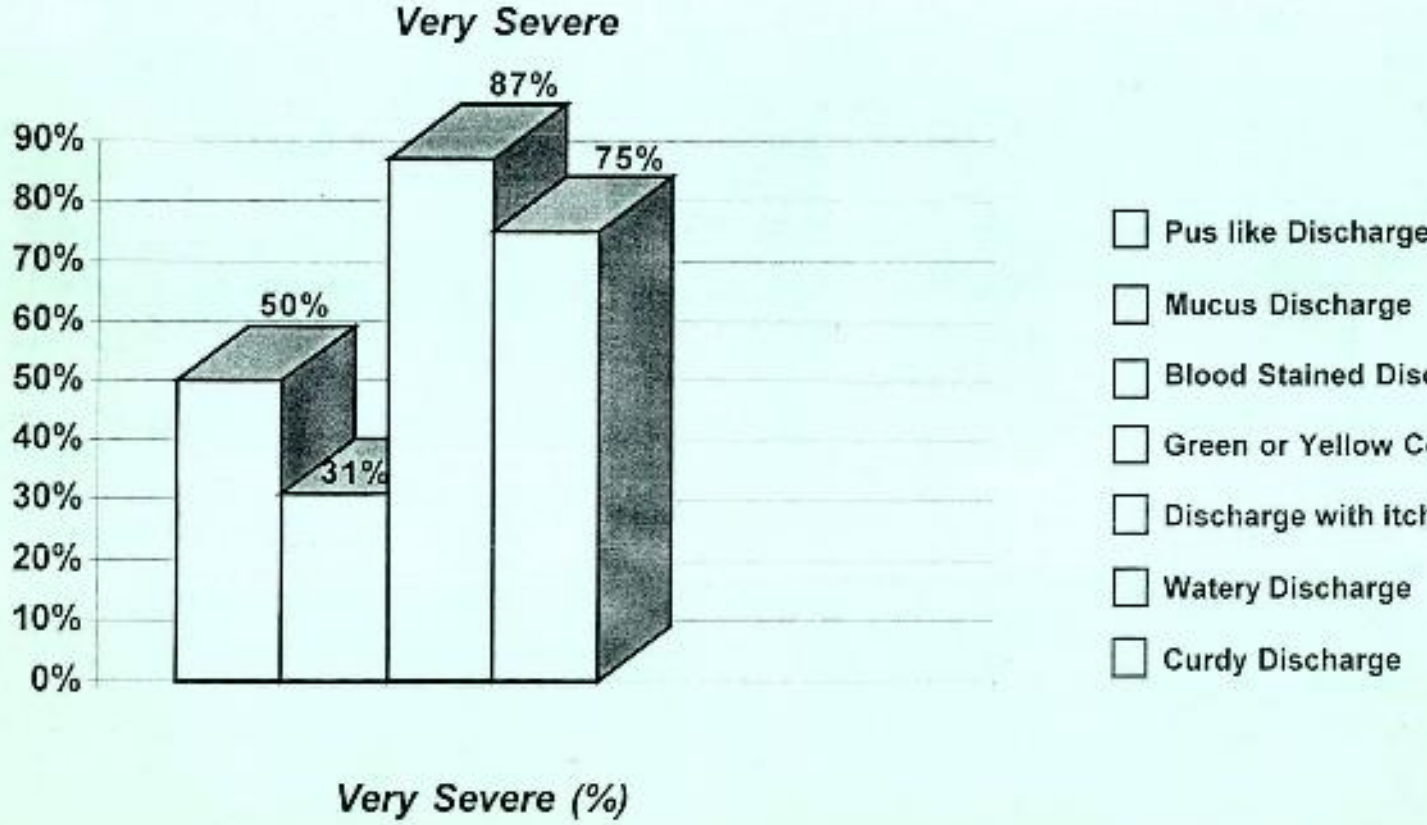
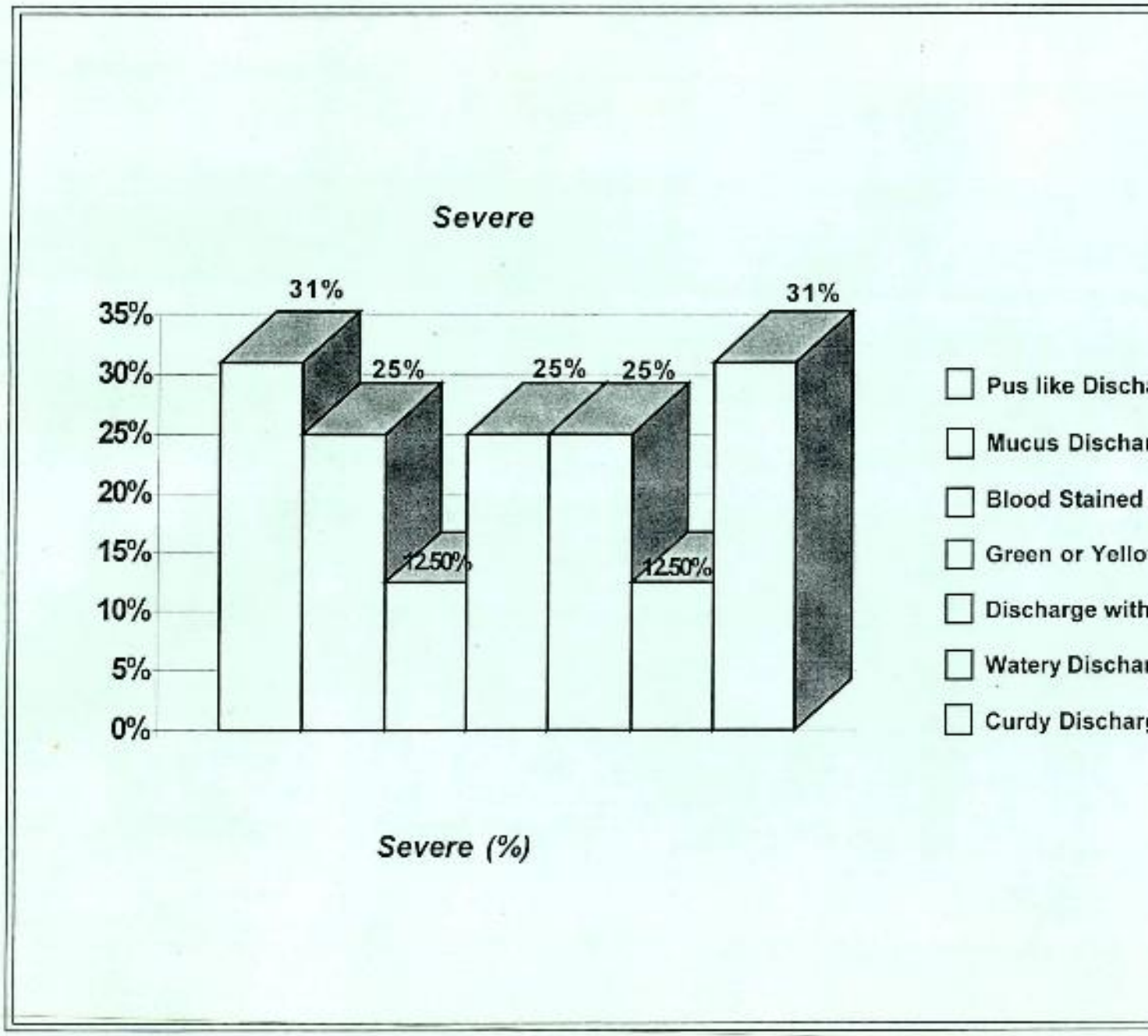
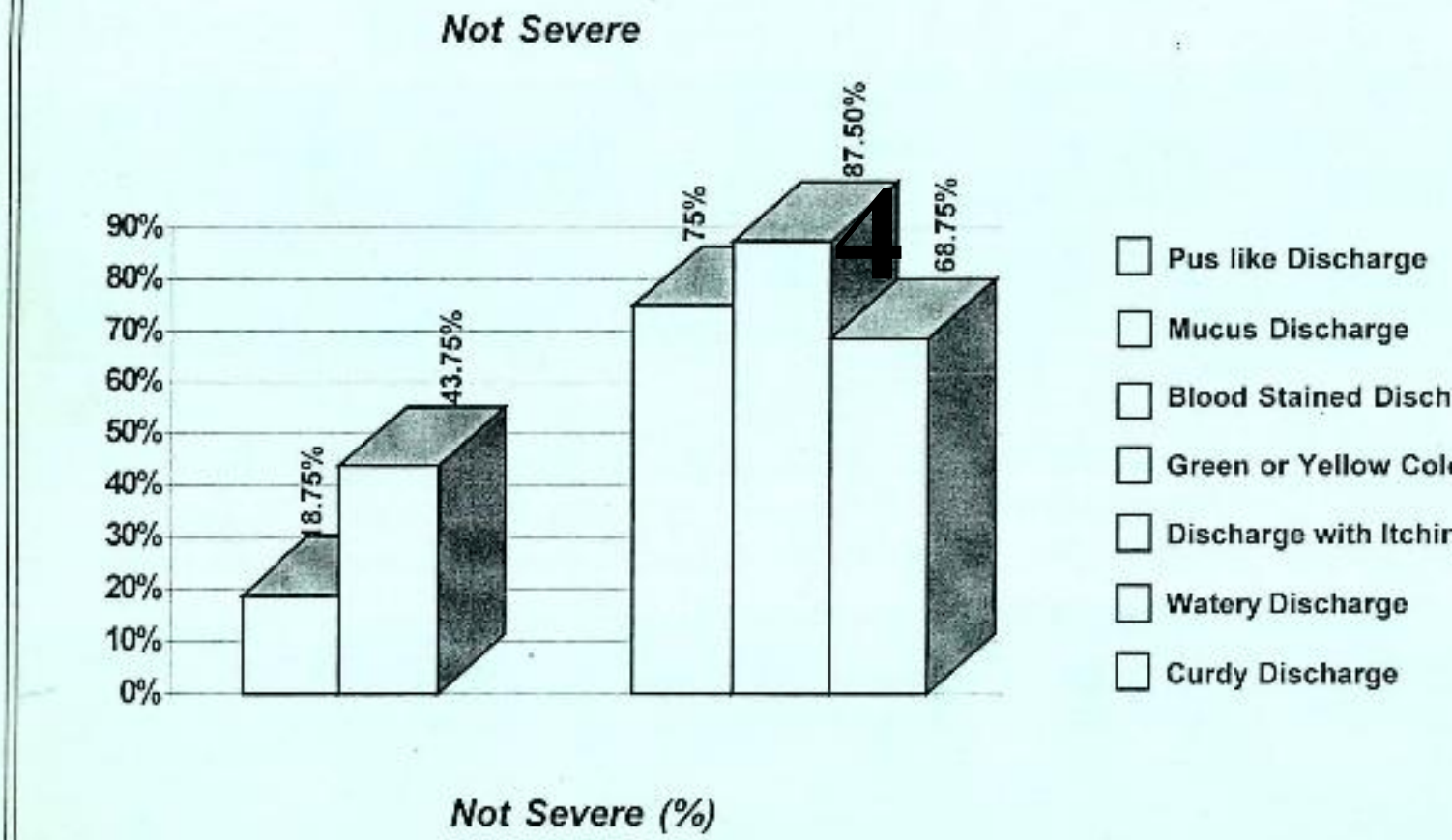
RANKING OF SEVERITY DONE BY RESPONDENTS WITH VAGINAL DISCHARGES




Severe
31%
25%
25%
25%
31%
35%
30%
25%
20%
15%
10%
5%
0%
12.50%
12.50%
Pus like Discha
Mucus Dischar
Blood Stained
Green or Yello
Discharge with
Watery Dischar
Curdy Dischar
Severe (%)


Not Severe
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
18.75%
43.75%
75%
87.50%
68.75%
4
Pus like Discharge
Mucus Discharge
Blood Stained Disch
Green or Yellow Col
Discharge with Itchir
Watery Discharge
Curdy Discharge
Not Severe (%)

PERCEIVED CAUSES & EFFECTS OF OTHER SYMPTO
GYNAECOLOGICAL MORBIDITY

SL. NO.	SYMPTOMS	CAUSES	
1.	Vaginal Ulcers	Promiscuous Behaviour*	It will get automati
2.	Swellings on the groin	Promiscuous Behaviour Evil Eye *	It will bec if not trea
3.	Boils on the genitals	Promiscuous behaviour, Evil Eye, Heat, Food Allergy	It is a ver It should immediat
4.	Genital warts	Do not know	It is like a the body.
5.	Excessive bleeding	Insertion of IUD Tubectomy Evil Spirit * Threat, Weakness, Heat	It will be is sprinkl is tied by It will lea Weaknes
6.	Lower abdominal pain	Tubectomy, Weakness & Heat	It will be

NATURE OF VAGINAL DISCHARGE	CAUSES	F
Watery Curdy Mucus	Body Heat	♦ Women ♦ Husban ♦ Alcohol
	Weakness Tubectomy Copper-T	♦ Poor Nu ♦ Side Ef ♦ Weaker ♦ Cutting
Purulent (Pus) Blood Foul Smelling Yellow	Most Commonly Due to Promiscuous Behaviour	

- *Most of the respondents have this kind of perception. Hence the tubectomy.*

ACCESSIBILITY & UTILISATION OF HEALTH CARE SERVI

Sl. No.	Health Care Services	Average distance from village	Very frequently %
1.	Traditional Birth Attendant	1 kms.	70
2.	Traditional Healer	1-10 kms.	60
3.	Manthrik Healer (Faith healer)	1 - 5 kms.	52
4.	VHN / Health Workers	1 - 5 kms.	85
5.	Private Practitioner (Indian Medicine)	3 - 5 kms.	40
6.	Private Practitioner (Allopathic)	5 - 10 kms	35
7.	Private Practitioner (Quacks)	1 - 5 kms.	50
8.	Sub Centre	3 - 5 kms.	12
9.	Primary Health Centre	5 - 30 kms.	12
10	Dispensaries (Private)	5 - 20 kms.	15
11.	Dispensaries (NGO)	5 - 20 kms.	38
12.	Hospitals (Private)	10 - 20 kms.	20
13.	Government Hospital	15 - 30 kms.	30
14.	Teaching Hospital	20 - 50 km.	15

ANNEX

BASIC INDICATORS OF MOST POPULOUS TWO COUNTRIES

Indicators	China	India
1. Population	1088.4	815.6
2. Area (thousands of Sq.km)	9561	3288
3. Average annual rate of inflation %	4.9	7.4
4. Life expectancy at birth (years)	70	58
5. Adult Illiteracy - Total	31	57
- Female	45	71
6. Crude birth rate /1000 population	21	32
7. Crude death rate /1000 population	7	11
8. Women of childbearing age as % of population	55	49
9. Married women of child bearing age using contraception (%) including men	74	35
10. Babies with low birth weight (%)	6	30
11. Infant Mortality Rate (per 1000 live births)	31	97
12. Percentage of urban population	50	27
13. Risk of dying by age five - Male	40	120
- Female	30	118
14. Maternal Mortality Rate (per 1,00,000 live births)	44	500
15. Enrolement in primary school (%)	124	81

Source : World Development Report 1990 - Poverty :World Bank

WH-11; 9.17-

Voluntary Health Association of India

Women and Health Programme

BY COURIER

PP:DSE:

September 21, 1998

Sub: VHAI-WAH! Workshop at Bangaloe - 6th to 9th Oct. '98

Dear

You must be aware of the WAH! initiative in training in women's health at regional levels having taken place in the south under the coordination of AIKYA and the western region under the coordination of CHETNA. VHAI to complement the efforts of gender sensitive training in women's health, has taken the responsibility to organise Preparatory Workshops and National Policy Seminar related to Women's Health titled *"Towards Comprehensive Women's Health Policies and Programmes"*. This letter is just to inform you about the dates of the Preparatory workshop which have been fixed for 6th-9th October i.e. three and half a days in Bangalore at:

Ecumenical Christian Centre (ECC),
Whitefield, Bangalore-560 066;
Phones: (080) 8452653, 8452270, 8453158.

In view of optimization of time, energy and cost, we decided after discussion with the WAH! core group to have the two Preparatory workshops combined as one. As you are aware the WAH! .nitiative has been supported by DSE. The local host of the workshop in Bangalore will be AIKYA and the contact person is Ms. Philomena Vincent and Ms. Neerjakshi of Karnataka VHA (VHA of Karnataka, Rajini Nilaya, No.60, 2nd Cross, Gurumurthy Street, Ramakrishna Mutt Road Cross, Ulsoor, Bangalore 560 008 Phone: 080-5546606).

While we would like to invite many outstanding health personnel who have contributed to women's health, we are limiting the number to those whose contribution to the process of compehensive women's health policies and pogramme planning would be valuable. We would hope to see experiences of the NGOs woking in women's health especially those from the South shared with those working on policies and programmes.

...2

You are cordially invited to participate in this workshop. This letter is to request you to kindly participate from 6th to 9th October '98 in the above workshop in Bangalore. A formal letter with the programme is being enclosed. This workshop is co-organised by VHAI-WAH!.

I will be grateful if you can confirm your participation. Please kindly note down the phone numbers, fax number and the Email number of VHAI and the dates in your diary and address of AIKYA is :

Ms. Philomena Vincent, Director,
AIKYA, 377, 42nd Cross, 8th Block,
Jayanagar,
Bangalore-560 082,

Phone: 080-8432363; Fax: 080-6643276.

With warm regards.

Yours sincerely,

Dr. Mira Shiva
H.O.D. Public Policy, VHAI &
Coordinator VHAI-WAH! Policy Wokshop

Encls: Objectives
Programme.

pr.

Voluntary Health
Association of India

Women and Health
Programme

Objectives of the workshop

1. To analyse selected national policies and programmes affecting women's health from the perspective of comprehensive health care, so as to :

   a) Identify priority areas of concern & intervention
   b) Areas of neglect and gaps
   c) Give suggestions for strengthening women's health and women's perspective in all policies

2. Identify factors that are health promoting and need to be supported and those that are detrimental to women's health that need to be resisted.

3. Share WAH's experience in training and perspective building in women's health.

4. To focus indepth on policy and program aspects of Reproductive & Child Health in the context of women's health and comprehensive integrated primary health care.

5. To bring together select persons, activity involved in women's health program at grass roots, to look at RCH and women's health to share experience of collaboration and problems in implementation.

6. Elaboration of recommendations
   - how to incorporate women's health concerns in national health policies
   - how to include traditional knowledge systems in sustainable health care programmes
   - how to organize training to improve women's health care and
   - how to improve cooperation between government and NGOs health programmes

ECUMENICAL CHRISTIAN CENTRE

WHITEFIELD, BANGALORE - 560 066

GENERAL INFORMATION

Whitefield is 18 kms from Bangalore city and the Ecumenical Christian Centre is a twenty minute walk from the **Whitefield Bus Stand.** There are signboards showing the way to the Centre.

The Centre is about 3 kms from the **Whitefield Railway Station.**

Buses take about 45 minutes from **Bangalore to Whitefield** and may be boarded at any of the following three bus stands:

Majestic Bus Stand [Opp. City Rly Stn]	:	Bus Nos. 315 B, 333 E, 334 A
Shivajinagar Bus Stand [1 Km. from Cantt.Rly Stn]	:	Bus Nos. 320, 331, 331 E, 339, 339 E
City Market	:	Bus Nos. 322, 324, 324 A, 326, 326E

Autorikshaw fare from the City to ECC may cost Rs. 100 to Rs.120.
From Whitefield to ECC is Rs.15/-

Delegates engaging a taxi, autorikshaw or coming from the City by a private vehicle are advised to take the Airport, HAL - Whitefield Road. Turning left just after Whitefield junction and driving past, ECC signboards will lead you to the Centre, which is about 1 1/2 kms from the Whitefield Junction.

Please note that you may not get porter facilities at Whitefield. Hence bring only a small travel bag which you can carry.

Accommodation

On arrival at the Campus, look for directions at the Office Building, enquire at the security room or office.

Your stay will be arranged in one of the hostels in a single/double room with attached toilet and shower facilities. Delegates will have to collect hot water from the common washroom in the building.

Please note that a mattress, a pillow, sheets, a blanket and a towel are provided for each resident.

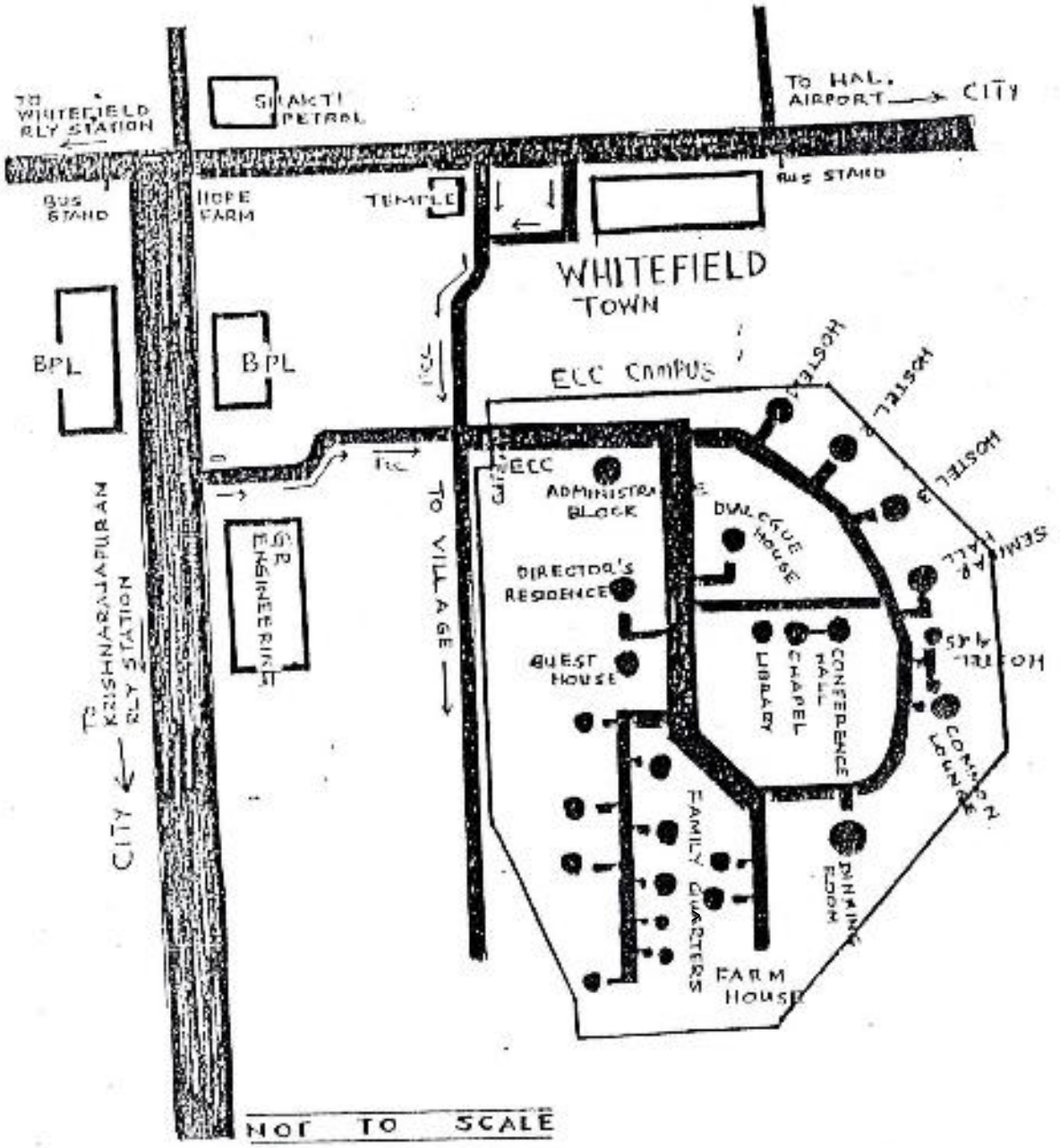
Food

Vegetarian and non - vegetarian food is served.

Telephone

Std Code 080
Nos. 8452653, 8452270, 8453158 (During office hours only)
Weekdays 8.30 a.m to 1.00 p.m & 2.00 to 5.00 p.m
Saturdays 8.30 a.m to 1.00 p.m

Fax: 91 - 080 - 8452653


TO WHITEFIELD RLY STATION
BUS STAND
SHAKTI PETROL
HOPE FARM
TEMPLE
TO HAL AIRPORT → CITY
BUS STAND
WHITEFIELD TOWN
BPL
BPL
ECC CAMPUS
HOSTEL
HOSTEL
HOSTEL
SEMINAR HALL
ECC
ADMINISTRA BLOCK
DWELLING HOUSE
DIRECTOR'S RESIDENCE
GUEST HOUSE
LIBRARY
CHAPEL
CONFERENCE HALL
COMMON LOUNGE
DINING ROOM
FAMILY QUARTERS
FARM HOUSE
SR ENGINEERING
TO VILLAGE
TO KRISHNARAJAPURAM RLY STATION
CITY
NOT TO SCALE

TOWARDS COMPREHENSIVE WOMEN'S HEALTH POLICIES & PROGRAMMES

WORKSHOP 6-9 OCTOBER 1998, BANGALORE

October 6, 1998

9.30 a.m.	Registration Welcome & Opening Remarks	VHAI Alok Mukhopadhyay Executive Director, VHAI. WAH! Secretariat - Indu Capoor DSE - Erika Fink
10.00 a.m-10.15 a.m	Objective of the workshop	Dr. Mira Shiva, VHAI
10.15 a.m-10.45 a.m	Introduction	
10.45 a.m-11.00 a.m	TEA BREAK	
11.00 a.m-12.30 p.m	Panel Discussion Review of Health Policy & Programme in the context of women's health.	Dr. Imrana Qadeer - JNU Dr. Shanti Ghosh Dr. Sudarshan, VGKK
12.30 p.m-01.45 p.m	Role of TSM in National Health Policy.	Darshan Shankar - FRLHT Dr. Saraswati Swain, NIAHRD
01.45 p.m-02.30 p.m	L U N C H	
02.30 p.m-03.45 p.m	Role of TSM in RCH & women's health.	Philomena - AIKYA/Shodhini Sister Eliza Smita Bajpai - Chetna Dr. Hari John - Deen Bandhu Vd. Gangadharan - LSPSS Dr. Manjunath
03.45 p.m-04.15 p.m	Discussion	
04.15 p.m-05.15 p.m	Gender Sensitive Initiative in women's health.	Manisha Gupte - Masum Dr. Srinivas Murthy - NIMHANS Laxmi Lingam - TISS
05.15 p.m-05.30 p.m	Discussion	

October 7, 1999

09.30 a.m-11.00 a.m	National Policy for women & major policies affecting women's health.	Dr. Sarla Gopalan Dr. Mira Shiva
	Economic Policy SAP Impact on Women's Health.	Geeta Sen
	Discussion	
11.00 a.m-12.30 p.m	RCH Policy & Programme components.	Daleep Mavlankar Daisy Dharamraj
12.30 p.m-01.30 p.m	Discussion	
1.30 p.m-02.30 p.m	L U N C H	
2.30 p.m-04.00 p.m	Panel Discussion RCH & TFA Major components, Analysis, status & trends.	Abhijeet - Sahayog Vimla Ramchandran - IIHMR, Rajasthan. Saulina Arnold - VHA, TN. Indu Capoor - Chetna, Gujarat.
04.00 p.m-04.15 p.m	TEA & Discussion.	
04.15 p.m-05.30 p.m	Comprehensive women's health health programme as part of primary health care.	Dr. Mabel Arole - DRHP, Jamkhed Dr. Hari John - Deen Bandhu Dr. Lata Desai - Sewa Rural
	Opportunities & Limitations of collaborating with Govt. Programme & Schemes for women.	Mirai Chatterjee - SEWA Ahmedaba Dr. Sudarshan - VGKK experience Shobha Shah - Sewa Rural experie Dr. Mabel Arole Sr. Elise - Sacred Heart

October 8, 1998

09.00 a.m-10.30 a.m	Nutrition Policy Food Security Women's Nutritional Status Priority Policy Concerns Strategy for action.	Dr. Veena Shatrughan - NIN Dr. Vanaja Ram Prasad - Coco Shobha Raghuram
10.30 a.m-11.45 a.m	The WAH initiative in Training for women's health WAH! Perspective DSE's Role in WAH! Southern Region WAH! Western Region	Dr. Mira Sadgopal - MFC Erika Fink - DSE Philomena - AIKYA/Kumar Pallavi/Indu - Chetna
11.45 a.m-12.00 noon	Women's Health Need assessment Maharashtra WAH! Women's Health.	Mira Sadgopal Dr. Kaushalya Devi
12.00 - 12.30 p.m	Discussion	
12.30 p.m-01.30 p.m	Gender Sensitive Training for RCH & women's health.	Philomena - Mahila Samakhya Jashodhara - Sahayog Shumita Ghose - Avard/Urmul Jyoti Gade - Chetna
01.30 p.m-02.30 p.m	L U N C H	
02.30 p.m-03.30 p.m	Sub theme & group discussion 1) Regional Diversity of women's health needs. 2) Women and work and occupational health hazards. 3) Strategies to integrate TSM in RCH & Women's Health. 4) Developing indicators & parameters for comprehensive sustainable RCH & Women Health Policy & programme & women's health index.	Shumita Ghose Abhijeet Mirai Chatterjee Laxmi Lingam Philomena Smita Bajpai Renu Khanna Daleep Mavlankar
03.30 p.m-04.15 p.m	Presentation of sub themes	

lication of Priorities in
icy & Programmes for
en's health
advocacy concern.

Dr. Sarla Gopalan

Dr. Veena Shatrughan
Dr. Sudarshan

advocacy concerns
tion/Intervention/
sponsibility
institutional level
state level
national level

n of Action

Renu Khanna
Dr. Mira Shiva

U N C H

nclusion

VHAI/AIKYA-WAH!/DSE

XXXXXXXXXX

WH-11, 9.

Voluntary Health Association of India

Dear Thelma,

From 6-8th Oct VHAI-WAH!
Workshop "Towards Comprehensive
Women's Health Policy" will be
held in ECC. This is an effort
to ensure that women's health
continues to be seen in the
context of PHC. & is not substituted
by RCH. Reproductive Health
is definately an important
component.

It would be very nice
if you can participate. Philo has
not been well, & because of
VHAI's GB. Meenakshi has had to
be away from Bangalore. I am
sending this hoping that you will
definately participate. Since the
2 imp components are related to
training & related to integration

T. Sent at 11.45 AM
VNR
Pl. email Hira at VHAI
That I will attend.
Also imp Philomena / Akhila
Role for papers from
previous meetings
received by
Bharat Post
Sent to 23/9
released
23/9/98
Sent Re on 23/9/98

Tong Swasthya Bhawan, 40 Institutional Area, South of I.I.T., New Delhi-110 016, INDIA.
Phone: 6518071-72, 6965871, 6962953 Fax: 011-6853708 Grams: VOLHEALTH N.D.-16 E-mail: VHAI@del2.vsnl.net.in
Donations exempted from IT under Section 80-G of IT Act 1961. Also exempted U/S 10(23C) IV as applicable to institutions of importance throughout India

« appropriate use of ISM
with TSM. in address of the health
problems.

Voluntary Health Association of India

VHAI - WAH

25/9/98

Dear Thelma,

Im leaving for Dhanbad for 3 days.
Got your confirmation.

This is the 1st workshop of this nature so there are no papers & reports from previous workshops.

I will reach Bangalore on the 4th. Will get some material for you. when I come.

If there is anything else you need let me know.

Since there will be Dussheera Holidays + weekend 1 — 4th. You can contact me at home 6855010, 651238.

Tong Swasthya Bhawan, 40 Institutional Area, South of I.I.T., New Delhi-110 016, INDIA.
Phone: 6518071-72, 6965871, 6962953 Fax: 011-6853708 Grams: VOLHEALTH N.D.-16 E-mail: VHAI@del2.vsnl.net.in
Donations exempted from IT under Section 80-G of IT Act 1961. Also exempted U/S 10(23C) IV as applicable to institutions of importance throughout India

Fax 6856795

With warmth

WH-11/9

TAMIL NADU VOLUNTARY HEALTH ASSOCIATION

TNVHA

NEWS LETTER

Vol. : 10:4 & Vol. 11:1 For Private Circulation only Sep. '97 - Mar. '98

Safe Motherhood

Pregnancy is special

Let's make it safe

18, Appadurai Main Street, Ayanavaram, Chennai-600 023
Phone : 613462/619585
Fax : 044-619585
E-Mail : tnvha@md2.vsnl.net.in
Internet : www.pesadvt.com/tnvha

HEALTH THROUGH PEOPLE

From TNVHA May 15, 1998

Dear Friends,

Greetings! Many things have changed since the last issue of this newsletter was published. Government has changed. The peaceful Tamil Nadu is being criticised as a place for terrorist. Overnight people here had voted unexpectedly changing the equations. India has also shown the world its neuclear capabilit. But the same change in that speed has not come in the lives of thousands of people. In many instance the situation has worsened. There are still thousands living under poverty. India's mortality and morbidity are still high. The maternal mortality rate of India is five times more than its neighbour Sri Lanka and many more than the most populous country China. Why this state? Could one blame only the politics and illiteracy? Could we the voluntary sector do something about this? We invite suggestions, experiences to motivate, initiate action for safe motherhood. This newsletter and supplement gives many information regarding this issue.

We hope all will join in our effort to improve the health status of mothers.

Yours Sincerely,
Sdl. J.P. Saulina Arnold
Executive Secretary

DAYS TO REMEMBER & CREATE AWARENESS

World Health Daty	April 7
Mother's Day	May 17
Anti Drug Day	June 26
Diabetes Day	June 27
World Breast Feeding Day & Week	August 1-7

Safe Motherhood

Neither Sophisticated Nor expensive

This is a very special year for the World Health Organisation. Exactly 50 years ago, the nations of the world came together to sign the charter that brought the Organisation into being. In pledging to improve the health of the peoples of the world, the founding Member States also affirmed the need to pay special attention to the health of women and children and, in particular, that of mothers. It is therefore, particularly appropriate that this year the theme for World Health Day is *Safe Motherhood*.

SAD LAPSE

Fifty years on, the peoples of the world are benefiting from considerable achievements in health. These are demonstrated by substantial gains in child survival, falling infant mortality, rising life-expectancy, and the elimination of many scourges of the past such as smallpox and, very soon, polio. WHO is proud to have contributed to these successes. We must acknowledge, however, that there are also areas in which success has proved elusive. Sadly, one of these is maternal health. Because of our collective failure to solve this problem, the tragedy of maternal mortality represents a major source of suffering and injustice in our societies.

Safe Motherhood

MESSAGE FROM THE DIRECTOR - GENERAL OF WHO

Pregnancy and childbirth are special events in women's lives, and, indeed in the lives of their families. This can be a time of great hope and joyful anticipation. It can also be a time of fear, suffering and even death. Although pregnancy is not a disease but a normal physiological process, it is associated with certain risks to health and survival both for the woman and for the infant she bears. These risks are present in every setting. In developed countries, they have been largely overcome because every pregnant woman has access to special care during pregnancy and childbirth. Such is not the case in many developing countries where each pregnancy represents a journey into the unknown from which all too many women never return.

MATTER OF JUSTICE

This situation cannot be allowed to continue. The interventions that make

motherhood safe are known and the resources needed are obtainable. The necessary services are neither sophisticated nor very expensive, and reducing maternal mortality is one of the most cost-effective strategies available in the area of public health. Access to family planning information and services can help reduce unwanted pregnancies and their adverse consequences. Access to health care, particularly at the critical time of birth, can help ensure that childbirth is a joyful event. It must be recognised that the reduction of maternal mortality is not only a matter of effective health care but also one of social justice. The risks that women face is bringing life in the world are not mere misfortunes or unavoidable natural disadvantages but injustices that society have a duty to remedy through their political, health and legal system. ■

BASIC INDICATORS OF MOST POPULOUS TWO COUNTRIES

Indicators		China	India
1. Population (million)		1088.4	815.6
2. Area (thousands of Sq.km)		9561	3288
3. Average annual rate of inflation %		4.9	7.4
4. Life expectancy at birth (years)		70	58
5. Adult Illiteracy	Total	31	57
	Female	45	71
6. Crude birth rate /1000 population		21	32
7. Crude death rate /1000 population		7	11
8. Women of childbearing age as % of population		55	49
9. Married women of child bearing age using contraception (%) including men		74	35
10. Babies with low birth weight (%)		6	30
11. Infant Mortality Rate (per 1000 live births)		31	97
12. Percentage of urban population		50	27
13. Risk of dying by age five	Male	40	120
	Female	30	118
14. Maternal Mortality Rate (per 1,00,000 live births)		44	570
15. Enrolement in primary school (%)		124	81

Source : *World Development Report 1990 - Poverty :World Bank*

Herbal

Herbal preparation cures gastric ulcers

A herbal preparation made and tested by scientists of Punjab University in Chandigarh can treat gastric ulcers.

The herbal preparation, labelled UL-409, reduced ulcers both acute and chronic, with treatment, and protected the mucous lining of the stomach of experimental rats, according to a report in the *Indian Journal of Experimental Biology*.

The preparation can be used alone or in combination with other ulcer-healing agents. It contained herbs mentioned in Ayurvedic texts for a condition that closely resembled peptic ulcers. They include *Glycerrhiza glabra* (liquorice), *Benincasa hispidda* (petha), *Saussurea lappa* (kuth), *Santalum album* (sandal wood), *Foeniculum vulgare* (fennel) and *Rosa damascena* (rose).

UI-409 was tested on a variety of ulcers induced by stress, drugs and closure of the pylorus (the small opening from the stomach to the duodenum). The preparation was tested in doses of 25,50 and 100 mg per Kg.

Courtesy : The Hindu, 10, September 1996

Pollution

50,000 INDIANS DIE TO AIR POLLUTION EVERY YEAR

An estimated 51,779 people die prematurely every year due to air pollution in 36 Indian cities, registering an increase of 28 percent in a three to four year period. A study conducted by the Centre for Science and Environment (CSE) reveals that the mortality due to air pollution doubled in Calcutta, Kanpur and Hyderabad annually in the last three to four years, while in Delhi the figure rose from 7,491 to 9,859 an increase of almost 32 per cent.

Deaths in Calcutta (10,647), Delhi (9,859), Mumbai (7,023), Kanpur (3,639) and Ahmedabad (3,006) with other major cities accounting for 66 percent of the total premature deaths in India in 1995-96.

In terms of the number of illness that require hospitalisation or medical treatment because of air pollution, the figure is currently 26 million a year as compared to the last figure of 19 million, an increase of about two million every year.

According to the report the suspended particular matter (SPM) that is dust and ash particles are often laden with toxic chemicals. SPM levels in Delhi, Kanpur, Mumbai, Calcutta among others are three to five times higher than the annual average acceptable limit set by the World Health Organisation.

Courtesy : A.P. Times, 3, November 1997

AIDS CLOCK

AIDS Clock depicts new HIV infection every 10 seconds

An "AIDS Clock" which ticks off the increasing global number of HIV/AIDS cases went on display in the public lobby of UN Headquarters in New York. The AIDS Clock features a c. .stantly changing collage of images from a world living with the disease. it reveals a hand sweeping over images of people living in the age of AIDS while ticking off a new HIV infection every ten seconds.

One of its unique features is that, with its moving images, it gives a human face to the HIV/AIDS epidemic, and at the same time, brings home the reality that over six people around the world become infected with HIV every minute. Today, people need to be reminded that the HIV/AIDS epidemic is far from over.

Sourse : AIDS Asia Dec. 97■

AIDS Week

IHO Observes AIDS Week

HIV ends in AIDS and Death, but AIDS WEEK began with Laughter

The Sunday of November 30 was an unforgettable day in the lives of the children of Falkland Road, a notorious red light district of Mumbai. Commensurated with the theme of World AIDS Day, IHO's Saheli Project organised a unique program with the theme "Give Children Laughter, in the World with AIDS."

Experts from the Laughter Club taught children to have light moments in the world with AIDS through Etiquette laughter, Bombay laughter, Patiala laughter, Joker's laughter etc.

Saheli Project reaches out to 6000 Sex Workers (SWs), in Mumbai alone, distributing 5,50,000 condoms per month and educating thousands of people. The HIV infection has been 44% among SWs from the Saheli project; while it is 72% among the rest. It is certain that their children are "Orphans in the Making". With a monotonous life, filled with filth, exploitation, disease and suffering, they are 'Children of a Lesser God'. Police, politicians, financiers, pimps and clients make the SWs and their children cry; there is hardly anybody who brings a little laughter to their lives and makes them feel that they are human beings too. With this program, IHO made an effort to teach the children to continue laughing against all odds in life, it being essential to maintain good physical health. Children walked in carrying placards with hard-hitting slogans: "We have no fathers, please save our mothers". "Everybody makes us Cry, only IHO help us laugh."

Source : *AIDS Asia, Dec. 1997*■

Prevention of HIV

Global strategies for the Prevention of Verfical HIV Transmission

[From Journal of the Internatinnal Association of Physicians in AIDS]

Although developed nations have enjoyed considerable success in their efforts to reduce the incidence of vertical HIV transmission, developing nations have had relatively little success. In fact, a June 1997 report from UNAIDS reveals that 1,000 children in developing countries become infected with HIV daily, while less than 500 children in the United States are newly infected with the virus each year. In developing nations, prevention efforts are not only hindered by the lack of a fundamental health care system, but also by social problems such as malnutrition, illiteracy, stigmatization, and ignorance.

(Courtesy : *Care. MacDougall. David S.)*

Source : *AIDS Asia Dec. 97* ■

U.S. Survey

40 million kids could lose parents to AIDS

A survey by the U.S. Agency for International Development (USAID) and the Census Bureau have predicted that the AIDS epidemic would create a "lost generation" of children at risk of exploitation and disease.

"More than 40 million children in 23 developing national will likely have lost one or both parents to AIDS by 2010. Brain Atwood, administor of USAID, has stated that in countries across Africa, Asia and Latin America, HIV/AIDS is unravelling years of progress in economic and social development.

Atwood has called for laws to be changed to protect children orphaned by AIDS and to allow surviving mothers to own land and to work, so they could care for their children when fathers died of AIDS. He also called for funds to help local agencies care for AIDS orphans.

Courtesy : Reuters/Health Action

Source : *AIDS Asia : Dec. 97* ■

Conference on HIV/AIDS

INTERNATIONAL CONFERENCE ON AIDS INDIA 2000

Chennai, Nov. 27th - Dec. 1st, 1997

An International Conference on HIV/AIDS, with largely Indian delegates, was held in Chennai. It was planned in such a a way as to end the Conference, with important deliberations, on the World AIDS Day.

The Conference brought together Indian experts with their vast experience and a few international experts with special exp ertise in recent developments in the field of HIV/AIDS: the geographic prevalence of the different clades, the pathogenesis of HIV disease, laboratory evaluation of clinical status and anti-viral therapy. The situation in India was assessed and tactics developed to slow down the spread of infection. The synergy between HIV and tuberculosis was examined since the latter is already highly endemic and the likelihood of a setback in its control is causing serious concern. Many lessons were learnt from several governmental and non-governmental intervention projects in different parts of the country.

Source : *AIDS Asia Dec. 97* ■

AIDS

HIV/AIDS Epidemic Growing Threat to Children says UNAIDS

A new report entitled "Children Living in a World with AIDS", was published by the Joint UN Programme on HIV/AIDS (UNAIDS) to mark the launch of a world AIDS campaign to increase public understanding of the devastating impact of HIV/AIDS on children and encourage further action to prevent HIV infection and improve care. In 1996 about 400,000 children world-wide under the age of 15 years became infected with HIV. Around 90% of these children acquired the virus from their HIV-positive mothers, whether before or during birth or through breast-feeding.

UNAIDS estimate that by the end of 1997 one million children under the age of 15 will be living with the virus and suffering the physical and psychological consequences of infection. Since the beginning of the epidemic, over 2 million HIV-positive children have been born to HIV-positive mothers and hundreds of thousands of children have acquired HIV through blood transfusions, sex or drug use. Over 9 million children are estimated to have lost their mothers to AIDS. ■

Source : *AIDS Asia Dec. 1997*

INFANTICIDE

FEMALE INFANTICIDE STILL PREVALENT IN OMALUR

Female infanticide is still prevalent in Omalur block of salem district. The project work of Alternative for India Development launched mainly to identify the incidents like female infanticide, marriage at a very young age (even around 11 and 12 years), unsafe abortion,etc. As per 1991 census, the sex ratio was woeful in this block - just 839 women as against 1,000 men. As per the questionaire circulated by them initially, at least 47 female infants had been killed in 1,000 families. According to the statistics compiled by the organisation, while it could prevent female infanticide in 136 families, still 85 had been killed. Besides there have been 243 female babies who reported dead within a month of their birth.

Source: *The Hindu dated 25.3.98*

TIT BITS

Mothers of the World Unite

Cows get a better deal than women when it comes to care for health and development," observed Mrs.Rebecca Kattikaran, a Hyderabad-based scholar-activist. Being involved in cattle care management in Andhra Pradesh, assisting the state government, Rebecca must know what she says.

"For example," she explained, "the rural livestock units far outnumber the primary health centers. There is a livestock unit for every three villages, but no PHC."

This also applied to nutrition. Women who take responsibility and do umpteen things to ensure health and nourishment of cows don't care that much for their own nutrition. They just adjust with whatever is left behind when everybody in the family has eaten. Often the family, too, hasn't enough to eat, let alone leave behind. Even the milk the cows give, the family members cannot afford to drink. They sell it away to buy other staple items of food to satisfy their hunger.

No wonder, anaemia ranks third as a cause for maternal death.

- Health Action

CME TO BE COMPULSORY FOR ALL MEDICAL PROFESSIONALS

Continuing medical education (CME) is likely to be made compulsory for all medical professionals in the country. A high powered committee of the Ministry of Health and Family Welfare has recommended amendments amendments to the Indian Medical Council Act to facilitate this. The Medical Council of India already has a separate cell, which has been actively conducting training programmes and workshops for the medical professional future, institutions like AIMS NewDelhi, JIPMER Pondicherry, PGIMER Chandigrah, and the National Academy of Medical Sciences have also been engaged in conducting CME Programmes.

In another development, the Department of Indian System of Medicine and Homeopathy under the Ministry of Health and Family Welfare has formulated a new IEC(Information, Education and Communication) strategy to popularise Ayurveda, Siddha and other alternative systems of medicine. The main component of the strategy would be to promote involvement of NGOs in the dissemination of information at the grass root level and utilise the expertise of agencies.

Source: *The Hindu dated 28.3.98*

POINT TO PONDER

"If a wife dies, I can marry again but if a cow dies I cannot buy it again"

GLOBAL MARCH AGAINST CHILD LABOUR IN CITY

A warm reception was accorded to a group of children and adults from various countries who have taken a 'Global March' aganist child Labour. Minister Rehman Khan presiding said the laws and ordinances alone would not help to eradicate child Labour. Parents, Non-governmental organisations and social service organisations should join hands with the Government to put an end to this social evil. The Marchers took part in a rally in the afternoonwhich started from near the Labour statue on Marina to Santhome St.Bede's Higher Secondary School campus.Speaking on the elimination of the rally, Dr.S.Ramadoss, PMK founder, called upon the state and the Centre to enact a bill making it compulsory for parents to educate children.

Mr. Johnson Raj, Annamma George and Usha Saju from TNVHA attended this Global March on 22nd of this month at Chennai.

Source: *The Hindu dated 23.3.98*

More AIDS Counselling Centres in Tamil Nadu

After the success of the centre for telephonic AIDS counselling in Chennai, the Government proposes to open similar centres at Trichy, Coimbatore, Madurai, Tirunelveli, Salem and Thanjavur according to Dr.P.K.Rajendran, Joint Director of the Tamil Nadu State AIDS Control Society. The programme proposes to cover about 4,00,000 school children, through NSS volunteers.

It has been estimated that by 2000 A.D., eleven out of 1,000 persons may be HIV positive. There are about 25 million youth in the State who are prone to HIV infection. Recent studies have revealed that the number of HIV positive and AIDS cases was steadily rising in rural areas too. In cities about 50 percent of the students were going in for pre-marital sex.

The World Bank will be sanctioning Rs.29 Crores for AIDS project in the State. Of this, Rs.10 crores will be given for I.E.C. Rs.5 crores each for training of workers and safe blood transfusion arrangements and Rs.2.65 crores to the 165 NGOs in the district for propagating the schemes.

The Society proposes to train 50,000 anganwadi workers in the Integrated Child Development Project and the Tamil Nadu Integrated Nutrition Development Project. Training was given to physicians in charge of AIDS management's in the district head quarter hospitals. The WHO experts had commended the system of monitoring, awareness programme and training programmes imparted by the society in Tamily Nadu and recommended the same model for other states.

Courtesy - The Hindu.

MANIPUR HIV PROJECT TO BE CLOSED DOWN

The Indian Council of Medical Research (ICMR) has decided to close down its project on HIV/AIDS and Substance Abuse in Imphal as per its Director - General's instructions to the principal investigator of the Imphal Project, Dr.S.K.Bhattacharya, without providing any concrete reason.

The ICMR decision has come as a surprise for the researchers working in the field of HIV/AIDS. In a memorandum to the ICMR, the staff demanded continuation of the project as there was no Union government organisation in the state dedicated exclusively to research in medical science at a community level. It argued that AIDS had become a major problem in Manipur and that the area was not serviced by any regional research facilities.

Courtesy : The Telegraph

All this after Manipur became the first state in India to have a policy on AIDS (AIDS ASIA: issue IV/3). What a come down.

- Health Action

CONFERENCES

VI MULTI FACULTY Medical Conference

Mumbai, India

AIDS Faculty	:	Chair - Dr.I S.Gilada
Date	:	June 24-25, 1998
Venue	:	World Trade Centre Special pre-geneva Conference Session
Fee	:	Registration Fee : Rs.750/-
Concession	:	NGOs/students

Contact

Indian Health Organisation
Municipal School Building,
J.J.Hospital Comp., Mumbai - 400 008
Tel: 3738999 Fax: 3864433
E-Mail : ihoaids@bom3.vsnl.net.in

WORLD CONFERENCE

The 12th World AIDS Conference will take place from June 28 - July 3, 1998 in Geneva, Switzerland. For more information :

Congress Secretariat, C/o. Conger (Sweeden) AB, P.B.Box 5619,
S-11486 Stockholm, Sweden.
Tel. (+468) 6126900
Fax: (+468) 612 6292
E-mail : aids98@congrex.se

An eye for an eye only ends up making the whole world blind

- Gandhi

INTERNATIONAL FAMILY DAY MAY 15th

VIOLENCE IN THE FAMILY

The family which ideally structures for security, safety and emotional needs for one's mental health often, in reality is the most frequent place for violence, point out research findings. In India violence against women is far greater. Department of women and Child Welfare has illustrated.

One rape every 54 minutes,
One molestation every 20 minutes,
One kidnapping / abduction every 43 minutes,
One act of women teasing every 5 minutes,
One dowry death every one hour and forty minutes,
One act of cruelty every 33 minutes.

Between 1987 and 1991, there was 37.6% increase in all types of crimes against women.

Source: Health Action dated February '98

"WHO" call for Safe Pregnancy

A significant reduction in maternal mortality
in the Region is an achievable goal.

The choice is ours : To grieve for the many thousands
that lose their lives, or to act decisively to save them.

Affordable technologies to prevent such deaths do exist.
The WHO Mother-Baby package offers life-saving
interventions for both mothers and their babies.

Let us monitor every pregnancy to detect threats to their lives;
but, even more importantly, let us value and respect
women's rights and ensure them equity and social justice.

Safe Motherhood should, thus, be placed firmly
on every development agenda.

Women's health is not just theconcern of the health sector, but
the combined concern of all development sectors and of
responsible policy-makers, individuals, media,
and communities alike

To make partnerships effective, they should be backed
by adequate resources, sustained commitment and shared credits.

Motherhood is a human right - let us empower women with the
knowledge and the means to have greater control over the
choices that affect their health and their lives, their families
and that of future generations.

WHO - 7 April 1998

A WORD ABOUT TNVHA

Tamil Nadu Voluntary Health Association, in short TNVHA is a non-profit, charitable, secular and registered society. It is functioning from 1970. It is an association of organizations working for health promotion. It is not a funding agency. Its areas of functioning are Tamil Nadu and Pondicherry States. It has 457 institutions (Hospitals, Dispensaries and Community based organizations) as its Members.

TNVHA's main goals are Health Promotion and Health Action. It hopes to create a healthy community through Primary Health Care activities.

TNVHA functions as a Networking (co-ordination) liaisoning and resource agency.

For Health promotion TNVHA's main activities are geared towards creating awareness and organising programmes to strengthen the health workers.

TNVHA co-ordinate with State and Central Government to implement many of their plans. TNVHA is governed by a general body consisting of its member institutions. The Elected Executive Board members manage the activities of the association.

There are also similar associations in most states of India. The Federation of those associations is Voluntary Health Association of India at New Delhi.

WH-11;9

TNVHA

TNVHA NEWS LETTER

SUPPLEMENT

For Private Circulation only **May 1998**

Safe Motherhood

HEALTH THROUGH PEOPLE

Tamil Nadu Voluntary Health Association
18, Appadurai Main Street,
Ayanavaram, Chennai-600 023
Phone : 613462/619585
Fax : 044-619585
E-Mail : tnvha@md2.vsnl.net.in
Internet : www.pesadvt.com/tnvha

Wanted - healthy mothers!

Have you heard the news? Yesterday three jumbo jet aeroplanes collided in mid-air, killing all 1,500 passengers on board. Tragically, all the passengers were pregnant women, and 1,485 of them were from the poorer countries.

Part of this story is not true. There was not an aeroplane crash yesterday. But 1,500 pregnant and newly delivered pregnant women did die yesterday. Why didn't you hear about it? Because 1,500 women die every day in child birth, so no newspaper reports it, no televisions cover the story. These women died because they did not have safe care when they were pregnant and when they delivered their babies. They died of infection, a long labour, high blood pressure, unsafe abortion and bleeding.

Women dying, or being damaged unnecessarily by childbirth is tragic enough. But women dies or suffers in childbirth, her baby dies or suffers too and her other children have little chance of surviving. We hope you agree that, for a child to be healthy, she or he needs a healthy mother. A child's chances of being well fed, educated, and given good health care all depend on the mother.

- *Health Dialogue*

Getting a Good Start

The conditions of a woman's life affect her health and that of her children

For women to be healthy during pregnancy and childbirth they need:

- good nutrition, especially during childhood.
- several years of education (beyond primary level)
- respect and consideration in their home and their society.

Health workers and communities need to know that :

- during infancy and childhood, girls need the same quantity and type of food as boys
- once they get their monthly periods, girls may need additional iron in their diet to prevent anaemia
- good nutrition during a girl's infancy, childhood and adolescence contributes to healtheir mothers and babies.

Attention !

During pregnancy the need for energy (calories), proteins, vitamins, and minerals increases. A pregnant woman needs about 2300 calories, and 60g of protein a day. Cereals and pulses give you all the calories, and a part of the proteins. Green vegetables supply iron and vitamin. A, B and some amount of C. Although wheat germ, lentills and green leafy vegetables contain substantial quantities of iron, its availability is limited by the other substances present.

Key message

Good nutrition for girls in infancy, childhood and adolescence is important for health childbearing.

Schooling for girls at least to primary level, but preferably beyond, will help them make educated choices about delaying marriage and using contraception.

Good maternal and child health depends on the status of women in society generally. A low status, with little respect or consideration, is bad for their health.

CARE

During Pregnancy

The principles of safe antenatal care.

Antinatal care should aim to :

- develop a kind and respectful relationship between each woman and the health workers, so that she will attend for antenatal care and be more likely to talk about any problems. She may also be more accepting of any advice given.

- find and treat any illnesses the woman already has
- identify which women can safely deliver at home and which women are more likely to have complications and should deliver in a health centre or hospital.
- explain to women the danger signs that can occur during pregnancy, labour and delivery so that they seek help early. ⌘

Key message

- A few antenatal visits for many women is much better than many antenatal visits for a few women.
- The biggest risk factor in pregnancy is poverty.
- Women will come for care if they can; make sure it is accessible, affordable and the health workers are kind and caring.

Links in the warm chain

- train all the people involed in the birth and early care of the baby
- provide a clean, warm, draughtfree room for delivery
- provided a clean and warm delivery surface
- dry the newborn baby immediately with a clean towel
- wrap the baby and give it to its mother quickly after birth
- put the baby to the mother's breast and start breast-feeding as soon as possible
- place a warm cap on the baby's head
- Make an earlydiagnosis of hypothermia
- quickly re-warm cold babies
- keep babies warm when moving them to another room or to another health facility.

Pregnancy should be a special and secure time in a women's life

Yet every time a woman goes through pregnancy, she risks losing her life

Safe Motherhood

Pregnancy is not a disease, yet it kills one woman every two minutes in the Region

Maternal Mortality in South-East Asia accounts for about 40% of global maternal deaths

Risk Factors in Pregnancy

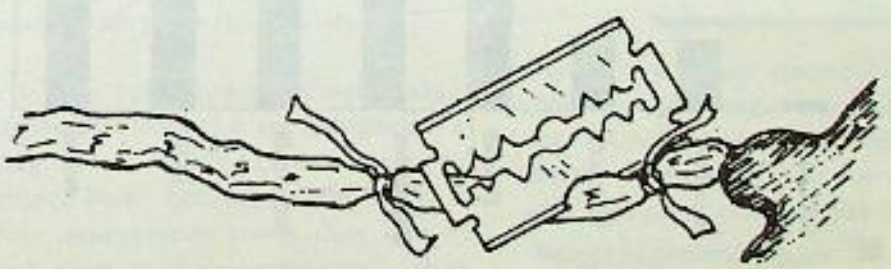
The risk factors imply a need for more careful monitoring though they are not necessarily of complications. For many of them (e.g. age) nothing can be done to alter the risk factor. However, additional care and watchfulness may prevent a complication arising or enable its early detection and management.

- Poor obstetric history.
- Strikingly short stature.
- Very young maternal age (<15 years)
- Nulliparity or grand multiparity
- Size-date discrepancy.
- Unwanted pregnancy.
- Extreme social disruption or deprivation.
- preterm labour in previous pregnancy
- Multiple generation.
- Abnormal lie/presentation.

Poor obstetric history

Women with a history of an operative delivery, stillbirth, neonatal death, or low birth weight baby are at risk. The outcome of the immediately-preceding pregnancy is the most important. Health care givers should identify such women at the first visit itself. They should also explore the circumstances to assess if the cause was a complication that may recur and may need to be treated in the antenatal period; or, would not be susceptible to preventive interventions during the antenatal period as it arose at the time of labour and delivery. Prolapsed cord could be an example of the latter.

In women with a history of a previous caesarean section, such monitoring should be done carefully during labour in a health facility able to undertake this type of surgery which, in most cases, will be a hospital. These women should be advised that home birth is extremely hazardous for them and if they come to them in labour, refer immediately to such facilities (see box).

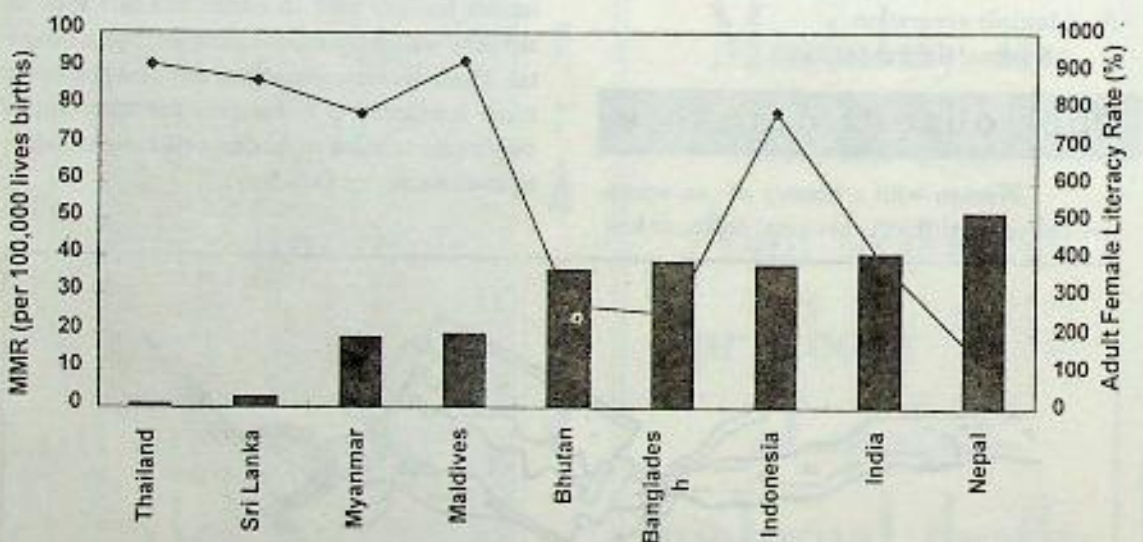


The lower the women's literacy, the higher the maternal mortality

Safe Motherhood

Women's status in the family and community determines their health status

Maternal Mortality Ratio [MMR] and Female Adult Literacy Rate, Sear Countries, 1995



In still birth

If a women had a stillbirth or neonatal death, efforts should be made to ascertain the cause of the stillbirth whether antepartum or intrapartum, or of the neonatal death.

Information on the following may help identify the cause.

- state of the fetus at birth (fresh or macerated)
- any signs of life at birth (to differentiate alive birth and subsequent early neonatal death from a stillbirth)
- any pregnancy complications
  - malpresentation
  - long labour
  - labour or delivery complications
  - current maternal syphilis serology.

In cases of neonatal death :

- how long did the baby live?
- did the baby ever feed?
- what does the mother think was the cause of death?

If you cannot ascertain the cause of stillbirth or neonatal death at a Type I health centre, refer her to a higher level of care. This is particularly important if the syphilis serology is nonreactive and another cause of stillbirth must be found.

Short Stature

Although short stature may be associated with a small pelvis, maternal height is not generally a good predictor of prolonged/obstructed labour. Where appropriate norms are available, short stature is defined as <5th percentile of the local height reference curve. Where norms are not available, it may be evaluated qualitatively to include women who are "Strikingly short" for that society.

The criterion of short stature (described as those who are recognised as "strikingly short" within a given community) is included here because height is one of the few assessment tools that can be applied even at the community level.

Health care providers need to be aware that domestic violence may have an adverse impact on the outcome of preganancy. If support groups are available the battered women may be referred.

Recognised short stature can be used as a basis for advising women about their level of risk and appropriate choice of place of birth. However, it is important that providers recognise that the predictive value of height is generally poor. ■

Nutritional anaemia during pregnancy is a major contributor of maternal deaths

Give pregnant women a fair share of nutritious foods-Lower the risk of maternal deaths

Safe Motherhood

A pregnant girl below 18 is 2-5 times more likely to die than a pregnant woman between 20-25 years

The causes of maternal deaths are avoidable, the means to prevent them are known

visits that save lives

Number, timing and content of antenatal visits

A Call for NGOs to Motivate ANMs

Timing of visits

First visit by the end of the fourth month (16 weeks) :

To screen and treat anaemia, screen and treat syphilis, screen for risk factors and medical conditions that can best be addressed in early pregnancy, initiate prophylaxis where required (eg. anaemia, malaria) and begin to develop the individualised birth plan.

Second visit in the sixth or seventh month (24-28 weeks) and, third visits in the eighth month (32 weeks) :

To screen for pre-eclampsia, multiple gestation, anaemia and to further develop the individualised birth plan.

Fourth visit in the ninth month (36 weeks) :

To identify fetal lie/presentation, and to update the individualised birth plan.

Content of Visits

The content of the antenatal visits for a normal pregnancy is described in three main categories :

- Assessment (history, physical examination and laboratory tests)
- Health promotion
- Care provision

There is inevitably some degree of repetition in the following, but it has been retained for the sake of completeness and ease of reference.

Assessment

A well-known history is the foundation stone of effective antenatal care. Establishing and recording key facts regarding a woman's general health and obstetric past assists in the rapid identification of problems and provides criteria for appropriate decisions about care and services.

Recording and monitoring of maternal weight is not recommended by WHO's technical working group. This has been dropped from the recommendations because there is no sound evidence to link weight gain with known risk factors or

Too many, too early, too frequent, too late, or unplanned pregnancies are risky

Family planning can minimize the risk to the lives of mothers and babies

Safe Motherhood

Many women lose their lives through lack of adequate access to quality maternal health care

Health care before and during pregnancy, during delivery and after, is a must to save lives

predictable outcomes, except where the pre-pregnancy Weight is known- a very rare situation in most countries. Moreover, few interventions are generally available for increasing maternal weight, (Food supplementation is generally possible only in specific situations). For these reasons weight has been dropped from the routine assessment.

The activities listed below are for all levels **at first contact, regardless of trimester.**

HISTORY

- Name
- Age
- Parity
- Date of last menstrual period, menstrual history & pregnancy symptoms.
- Contraceptive history.
- History and circumstances of :
  - antepartum / postpartum haemorrhage
  - multiple gestation.
  - eclampsia, sepsis or other complications.
  - operative delivery.
  - stillbirth or neonatal death
  - small infant (premature or intra-uterine growth retarded)
  - "wantedness" of the pregnancy
  - social history and support
  - history of medical problems
  - history of female genital mutilation (country / population specific)
  - any other complaints or problems.

PHYSICAL EXAMINATION

- General appearance
- Height (noting "strikingly small stature")
- Blood pressure measurement
- Clinical signs of anaemia
- Signs of previous caesarean section (scar)
- Uterine size (external examination) or fundal height in second and third trimester
- Fetal well-being, using fetal movements or fetal heart sounds in the second and third trimester.
- Signs of physical abuse
- Physical examination for assessment of complaints.

LABORATORY

Syphilis - clinic - based test with same day treatment of positive results and follow-up of partners.

The activities listed below are for all levels at subsequent visits.

HISTORY

- Social support, family, community
- Any complaints or problems
- Follow-up on advice, care or referral provided at previous visit

Without regular health care throughout pregnancy we may not detect risks until it is too late

With early referral and timely treatment we can save many thousand lives

Safe Motherhood

Maternal mortality is higher if deliveries are not attended by trained personnel

By ensuring trained personnel at every childbirth we can save many lives

PHYSICAL EXAMINATION

- General appearance
- Blood pressure
- Clinical signs of anaemia
- Fundal height in second and third trimester
- Fetal well-being, using fetal movements or fetal heart sounds in the second and third trimester
- Signs of physical abuse
- Lie and presentation in the third trimester
- Physical examination for assessment of complaints

Health Promotion (at all visits)

Antenatal care is an opportunity to promote dialogue with clients, and nature confidence, as well as to reinforce maternal health messages on, for example :

- Nutritional advice, such as specific foods and taboos
- Rest
- Discomforts of pregnancy
- Hygiene
- Safer sex
- Planning for place of birth, birth attendant, promotion of clean delivery kits of home birth
- Counselling on referral hospital, transportation and blood transfusion.
- Counselling on new-born care, including breast-feeding
- Family planning and child spacing

(Country/population-specific protocol) :

- smoking, alcohol, drug cessation
- iodine supplementation
- malaria prophylaxis
- prevention of intestinal parasites.

Care provision

Minimum care that should be provided at each visit :

- Development of an individual delivery plan which should be initiated at the first visit and reviewed at subsequent visits. The plan should take account of :
  - the woman's preference for place of birth and skill level of birth attendant
  - family and social support
  - assessment of a woman's risk of complications during labour and delivery
  - assessment of satisfactory arrangements for transportation in case of emergency referral, and distance (time) to referral facility
  - economic status
  - expected place of birth and skill level of attendant (confirmed at last antenatal visit)
- Tetanus toxoid immunisation (number of doses according to need)
- Iron and folic acid supplementation
- Disposable delivery kit of home birth planned (at first visit)
- Home-based maternal records (given at first visit; subsequent visit and care recorded)

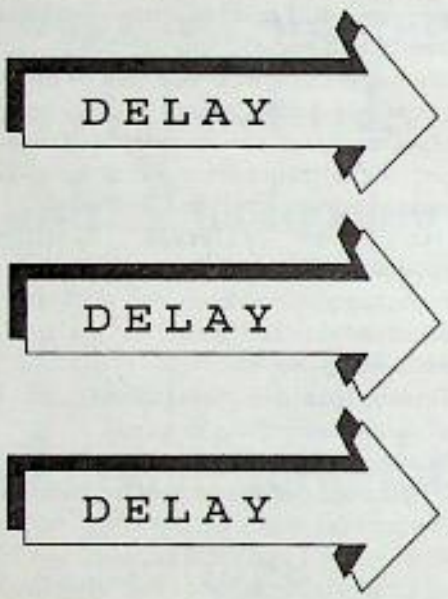
(Country/population-specific policy/ protocols) :

- idoine supplementation
- malaria prophylaxis
- treatment for intestinal parasites

- Psychosocial support
- Timing of next antenatal visit.

- Adopted from WHO Document / Health Action

Three DELAYS increase the risk to a woman's life during pregnancy



in deciding to seek medical care

in reaching a medical facility with adequate care

in receiving quality care at the facility

We must recognize complications and act quickly to save a woman's life

Herbal Tips For

(Sr. Mary Sebastian of St Ann's Dispensary, Gharghoda, MP, attended a seminar on herbal treatment related to pregnancy and child-birth. She shares with us the various prescriptions).

-From Health Action

Would-be Mothers

HERBS FOR PREGNANCY

For women

① The root, bark, flower, leaf and fruit of Bael (Aegle marmelos) jeera, (cumin seed) methi (fenugreek) elaichi (cardamom), grambu (lawng) and liquorice. Take these in 1:1 proportion. Grind them separately and mix together. Add honey and make gooseberry-size pills. Take this after menses, twice a day for three days.

② Grind 10g of the root of Bariar (Sida cordifolia), in cow's milk. Add ghee and sugar and take on empty stomach during ovulation or after menses for seven days.

③ Take 5g of pomegranate powder with ghee just after the cessation of menses. Also include enough milk in your diet.

For Men

① Take high protein diet. Sprouts of seeds like groundnut, chenna, ragi, wheatgrass, etc. are ideal.

② Take 2g of satavar root mixed with honey, twice daily for 3 months.

③ Root of (one year old) lady's finger plant (Abelmoschus esculentus) too, helps to increase the vitality of sperm.

TONIC FOR EXPECTANT MOTHERS

To increase haemoglobin level, prepare a glassful (300 ml) of drumstick leaf juice. Melt 1 Kg. Of jaggery with a little water and strain it. Add the drumstick leaf-juice to the jaggery solution and boil it on slow fire until becomes a thick syrup. Add a little powder of jeera, somph, cardamom and cinnamon. It could be stored for a couple of months.

Dose : One tablespoonful, twice a day after meals.

Of the total infant deaths over 50% occur during neo-natal period, mostly due to maternal health problems

Preventing maternal deaths also means saving babies – both born and unborn

Safe Motherhood

Motherhood is a Human Right – It requires strong partnerships to safeguard it

What is missing are the resources, effective partnerships and the will to act

Morning Sickness

- Include ash pumpkin leaves in your diet.
- Make a decoction with 5g of the root of Bael (Aeglemarmelos) and 5g of the root of Bariar (sida cordifolio); Add a little sugar and drink.
- Grind chiretta to a paste and add equal parts of sugar and honey. Take one tea spoonful daily.
- Fry the kernel of mango seed, add some salt and eat.
- Grind two lemon seeds to a paste and eat. Or mix it with water and drink.

Insomnia

Grind a few grams of wheat and apply on the soles of the feet before going to sleep.

Constipation

Grind the root of the white variety of Aparajita (Clitoria ternatea) and take it in milk. Ripe guava is also good.

Threatened abortion

- Grind 1 bud (tender shoot) of banyan tree, add butter, and take on empty stomach although pregnancy make sure also to take food only after it gets digested.
- Prepare the decoction of 10g of Barrier root and rice and drink.
- Take ghee regularly with meals.
- Break an egg into a glassful of milk and take daily or often.

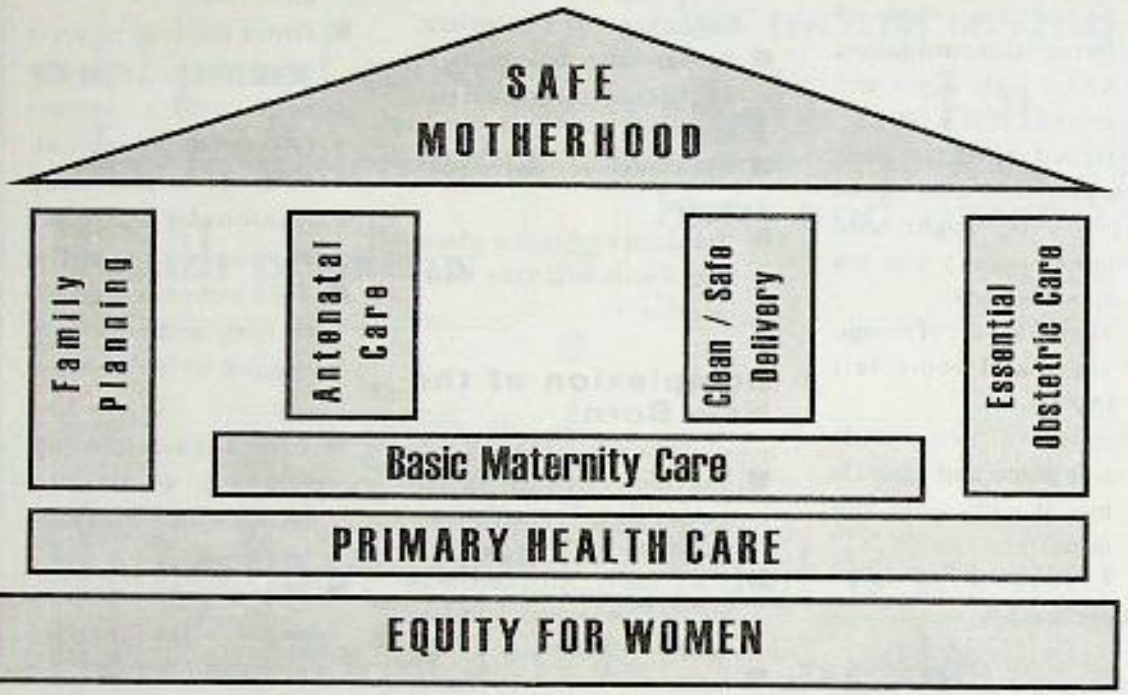
Complexion of the New Born

- Take unfermented coconut toddy twice or thrice a week, during pregnancy.
- Take daily, till confinement, 2g of liquorice paste mixed with ghee.
- Egg, milk, meat, fruit, sweet and nutritious foods are to be taken.

To Induce Labour Pain

- Grind 10g of mung (phaseolus mango), mix with a glass of milk, add a tablespoonful of ghee and drink.
- Grind the root of pipli (long pepper) and the root of iswari (Aristolachia indica), add a little hing (asafoitida) and make channa-size pills.
- Take a channa-size pill of hing and rock-salt, ground with rice-wash water.
- Grind to paste tamarind leaves of an old tree, mix it with butter milk and drink.
- Mix 3 g of liquorice paste with jaggery syrup and drink.

A pregnant woman and her baby are one entity - What affects one, affects the other



The WHO Mother-Baby package interventions protect both, effectively

Names of herbs in other languages

1. Aegle marmelos (Bot); Bel (Hin); Koovvalam (Mal); Vilvam (Tam); Bilvama (Tel); Belapatri (kan).
2. Cardiospermum halicacabum (Bot); Heart's (Eng); Kanphuti (Hin); Ulinna (Mal); Mudukkottan (Tam); Vekkudutiga (Tel); Kanakayya (Kan)
3. Sida cordifolia (Bot); Jamglimedhi (Hin); Kurunkotti (Mal) Alamaram (Tam); Peddamarri (Tel).
4. Ficus benghalensis (Bot); Bat (Hin); Ala(kan); Peraal(Mal); Alamaram (Tam); Peddamarri (Tel).
5. Andrographis paniculata (Bot); Green chiretta (Eng); Nalaberu (Kan); Kiriyatta (Mal); Nilavempu (Tam); Nelavembu (Tel).
6. Clitoria ternatia (Bot); Sankapuspa (Kan); Samkhupushpam (Mal); Kannikkoti (Tam); Gilagarnika (Tel).

To Expel Placenta

Grind dry ginger, pepper, pipli (long pepper), and turmeric to a paste. Take one tablespoonful of the paste, mix in a glass of warm water and drink.

- Fry jeera power, add a little ghee and drink soon after delivery.
- Fry hing(asafoetida), add garlic, grind with jaggery or mix in honey and take.
- Drink 50 ml of neem leaf juice. It is also good for the contraction of uterus.
- Grind turmeric and mix with the juice of avala (goose berry) and drink.
- Make a decoction of the leaves or tender shoots of bamboo and drink.

To Increase Breast Milk

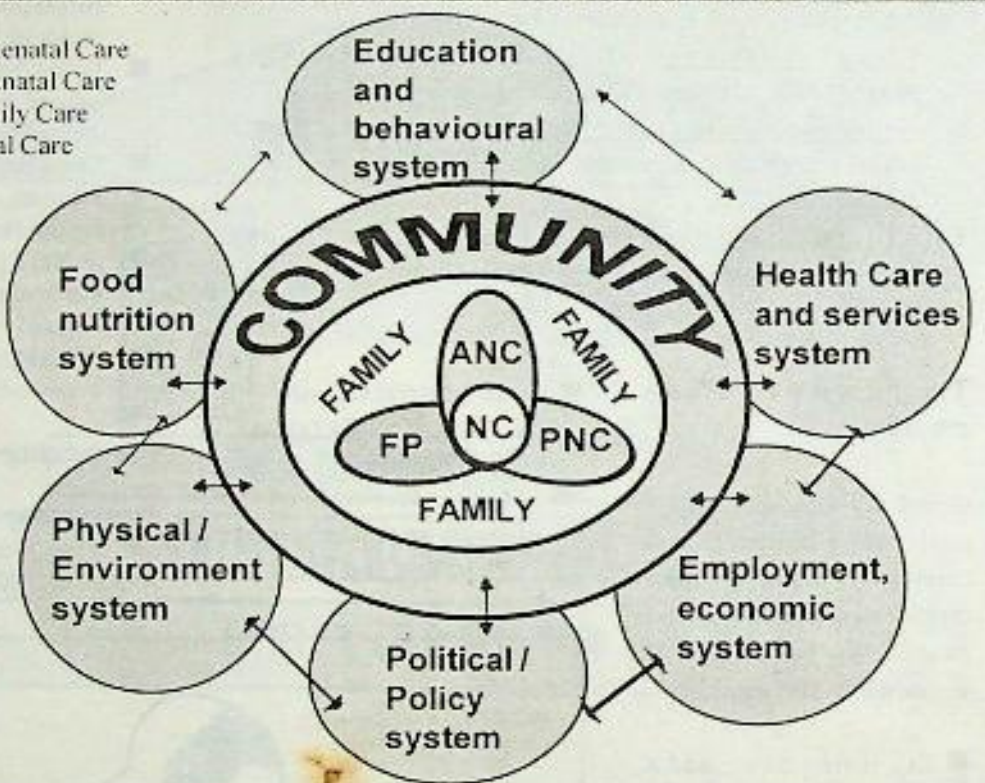
- Grind til (sesame seeds) in fresh cow's milk and apply on the breasts.
- Mix thirty grains of tippali with the same amount of pepper powder, mix in milk and drink.
- Grind 5g of the root of satavar, mix it in a glass of milk and drink.
- Drink decoction of castor oil plant. Apply leaf-pulp on the breasts.
- Take 3g of liquorice (jetimadh) with milk and sugar.
- Make kanji with methi, coconut, onion and take.

For Intelligence

Once the baby is a few months old, give a teaspoonful of Brahmi juice with honey. ■

Implementing the Mother-Baby package requires many partners beyond the health sector

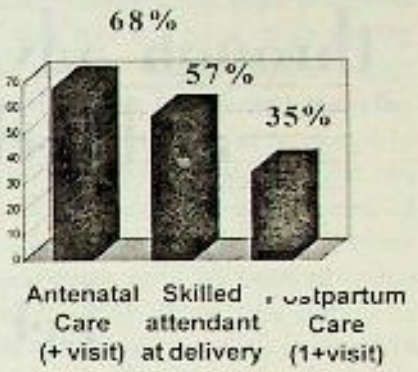
ANC - Antenatal Care
PNC - Postnatal Care
FP - Family Care
NC - Natal Care



Preventing maternal deaths should be a shared responsibility among all development partners

GLOBAL COVERAGE OF MATERNITY CARE

How postpartum care is neglected ?



Care within the first eight hours of birth

The Mother Postpartum haemorrhage is the single most important cause of maternal death. It kills 144,000 women each year and nearly nine out of 10 of these deaths take place within four hours of delivery. A woman who is anaemic is usually less able to cope with blood loss than a woman who is well nourished. During the first hours after the birth, the care-giver has to make sure that the uterus remains well contracted and that there is no heavy loss of blood. If the bleeding is particularly severe, blood transfusion may be the only way of saving a woman's life.

In the postpartum period, women need :

- information/counselling on
  - care of the baby and breast feeding
  - what happens to their bodies
  - self-care
  - sexual matters,
  - contraception
  - nutrition;
- support from health care providers, from partner and from family;
- time to care for the baby;
- help with domestic tasks;
- maternity leave

Women may fear;

- inadequacy :
- loss of marital intimacy :
- isolation :
- the constancy of taking care of the baby and others.

New borns need:

- nuturing, cudding, stimulation
- Warmth;
- appropriate food;
- easy accessibility of the mother;
- parental care;
- safety;
- cleanliness;
- observation of body signs by someone who are and can take action if necessary:
- protection from
  - disease,
  - harmful practices,
  - abuse/violence:
- to be accepted whether maleor female and whatever their size or appearance.

WHO shows the way
through advocacy, setting standards
and technical cooperation

Let us join hands
to assure every woman her right
to safe motherhood

Together we can make every
pregnancy safe, save lives and
improve the quality of future
generations

TNVHA hopes its members
would join hands in this venture

IMMUNISATION

All mothers should be immunized with atleast two doses of tetanus toxoid to protect both themselves and their new-borns. Where this has not been done during pregnancy it should be completed during the postpartum period. Where there is a high risk of tuberculosis infection, BCG immunisation should be given to infants soon after birth. Diphtheria-pertussis-tetanus vaccine is recommended for all children at 6, 10 and 14 weeks. A single dose of oral polio vaccine should be given at birth or within the first two weeks of life, and the normal polio immunisation schedule should follow at 6,10 and 14 weeks. Meales vaccination is recommended for infants at nine months of age, while yellow fever vaccine should be given at the same age in countries at risk. Where perinatal infections with hepatitis B are common, the first dose of hepatitis B vaccine should be given as soon as possible after birth and should be followed by further doses at 6 and 14 weeks.✪

Test your vocabulary of Postpartum Care

Birth Asphyxia
Absent or depressed breathing in a new-born baby.

BFHI - Baby Friendly Hospital Initiative
This initiative aims to promote Breastfeeding by encouraging hospitals to adopt policies and routines that are Breastfeeding friendly baby-friendly.

Eclampsia
Convulsions, sometimes followed by coma, occurring in a woman who is pregnant or has just given birth.

Exclusive Breastfeeding
Exclusive Breastfeeding means that an infant receives only breast milk and that no other drink or food is given. The infant should be fed frequently on demand.

Hypothermia
Body temperature below 36.5 C(97.7F)

Infant Mortality Rate[IMR]
The annual number of deaths among children below one year of age 1 per 1,000 live births.

LAM - Lactation Amenorrhea Method
Contraceptive option for the post-partum period which is 98% effective for the woman :

1. who is Breastfeeding (lactating) on demand and not regularly giving other liquids or foods;
2. who has not begun menstruating (i.e., who is amenorrheic); and
3. whose baby is less than six months old.

Low birth weight

Birth weight less than 2500 grams

Maternal Mortality

A maternal death is the death of a woman while pregnant or within 42 days of termination of the pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Maternal Mortality Rate[MMR]

The annual number of deaths among women aged 15-49 from complications of pregnancy and childbirth, per 100,000 women in this age-group. This rate is influenced by the likelihood of becoming pregnant, as well as the risk of buying in childbirth.

Maternal Mortality Rratio

The annual number of deaths among pregnant women from complications of pregnancy and childbirth, per 100,000 live births. This ratio measures a woman's chance of being once pregnant.

Morbidity	:	Disease
Mortality	:	Death
Neonate	:	Infant who is 0-28 days old

Neonatal death

The death of an infant born alive within the first twenty-eight full days of life. Neonatal deaths can be subdivided into early neonatal deaths, which occur during the first seven days of life, and late neonatal death, which take place after the seventh but before the twenty-eight day.

Neonatal death rate

The number of death per 1,000 live births during the first full twenty-eight days of life.

Obstructed labour

A labour in which progress is arrested by mechanical factors and delivery often requires caesarean section.

Perinatal mortality

The number of deaths of fetuses weighing at least 500 g (or when birth weight is not available, after 22 completed weeks of gestation or with a crown-heel length of 25 cm or more) plus the number of infant deaths during the first seven days of life, per 1000 total births.

Puerperium : The six-week period following childbirth.

Puerperal sepsis

Infection of the genital tract occurring at any time between the onset of rupture of membranes or labour, and the 42nd day postpartum in which, apart from fever, one or more of the following are present.

- pelvic plan
- abnormal vaginal discharge (e.g. presence of pus)
- abnormal smell/foul odour of discharge
- delay in the rate of reduction of size of uterus (<2ch/day during first 8 days)

Postpartum haemorrhage

Defined as the loss of 500 ml or more of blood from the genital tract after delivery of the body. In anaemic mothers, a lower level of blood loss should be the cut-off point for starting therapeutic action. ■

Some Vital Statistics To Think Over

Maternal Mortality in the countries of the SAARC region *[WHO, 1996]*

Countary	M. Mort. Rate live births [1 lakh]	No. of Mat. Deaths	Life-time risk of M. death 1 in
Bangladesh	850	33000	21
Bhutan	1600	980	9
India	570	147000	37
Nepal	1500	11000	10
Pakistan	340	18000	60
Sri Lanka	140	520	230
Singapore	10	5	4900
United Kingdom	9	70	5100
Norway	6	5	7300

Female Literacy and reproductive health in the SAARC region

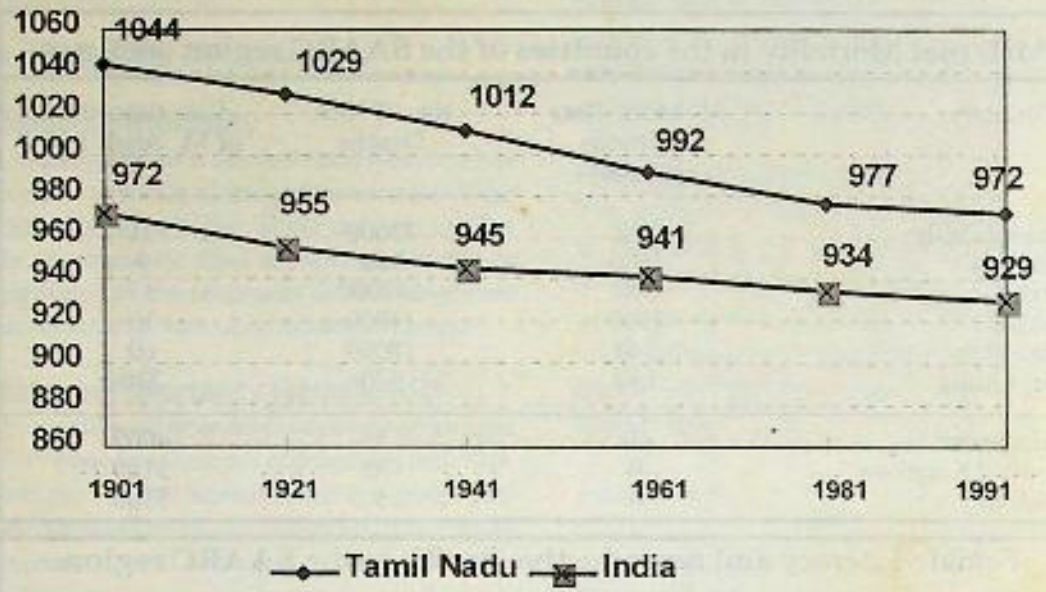
Country	F. Lit. % 1995	CP % 1990-97	TFR 1996	IMR 1996	MMR 1990
Bangladesh	26	49	3.2	83	850
Bhutan	28	19	5.9	90	1600
India	38	41	3.2	73	570
Nepal	14	29	5.1	82	1500
Pakistan	24	12	5.2	95	340
Sri Lanka	96	66	2.1	17	140

CP : Contraceptive Prevalence TFR : Total Fertility Rate *UNICEF, 1998*

Coverage of Maternity Care in the SAARC region *[WHO, 1996]*

Country	Prenstai Care	Institutional Care	Skilled Attendat	MMR
Bangladesh	23	5	14	850
Bhutan	51	11	12	1600
India	62	26	35	570
Nepal	15	6	8	1500
Pakistan	27	13	18	340
Sri Lanka	100	94	92	140
Singapore	100	99	100	10

Sex Ratio Tamil Nadu and India



YEARS	1901	1921	1941	1961	1981	1991
Tamil Nadu	1044	1029	1012	992	977	972
INDIA	972	955	945	941	934	929

Maternal Mortality Rate

Sl. No.	State	Maternal Deaths per 1,00,000 Births	Sl. No.	State	Maternal Deaths per 1,00,000 Births
1.	Kerala	87	2.	Maharashtra	336
3.	Punjab	369	4.	Tamil Nadu	376
5.	Gujarat	389	6.	West Bengal	389
7.	Andhra Pradesh	436	8.	Haryana	436
9.	Karnataka	450	10.	Himachal Pradesh	456
11.	Bihar	470	12.	Assam	544
13.	Rajasthan	550	14.	Uttar Pradesh	624
15.	Madhya Pradesh	711	16.	Orissa	738
17.	INDIA	453			

Source : Indirect estimates based on the MMR-IMR linkage. [The Progress of Indian State Nov. 1995. UNICEF]

BOOKS - PUBLICATION

■ **Directory of funding sources for Safe Motherhood projects.** WHO/FHE/MSM/95.2.E.

■ **Health benefits of Family planning.** Explains how family planning saves women's lives and improves women's and children's health WHO/FHE/FPP/95.11.E

■ **Home based maternal records: Guidelines for development, adaption and evaluation.** A comprehensive guide to all aspects of home-based maternal records. 1994, ISBN 92 4 154464 3, Price Sw fr 20. or US$ 15. In developing countries Sw fr 14. E, F, S.

■ **Low birth weight : A tabulation of available information.** Comprises data on low birth weight rates and preterm birth rates world-wide. WHO/MCH/92.2.E.

■ **The Maternal Health and Safe Motherhood Programme progress report, 1993-1995.** Sets safe motherhood within the broader context of reproductive health and described technical collaboration with countries, information and advocacy, strengthening human resources, research, and the findings of a number of technical working groups that met during the period under review. (Document WHO/FRH/MSM/96.14)

■ **Preventing maternal deaths** - A comprehensive text edited by Erica Royston and Sue Armstrong, WHO 1989, IDBN 92 4 156128 9. Sw fr 40, E,F, S.

■ **Women's groups, NGOs and safe motherhood.** A description of grassroots efforts to prevent and reduce maternal mortality and morbidity. by Marge Berer. WHO/FHE/MSM/92.3.E.

WE ACKNOWLEDGMENT

OUR THANKS

TO THE FOLLOWING SOURCES

"World Health Day"
WHO News, April '98

"Health Action"
CHAI, February '98

"Health Dialogue"
CMAI & AHRTAG, March '98

"AIDS Action"
CHAI - Vol. IV, November '97

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Edwin Raj
TNVHA

"WHO" call for Safe Pregnancy

A significant reduction in maternal mortality in the Region is an achievable goal.

The choice is ours : To grieve for the many thousands that lose their lives, or to act decisively to save them.

Affordable technologies to prevent such deaths do exist. The WHO Mother-Baby package offers life-saving interventions for both mothers and their babies.

Let us monitor every pregnancy to detect threats to their lives: but, even more importantly, let us value and respect women's rights and ensure them equity and social justice.

Safe Motherhood should, thus, be placed firmly on every development agenda.

Women's health is not just theconcern of the health sector, but the combined concern of all development sectors and of responsible policy-makers, individuals, media, and communities alike

To make partnerships effective, they should be backed by adequate resources, sustained commitment and shared credits.

Motherhood is a human right - let us empower women with the knowledge and the means to have greater control over the choices that affect their health and their lives, their families and that of future generations.

WHO : 7 April 1998

A WORD ABOUT TNVHA

Tamil Nadu Voluntary Health Association, in short TNVHA is a non-profit, charitable, secular and registered society. It is functioning from 1970. It is an association of organizations working for health promotion. It is not a funding agency. Its areas of functioning are Tamil Nadu and Pondicherry States. It has 457 institutions (Hospitals, Dispensaries and Community based organizations) as its Members.

TNVHA's main goals are Health Promotion and Health Action. It hopes to create a healthy community through Primary Health Care activities.

TNVHA functions as a Networking (co-ordination) liaisoning and resource agency.

For Health promotion TNVHA's main activities are geared towards creating awareness and organising programmes to strengthen the health workers.

TNVHA co-ordinate with State and Central Government to implement many of their plans. TNVHA is governed by a general body consisting of its member institutions. The Elected Executive Board members manage the activities of the association.

There are also similar associations in most states of India. The Federation of these associations is Voluntary Health Association of India at New Delhi.

WH-11;9.

It was 30 May 1997 around 12.40 p.m. when Sudhadevi sustained burn injuries. Except for her head and face the whole body was burnt. She was immediately rushed to St. Johns Hospital by her family members where she was given first aid but were refused admission until they brought police permission. They also said that there were no beds available. More than 15 to 16 hospitals were contacted but not one of them were willing to offer her admission. In desperation she was taken to the burns centre in the Victoria Hospital. It was by nine 3.00 a.m. The situation here was appalling. There were no doctors on duty - not one was available to help relieve the pains of Sudhadevi. For 5 hours she lay in agony. Slowly her breathing began to grow weak. By the time the junior doctor arrived to attend on her it was 8.30 am. He gave her a pain killer and told the family that the rest would be taken care of by the senior doctor who was busy at a meeting. But by the time he came it was too late. He just began the treatment when she breathed her last. It was 12.00 noon.

Victoria Burns Ward: The Dark Hole of Despair and Death

Many women who are victims of burn injuries are admitted to Victoria Hospital — this being the only specialised State run burns centre to meet the needs of special care and treatment of the entire state. But there are only 25 beds for men and women.

Hospital figures record that on a daily basis atleast 5 women, married and in their early twenties, with burn injuries from 35% to 100% are admitted.

In the month of January, 61 burn cases of women were reported. In February it was 65, in March 73, in April 66, in May 60 and in June 70 — the numbers keep growing but there is neither care nor human concern in the service provided.

From the surroundings, to the wards, the smell of burnt flesh is all pervasive. Where it should be a place of peace and calm the centre is housed in the midst of noise and squalor. Where it should be a sight of great hygine so as to prevent further infection, what greets the eye is dirt and filth. It feels like a public thoroughfare with people moving in and out freely carrying with them all kinds of infection and germs from the environs of the larger hospital.

It is no wonder then that every burn case admitted here is almost always discharged 'dead'.

While on the one hand the hospital environs are more detrimental to recovery than helpful, on the other it is the absolute apathy, callousness and indifference of all the staff that is even more condemnable.

Still fresh in public memory is the case of little Irfan who was dumped in the bathroom cold and shivering, because her parents failed to bribe the Victoria Hospital staff on duty.

It is the experience of all the parents of burns victims at the Victoria Hospital that right from the time of admission to the time of discharge, which is death, it is only money that speaks; it is money that gets things moving.And it is not only the class III and IV employees that should be accused of this. Instances have been reported of doctors too refusing to start treatment until demands for money are met.

There can be no doubt in anyone's mind that the Centre for the treatment of burns must be one where the highest degree of human consideration must be shown; where the spirit to save every life must be utmost. But it is not so. The all pervading attitude is that every case is a "gone case" - so there is no urgency nor sympathy in handing out medical care. Humanity where is thy soul?

And the big question the government must answer us today is: If Sanjay Khan and the famed Vibha Mishra could survive with more than 80% burns why can't all the Sudhadevies also see the light of day. What ails the Victoria Hospital Burns Centre? Will the government not heed the anguish of burn victims, their families and the concerned public?

We Demand: An immediate investigation, review and restructuring of the Burns Ward in Victoria Hospital.

A Movement to Defend Women's Right to Live
Vimochana

In the process of following up the tragic and criminal suicides and murders of women due to dowry demands or other forms of violence within marriage, our attention has also been drawn to the medical care available for the victims who manage to survive — particularly those who are victims of burn injuries.Tragically we have found that even if they survive the torture inflicted within the house by their own people, the callousness of the government medical establishment which is the only hope of the majority who cannot afford private medical care drives the women to a painful death.

Vimochana, through the Movement to Safeguard a Women's Right to Live seeks to make accountable public institutions that are there to provide care and justice particularly to the vulnerable sections of society - women or men.

Vimochana - C/o "Angala", 2124, 1st A cross, 16B, Main, HAL 2nd Stage, Bangalore - 560 008. Tel : 5269367

ಸಾವಿನ ಕೂಪವಿದು : ವಿಕ್ಟೋರಿಯ ಸುಟ್ಟ ಗಾಯಗಳ ವಿಭಾಗ

ಅಂದು ಮೇ 30, 1997; ರಾತ್ರಿ 11-40ರ ಸಮಯ. ಸುಧಾದೇವಿ ಸಂಪೂರ್ಣ ಸುಟ್ಟ ಗಾಯಗಳಿಂದ ನರಳುತ್ತಿದ್ದಳು. ಅದೃಷ್ಟವಶಾತ್ ಅವಳ ಮುಖ ಹಾಗೂ ತಲೆ ಮಾತ್ರ ಸುರಕ್ಷಿತವಾಗಿತ್ತು. ಅವಳನ್ನು ಕೂಡಲೆ ಸಿಂಪ್ಸ್ ಜಾನ್ಸ್ ಆಸ್ಪತ್ರೆಗೆ ಸಾಗಿಸಲಾಯಿತು. ಅಲ್ಲಿ ಸುಧಾದೇವಿಗೆ ಪ್ರಥಮ ಚಿಕಿತ್ಸೆ ನೀಡಿದ ವೈದ್ಯರು ಪೋಲೀಸ್‌ರ ಆನುಮತಿ ಬೇಕೆಂಬ ಕಾರಣ ಮುಂದೊಡ್ಡಿ ಆಕೆಯನ್ನು ಆಸ್ಪತ್ರೆಗೆ ದಾಖಲಿಸಿಕೊಳ್ಳಲು ನಿರಾಕರಿಸಿಬಿಟ್ಟರು. ಪಂತರ 15-16 ಆಸ್ಪತ್ರೆಗಳನ್ನು ಸಂಪರ್ಕಿಸಿದ ಆಕೆಯ ಕುಟುಂಬದವರು ಯಾವ ಆಸ್ಪತ್ರೆಯೂ ಸಿಗದೆ ಕೊನೆಗೆ ವಿಕ್ಟೋರಿಯ ಆಸ್ಪತ್ರೆಗೆ ತಂದರು. ಆಗ ಬೆಳಿಗಿನ ಜಾವ 3-00 ಗಂಟೆ. ಇಲ್ಲಿನ ತುರ್ತು ಚಿಕಿತ್ಸಾ ವಿಭಾಗದಲ್ಲಿ ಆ ಸಮಯದಲ್ಲಿ ಯಾವುದೇ ವೈದ್ಯರು ಲಭ್ಯವಿರಲಿಲ್ಲ. ಸಹಿಸಲಸಾಧ್ಯ ನೋವಿನಿಂದ ನರಳುತ್ತಿದ್ದ ಸುಧಾದೇವಿಯನ್ನು ಕಿರಿಯ ವೈದ್ಯರೊಬ್ಬರು ಬಂದು ನೋವು ನಿವಾರಕ ಔಷಧಿಯನ್ನು ಕೊಟ್ಟಾಗ ಬೆಳಿಗ್ಗೆ 8-30 ಗಂಟೆ. ಮುಂದಿನ ಚಿಕಿತ್ಸೆಗಾಗಿ ಮೀಟಿಂಗ್ ಒಂದರಲ್ಲಿದ್ದ ಹಿರಿಯ ವೈದ್ಯರನ್ನು ಕಾಯಬೇಕಾಯಿತು. ಆ ಹಿರಿಯ ವೈದ್ಯರು ಬಂದು ಸುಧಾದೇವಿಯ ಚಿಕಿತ್ಸೆ ಪ್ರಾರಂಭಿಸುವಾಗ ಬಹಳ ತಡವಾಗಿತ್ತು. ಆ ಹೊತ್ತಿಗೆ ಆಕೆಯ ಪ್ರಾಣ ರಕ್ಷಿಸಿ ಹಾರಿ ಹೋಗಿತ್ತು. ಆಗ ಸಮಯ ರಾತ್ರಿ 12-00 ಗಂಟೆ.

ರಾಜ್ಯ ಸರ್ಕಾರದ ಸ್ವಾಮ್ಯಕ್ಕೆ ಒಳಪಟ್ಟು ಇಡೀ ರಾಜ್ಯಕ್ಕೆ ಇರುವ ಒಂದೇ ಒಂದು ಸುಟ್ಟ ಗಾಯಗಳ ಸುಸ್ಸಜ್ಜಿತ ಕೇಂದ್ರ ಈ ವಿಕ್ಟೋರಿಯಾ ಆಸ್ಪತ್ರೆಯಲ್ಲಿದ್ದು, ಇಲ್ಲಿಗೆ ಚಿಕಿತ್ಸೆ ನಿರೀಕ್ಷೆಯಲ್ಲಿ ಬರುವ ರೋಗಿಗಳಿಗೆ ಲಭ್ಯವಿರುವ ಹಾಸಿಗೆಗಳ ಸಂಖ್ಯೆ ಕೇವಲ ಇಪ್ಪತ್ತೈದು.

ಆಸ್ಪತ್ರೆಯ ದಾಖಲಾತಿಯ ಪ್ರಕಾರ ಕನಿಷ್ಟ ಐದು ಯುವ ಮಹಿಳೆಯರು ಶೇ. 35 ರಿಂದ 100 ರಷ್ಟು ಸುಟ್ಟ ಗಾಯಗಳೊಂದಿಗೆ ಇಲ್ಲಿಗೆ ಚಿಕಿತ್ಸೆಗಾಗಿ ಬರುತ್ತಾರೆ. ಅಧಿಕೃತ ಮಾಹಿತಿಯ ಪ್ರಕಾರ ಈ ವರ್ಷದ ಜನವರಿಯಲ್ಲಿ 61 ಸುಟ್ಟ ಗಾಯಗಳ ಪ್ರಕರಣಗಳು ದಾಖಲಾಗಿದ್ದರೆ; ಫೆಬ್ರವರಿಯಲ್ಲಿ 65; ಮಾರ್ಚ್‌ನಲ್ಲಿ 73; ಏಪ್ರಿಲ್‌ನಲ್ಲಿ 66; ಮೇನಲ್ಲಿ 60 ಹಾಗೂ ಜೂನ್‌ವರೆಗೆ 70 ಇಂತಹ ಪ್ರಕರಣಗಳು ದಾಖಲಾಗಿವೆ.

ಸ್ವಚ್ಛತೆಯ ತಾಣವಾಗಬೇಕಾಗಿದ್ದ ವಿಕ್ಟೋರಿಯಾ ಆಸ್ಪತ್ರೆ ಆದರಲ್ಲೂ ಸುಟ್ಟಗಾಯಗಳ ಚಿಕಿತ್ಸಾ ಕೇಂದ್ರದಲ್ಲಿ ಹಾಗೂ ಸುತ್ತಮುತ್ತ ಅನಹ್ಯ ಗಲೀಜು ವಾತಾವರಣ ಸೃಷ್ಟಿಯಾಗಿದೆ. ಸುಟ್ಟ ಗಾಯಗಳ ವಾಸನೆ, ಅನಾಗತ್ಯ ಜನ ದಟ್ಟಣೆ, ಆತಿ ಗಲಾಟೆ, ಅಸ್ವಚ್ಛತೆಯಿಂದ ಹರಡುವ ಸೋಂಕು - ಹೀಗೆ ರೋಗಿಗಳನ್ನು ಇನ್ನಷ್ಟು ರೋಗಿಗಳನ್ನಾಗಿ ಮಾಡುತ್ತವೆ. ಹೀಗಾಗಿ ಈ ಆಸ್ಪತ್ರೆಗೆ ಸೇರಿಸುವ ಬಹುತೇಕ ರೋಗಿಗಳು ಹೊರ ಹೋಗುವುದು ಶವವಾಗಿಯೇ ಎಂದಾಗ ಆಶ್ಚರ್ಯ ಪಡಬೇಕಾದ್ದಿಲ್ಲ.

ರೋಗಿಗಳ ಈ ಸ್ಥಿತಿಗೆ ಮತ್ತೊಂದು ಕಾರಣ ಇಲ್ಲಿನ ಸಿಬ್ಬಂದಿಯ ಉದಾಸೀನತೆ; ಅಲಕ್ಷ್ಯತೆ; ಅಮಾನವೀಯತೆ. ಕೈ ಬಿಸಿ ಮಾಡದ ಹೊರತು ಆಸ್ಪತ್ರೆಗೆ ಬರುವ ಸುಟ್ಟಗಾಯಗಳ ರೋಗಿಗಳನ್ನು ವಾಹನದಿಂದ ಸಾಗಿಸುವ ಕೆಲಸಕ್ಕೆ ಯಾವುದೇ ವಾರ್ಡ್‌ಬಾಯ್‌ಯಾಗಲೀ ಮುಂದೆ ಬರುವುದಿಲ್ಲ; ಅಲ್ಲದೆ ಕೆಲವು ವೈದ್ಯರೂ ಸಹ ರೋಗಿಗೆ ತುರ್ತು ಚಿಕಿತ್ಸೆ ನೀಡಲು ಹಣದ ನಿರೀಕ್ಷೆಯಲ್ಲಿರುತ್ತಾರೆ ಎಂದು ಅವೇಕಯ ಪಮ್ಮ ನಿಕ್ಕದ ಅನುಭವವನ್ನು ಹೇಳುತ್ತಾರೆ. ಅಲ್ಲದೆ ಇನ್ನು ಕೆಲವು ಪ್ರಕರಣಗಳಲ್ಲಿ ರೋಗಿಯ ದಾಖಲಾತಿಯಿಂದ ಹಿಡಿದು ಮರಳಿ ಮನೆಗೆ ಕರೆದುಕೊಂಡು (ಬದುಕಿದ್ದರೆ) ಹೋಗುವವರೆಗೆ ಇಲ್ಲವೆ ಹಣವನ್ನು ತೆಗೆದುಕೊಂಡು ಹೋಗುವವರೆಗೂ ಲಂಚದ ಹಾವಳಿ ಇದ್ದದ್ದೇ ಎನ್ನಲಾಗುತ್ತದೆ.

ವೈದ್ಯಧರ್ಮದ ದೃಷ್ಟಿಯಿಂದ ಹೇಳುವುದಾದರೆ ಆಸ್ಪತ್ರೆಗೆ ಬರುವ ಪ್ರತಿ ರೋಗಿಯ ಜೀವವನ್ನು ಪವಿತ್ರವೆಂದು ಭಾವಿಸಿ ಅದನ್ನು ರಕ್ಷಿಸಲು ಕೊನೆಯ ಪಂತದವರೆಗೆ ಪ್ರಾಮಾಣಿಕ ಪ್ರಯತ್ನವನ್ನು ಮಾಡಬೇಕು. ಈ ದೃಷ್ಟಿಯಿಂದ ಹಿರಿಯರು ವೈದ್ಯರನ್ನು ಶ್ರೀಹರಿ, ನಾರಾಯಣರಿಗೆ ಹೋಲಿಸಿದ್ದಾರೆ. ಆದರೆ ವಿಕ್ಟೋರಿಯಾ ಆಸ್ಪತ್ರೆಗೆ ಸುಟ್ಟಗಾಯಗಳಿಂದ ಬರುವ ಪ್ರತಿ ರೋಗಿಯನ್ನೂ ಇಲ್ಲಿನ ಸಿಬ್ಬಂದಿವರ್ಗ 'ಮುಗಿದ ಕತೆ' ಎಂದೇ ಪರಿಗಣಿಸಿ ನಿರ್ಲಕ್ಷ್ಯ ತೋರುತ್ತಾರೆ ಎಂದು ಬಹಳಷ್ಟು ದೂರುಗಳು ಕೇಳಿ ಬರುತ್ತಿವೆ. ಸುಟ್ಟ ಗಾಯಗಳಿಂದ ನರಳುವವರ ನೋವಿನ ಯಾತನೆಯನ್ನು ಯಾರಿಂದಲೂ ಊಹಿಸಲು ಸಾಧ್ಯವಿಲ್ಲ. ಅಂತಹ ರೋಗಿಗಳಿಗೆ, ಸತದೃಷ್ಟವಶಾತ್ ಎಲ್ಲಿಲ್ಲದ ಆದ್ಯತೆಯ ಸುಸ್ಸೂಷೆ, ಚಿಕಿತ್ಸೆಗಳು ಲಭ್ಯವಾಗಬೇಕು; ಇದನ್ನು ಆಲ್ಲಿನ ಸಿಬ್ಬಂದಿವರ್ಗಕ್ಕೆ ಮನದಟ್ಟು ಮಾಡಿಕೊಡಬೇಕಾಗಿದೆ. ಇದು ಇಂದು ನಮ್ಮ ನಿಮ್ಮೆಲ್ಲರ ಕರ್ತವ್ಯವಾಗಿದೆ. ಏಕೆಂದರೆ ಅಪಘಾತಗಳೇ ಆಕಸ್ಮಿಕ. ಅವು ಎಂದು ಯಾವಾಗ ಯಾರಿಗೆ ಬಂದು ಅಮರಿಕೊಳ್ಳುತ್ತವೋ ಹೇಳಲಾಗದು. ಆದರಲ್ಲೂ ಇತ್ತೀಚಿನ ದಿನಗಳಲ್ಲಿ ಹೆಚ್ಚುತ್ತಿರುವ ಮಹಿಳೆಯರ ಮೇಲಿನ ದೌರ್ಜನ್ಯಗಳು, ವರದಕ್ಷಿಣೆ ಕಿರುಕುಳಗಳು ಉದ್ದೇಶಪೂರ್ವಕವಾಗಿಯೇ ಮಹಿಳೆಯರಿಗೆ, ಕೈ ಹಿಡಿದ ಮಡದಿಯರಿಗೆ ರಕ್ಕಸ ಮನಸ್ಸಿನ ಗಂಡಂದಿರು ಬೆಂಕಿ ಹಚ್ಚಿ ಕೊಲೆಗೈಯಲು ಮುಂದಾಗುತ್ತಿರುವ ಪ್ರಕರಣಗಳು ಬೆಳಕಿಗೆ ಬರುತ್ತಿವೆ. ಈ ದುರುದ್ದೇಶಪೂರ್ವಕ ಕೃತ್ಯಗಳಿಗೆ ಬಲಿಯಾಗಿ ಉಳಿದುಕೊಳ್ಳುವ ಅಮಾಯಕ, ಮುಗ್ಧ ಹೆಣ್ಣು ಜೀವಗಳನ್ನು ರಕ್ಷಿಸಿಕೊಳ್ಳಲು ರಕ್ಷ ವೈದ್ಯ ಸೌಲಭ್ಯದ ಅಗತ್ಯವಿದೆ. ಅದನ್ನು ಪಡೆಯುವ ಹಕ್ಕು ನಮಗೆ ನಿಮಗೆಲ್ಲ ಇದೆ. ಶೇ. 80 ರಷ್ಟು ಸುಟ್ಟ ಗಾಯಗಳಿಗೆ ತುತ್ತಾಗಿದ್ದ ಸಿನಿಮಾ ನಟ ಸಂಜಯ್‌ದತ್, ವಿಧಾ ಮಿಸ್ಸಾರಂತಹವರು ಬದುಕಿ ಉಳಿಯಲು ಸಾಧ್ಯವಾಗಿರುವಾಗ ಸುಧಾದೇವಿಯಂತಹ ಅಮಾಯಕ ಹೆಣ್ಣುಗಳಿಗೆ ಬದುಕುಳಿಯುವ ಸಾಧ್ಯತೆಗಳು ಏಕೆ ಇರುವುದಿಲ್ಲ? ಇದಕ್ಕೆ ವಿಕ್ಟೋರಿಯ ಆಸ್ಪತ್ರೆಯ ಆಡಳಿತ ವರ್ಗದ ಬಳಿ ಯಾವ ಉತ್ತರವಿದೆ?

ನಮ್ಮ ಬೇಡಿಕೆ:

ಹಕ್ಕಾರು ಆಸ್ಪತ್ರೆಗಳ ತಾಣವಾಗಿರುವ ವಿಕ್ಟೋರಿಯ ಸುಟ್ಟಗಾಯಗಳ ವಿಭಾಗದ ಬಗ್ಗೆ ಸಂಬಂಧಪಟ್ಟವರು ಕೂಡಲೆ ಪರಿಶೀಲನೆ ಮಾಡಿ, ಸೂಕ್ತಕ್ರಮ ಕೈಗೊಂಡು, ಹೊಸ ರೂಪ ನೀಡಿ, ಆರೆ ಜೀವಗಳಿಗೆ ಮರು ಜೀವ ನೀಡುವಂತಾಗಬೇಕು.

ವೈವಾಹಿಕ ಚೌಕಟ್ಟಿನೊಳಗೆ ಮಹಿಳೆಯರು ಅನುಭವಿಸುವ ವರದಕ್ಷಿಣೆ ಮುಂತಾದ ಕಿರುಕುಳಗಳಿಗೆ ಬಲಿಯಾಗಿ ಆರೆಜೀವಗೊಳ್ಳುವ ಹೆಣ್ಣುಗಳ (ಸುಟ್ಟು ಗಾಯಗಳಿಂದ) ಜೀವ ರಕ್ಷಣೆಗೆ ಇರುವ ಒಂದೇ ಆಕಾರಣವೆಂದರೆ ಆಸ್ಪತ್ರೆಗಳು. ಬಡ ಹೆಣ್ಣುಗಳು ಮುಖಾರಿ ಖಾಸಗಿ ಆಸ್ಪತ್ರೆಯ ಕನಸು ಬಿಟ್ಟು ಸರ್ಕಾರಿ ಆಸ್ಪತ್ರೆಗಳನ್ನೇ ನಂಬಿಕೊಂಡು ಹೋಗುತ್ತಾರೆ. ಆದ್ದರಿಂದಲೇ ರಾಜ್ಯಕ್ಕೆ ಒಂದೇ ಇರುವ ವಿಕ್ಟೋರಿಯ ಆಸ್ಪತ್ರೆಯ ಮೇಲೆ ನಮ್ಮ ಆಕ್ರೋಶ. ಏಕೆಂದರೆ ಇಂತಹ ಸಾರ್ವಜನಿಕ ಸಂಸ್ಥೆಗಳು ಸಾರ್ವಜನಿಕ ಜನಸಾಮಾನ್ಯರ ಜೀವ ರಕ್ಷಣೆಯ ಹೊಣೆ ಹಾಗೂ ಜವಾಬ್ದಾರಿಯನ್ನು ಹೊತ್ತಿರುತ್ತವೆ. ಅದನ್ನು ಅವು ದಕ್ಷತೆಯಿಂದ ನಿಭಾಯಿಸಬೇಕೆಂಬುದೇ ನಮ್ಮ ಆಗ್ರಹ.

ಮಹಿಳೆಯರ ಬದುಕುವ ಹಕ್ಕನ್ನು ರಕ್ಷಿಸುವ ಆಂದೋಲನ

ವಿಮೋಚನಾ

ಕೇರಾಫ್, "ಅಂಗಳ", 2124, ನೇ-ಎ ಆಡ್ಡರಸ್ಸೆ 16-ಬಿ ಮುಖ್ಯರಸ್ತೆ ಹೆಚ್.ಎ.ಎಲ್. 2ನೇ ಹಂತ, ಬೆಂಗಳೂರು - 560 008. ದೂ.ವಾ: 5269307

CHETNA NEWS

April to June 1998

Centre for Health Education, Training and Nutrition Awareness

CHETNA

WR-0179

OVERVIEW

Improving access to quality health care is the key strategy to promote the health of disadvantaged women all over the globe. Since 1997, the Netherlands based Women's Global Network for Reproductive Health is promoting a worldwide campaign under the theme "Access to Quality Health Care: Women's Right", to make it a reality. Promoting this theme, the network has made appeals worldwide inviting NGOs and GOs to celebrate May 28,- as the International Day of Action on Women's Health. CHETNA celebrated the day by organising an innovative diagnostic, treatment and educational gynaecological health camp, as a demonstrative strategy to achieve the goal of access to quality health care for disadvantaged women. The camp took into account the key concepts of quality health care, namely counselling, education and rational health practices.

The process of any development and social change demands active involvement of various stakeholders including the general public to make health information reach the masses. CHETNA actively participated in the planning and designing of an exhibition, **"Niramay Jeevan"**, organised by the Government of Gujarat which was attended by 3000 people. CHETNA displayed interactive exhibits on **Reproductive and Child Health** topics.

In the area of Early Childhood Care and Development (ECCD), CHETNA has 15 year experience of capacity building, especially with the Integrated Child Development Services (ICDS) programme. In Gujarat, CHETNA has a contributed its expertise and experiences to develop government policies and programmes to strengthen the supplementary nutrition component of ICDS. During this quarter CHETNA took an initiative to extend its expertise to the ICDS programme in the state of Bihar. To share its expertise, CHETNA is also making a steady progress working in the state of Madhya Pradesh through the project "Community Entrepreneurship for the Local Production of Complementary Food" in collaboration World Food Programme and Department of Women and Child Development, Government of Madhya Pradesh.

Since 1990, adolescent reproductive health has been CHETNA's special interest area. To learn from researches conducted in India, CHETNA participated in a workshop on Adolescent Sexuality and Fertility in India, at Bangalore. A Seminar on Education and Sustainability at Mussoorie was another meaningful learning opportunity.

In urban areas too, access to quality health care is a major concern for the slum population. CHETNA through its **Ben Lilavati Lalbhai Holistic Health Centre** aims to address this issue. In the last quarter, about 265 women and children received curative health care. The centre also promotes the concept of preventive and promotive health care through creating health awareness.

CHETNA's western region Women and Health (WAHI) training is presently going through a follow up phase. On the persistant demand of the participants, a gender sensitive training for their family members was organised. The participants alongwith their family members planned a strategy to incorporate gender concepts in thier daily life.

In collaboration with the Department of Women and Child Development (DWCD) Rajasthan, CHETNA, Rajasthan Cell took initiative to review the Women's Policy for Rajasthan State by organising the meeting of key representatives of NGOs and academic institutions. In collaboration to **Health Watch**, CHETNA, Rajasthan Cell, initiated the process of developing a women's forum in the state. In the era of paradigm shift from target to choice, the forum envisages to monitor the activities related to women's health and development of NGOs and GOs at the state level.

Advocacy, through sharing of experiences and networking is becoming a integral part of CHETNA. During this quarter, CHETNA participated and shared its experiences in several national and international workshops. Some of the noteworthy ones being Media Advocacy on Reproductive Health at New Delhi, Mumbai and Ahmedabad, Men as Supportive Partners in Reproductive and Sexual Health in Nepal, Understanding the Society and Health Interface- New Opportunities for Improving Health in Italy and Women's Health: Monitoring and Implementing the Beijing Platform for Action in Malaysia etc. To strengthen its own understanding on **Reproductive Health**; CHETNA participated in a workshop, A Training on Operationalising Reproductive Health: Leadership and Management Development for Reproductive Health Programme at Jaipur. To enrich the growing process of gender training in the South Asian countries, CHETNA participated in a Gender trainer's workshop at Dhaka, Bangladesh. CHETNA has been proposed as one of the regional centres in India for Gender Trainers network.

CHETNA is committed to continue work on concerns related to disadvantaged women and children's health and development from a holistic perspective. We appeal to all stakeholders to join hands to work towards our endeavour to achieve Holistic Health of Indian Families.

FOCUS

Access to Health Care: 28 May, 1998 Celebrating International Day of Action for Women's Health.

Global attention has focused towards significant concerns related to women's health since May 1987 when the Fifth International Women and Health Meeting (IWHM) was held in Costa Rica. It was decided to initiate an annual campaign on Maternal Mortality to raise public awareness on the theme. Following this decision, at a meeting of the Women's Global Network for Reproductive Rights (WGNNR - a Netherlands based International Network), held on May 28, it was decided to celebrate day as the "International Day of Action for Women's Health".

May 28 has become symbolic for individuals, women's groups and networks working worldwide to focus attention on different concerns of women's health every year. Inspite of these efforts, the problems associated with women's health due to their poor access to quality health care, deeply embedded patriarchal values, gender inequities and socio-cultural economic factors, have still not been fully addressed to bring about a change in the grim scenario. Statistics on maternal mortality, morbidity, disparity in sex ratio and female literacy shows that a paradigm shift in planning, implementing and monitoring comprehensive and holistic programmes on women's health is urgently required to create any positive impact.

This year the theme of the campaign was **"Access to Quality Health Care: A Woman's Right"**. Access to health care encompasses the broad vision, including the concept of gender and comprehensive health care. Quality care can be defined as that which is founded on the concept of comprehensive health and would solve the health problems brought to the consultation both at a biological level and at a level which increases a woman's self esteem, autonomy and appreciation and the exercise of dignity and rights. This can be achieved using the health care providers' technical competence and through taking into account the history, daily work and the subjective feelings of all women.

CHETNA Celebrates 28th May 1998

CHETNA organised an innovative diagnostic, treatment and educational gynaecological health camp as a strategy to achieve the goal of making access to quality health care a reality for disadvantaged women. The camp integrated the above listed definition of quality care through the conduct of various activities. This camp was a learning experience for many NGOs and GOs to enable them to replicate and ensure quality care for poor women.

The camp was organised through CHETNA's Lilavati Lalbhai Holistic Health Center. This centre, operating since the last 3 years is providing integrated health services to poor women and children from nearby slum areas. The camp was a resounding success both as a celebration for the International Day of Action for Women's Health and improving the access of health care. Special efforts were made to integrate an educational and diagnostic process through which each woman could enrich her knowledge on reproductive health, understand the complexity of the

problem and receive rational treatment for the same.

The women who attended the camp were interviewed individually to record their reproductive health history and document any complaints that they may have had before the internal examinations were facilitated by the gynaecologist. Efforts were made to understand the sociocultural aspects linked with their health problems. This information was provided to the medical doctors prior to the examination of the woman so as to ensure an integrated and holistic treatment. Each woman went through an interactive exhibition displayed at the campsite providing them with accurate scientific knowledge on the reproductive system and different common gynaecological health concerns of women. Innovative teaching aids, models to demonstrate the reproductive system, electrically operated games on matching pairs of correct responses and a bioscope to explain the process of childbirth were found to be an eye-opening learning experience particularly by the semi-literate women.

The women actively participated in group discussions on the effect of gender inequality on women's health. Various examples from the group were discussed to clarify the concept. These included early marriage, negotiation skills in reproductive and sexual health, lack of control on fertility etc. During the discussion one significant suggestion that came forth was to actively involve men from their families in the health education programmes to raise their awareness and bring about a positive change in their behaviour towards the reproductive health concerns of women. CHETNA is committed to act upon this suggestion in the near future.

During the health checkup, Allopathic and Ayurvedic health professionals jointly remained present to provide their technical expertise, ensure rational health treatment and counselling for their prevention.

Special efforts were made on counselling to ensure prevention. Special facilities for Hemoglobin estimation and Pap test were provided to treat anaemic women and to detect cancers. More than 100 women participated in the event, out of which 50 went through the health checkup, whereas the rest participated in other activities. Majority of the women were found to be suffering from bacterial and fungal infections.

The camp got voluntary contributions from organisations like Gujarat Sarvar Mandal, Green Cross Laboratory, Parivar Seva Sanstha, Ahmedabad Municipal Corporation and private doctors who provided free medicines, laboratory services, diagnosis and treatment. The camp proved to be a pioneering example of providing quality care for women on reproductive health.

CHETNA, being one of the co-ordinating agencies disseminated information about this campaign in India and South Asian Countries.

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Child-Centred Health Education: Innovations in Training and Networking

CHEITAN

District Level Workshop on Early Childhood Care and Development (ECCD), Idar, Gujarat

Health and development of young children below five years of age is a major concern of Non Government organisations (NGOs) and government programmes. The Family and Child Welfare Committee of the Government of Gujarat organised a district level workshop on April 27, 1998 at Idar to understand the concerns of the organisations implementing child care projects. The views of 32 participants from 25 NGOs including CHETNA and Government representatives were actively solicited for the formation of an NGO network like FORCES in Gujarat.

Among the other important issues discussed during the workshop included on the role of the Panchayat Administration at the district, block and village level in contributing towards child care programmes. The education of parents on child development was strongly recommended. Detailed discussions took place on activities that can be organised for child care programmes and the reference materials that can be used. Strategies for sustainability were also discussed.

Some of the Recommendations made during the workshop included starting child care centers for every 100 households, avoiding the duplication of efforts by various departments throughout the planning process, the forest department developing gardens for children, creating a permanent child care fund at the block level through vegetable and milk co-operatives, etc., and the use of wastelands for growing trees of nutritional value like Amla (Indian gooseberry), Papaya, Mangoes, etc.

For further details contact : Shri Mahipat Singh Jadeja, Secretary, Family and Child Welfare Committee, Gandhiwadi, Station Road, Idar, District Sabarkantha-383430, Gujarat.

Meeting to Discuss Improvement in Supplementary Nutrition for ICDS in the State, Gandhinagar, Gujarat

Integrated Child Development Services (ICDS) is the single largest nutrition programme in India. ICDS aims to improve the nutrition and health status of children below the age of 6 years and pregnant and nursing mothers. Large numbers of ICDS centres (Anganwadis) are open at the village level. In the state of Gujarat, a special committee was set up to review the present supplementary nutrition food served at the ICDS centres. It was observed that the food was not suitable for children under two years age. The recommendation of providing food that is more acceptable and palatable to children of under two years of age was made. To review the present system of providing supplementary nutrition in the ICDS programme and elicit suggestions for its qualitative improvement, the State Commissioner for Health Medical Services and Medical Education called a special meeting at the Secretariat, Gandhinagar on May 21, 1998.

The meeting was chaired by the Honourable Minister of Health, Government of Gujarat, Shri Ashok Bhatt and included key officials from the department of Health responsible for monitoring the ICDS. Several NGOs and agencies involved in processing of 'ready-to-eat' nutritious food and UNICEF representative were also invited. CHETNA as a part of the expert committee remained present to share its experiences.

At the outset, the Secretary of Health and Family Welfare, Mr.Virdi presented an overview of the State ICDS, highlighting the number of operational blocks as of March 1998 and future plans for expansion.

The Honourable Minister welcomed suggestions for the improvement in the quality of supplementary nutrition. The present budgetary provision of Rs.1/- per beneficiary per day may also not be sufficient. However on this the State Government would have to take a policy decision on raising this limit after adequate field testing and reviewing of sample recipes by experts.

He further suggested a combination of processed and cooked food to be served at the ICDS centres.

For further details contact : DR. K.N. Patel, Joint Director of ICDS, Commissionerate of Medical and Health Services, Block No.5, Dr.Jivraj Mehta Bhavan, Old Sachivalaya, Gandhinagar, 382010.

CHETNA's Efforts in ICDS Bihar

Based on CHETNA's 15 year long rich experience and expertise in training, documentation and development of material related to the ICDS programme, they were invited to strengthen the Bihar ICDS programme.

Joint Training on Early Childhood Education, Ranchi, Bihar

As a part of this strategy, a joint training on Early Childhood Education (ECE) was organised by the Directorate Social Welfare, Government of Bihar and UNICEF at the Bihar Institute of Sustainable Development, Ranchi from May 18-20, 1998. Resource persons from CHETNA Ahmedabad, State Institute of Education, Research and Training (SIERT) Udaipur and Bihar Education Project addressed the concerns of 65 participants present from 16 select ICDS projects including ICDS workers and NGO representatives.

The strategy adopted for strengthening the Early Childhood Education (ECE) component in the ICDS, was to select 4 centres from each sector, where the supervisor is posted and to conduct a joint training of Aganwadi Workers and school teachers to establish the linkages of ICDS centres with schools. It was also recommended in this pilot project to form village groups for orientation and to use inputs from the supervisors and NGOs in the strengthening of ECE.

Workshop on strengthening of Management Information System (MIS) in ICDS, Ranchi, Bihar

In continuation with the above mentioned training another four day workshop was attended to strengthen the Management Information System (MIS) in ICDS which was held at Ranchi from May 21-24, 1998. Approximately 55 participants from 5 ICDS blocks of Ranchi district which included ICDS and health workers and NGO representatives participated in the workshop. CHETNA was invited as one of the workshop facilitators.

The workshop focused on the need for the participants to arrive at a common understanding of the status of women and children under three years of age, review various aspects of MIS, types of records and formats currently being used in the ICDS. Also topics like community based monitoring and techniques of Participatory Learning Action (PLA), a technique used for data collection at the village level were discussed. A two day field visit helped participants become familiar with the techniques used and the analysis of the data generated.

State Level ICDS Training Review Meeting for Anganwadi and Middle Level Training Centre, Patna, Bihar

With the globalisation of ICDS in the country, need for orientation and refresher trainings has become a major strategy adopted by the States. To review the ICDS training status in the State, a two day meeting was organised by the Directorate of Social Welfare, Bihar from June 11-12, 1998. 25 Principals, Secretaries and Instructors from various Anganwadi and middle level training centres participated. The meeting was facilitated by the State Programme Officer, Bihar and representatives from UNICEF, CHETNA Ahmedabad, Sahyog Bharatpur (Rajasthan) and Institute of Integrated Rural Development (IIRD), Jaipur.

Every week, a quarter of a million children die in the developing world. Many millions more live on with ill health and poor growth.

The participants discussed problems and constraints faced by the training centres (including administrative and resource related issues, and moral/attitude aspects) with the objective of bringing qualitative improvement in the trainings of the ICDS, and to cope with the expansion phase. The Their training needs were also enlisted.

The State Programme Officer explained the strategy required to cope with the backlog of trainings. He proposed four trainings for capacity building of trainers of training centres by March 1999.

For further details contact: Mr.Krishna Mohan Prasad, Training Officer, World Bank ICDS II, Second Floor, Indira Bhawan, R.C. Singh Path, Patna - 800 001, Bihar.

Workshop on Adolescent Sexuality and Fertility in India, Bangalore, Karnataka

A Washington based organisation, International Center for Research on Women (ICRW), has supported several research projects in developing countries on adolescent sexual health including four Indian organisations. A two day workshop on 'Adolescent Sexuality and Fertility in India' was organised at Bangalore on May 6-7, 1998 to share their research data and experiences. A three member team from CHETNA participated.

Source : Women in development

In India, it is estimated that there are about 180 million adolescents in the age group 10-19 years, almost one fifth of the entire population. About 36 % of girls in the age group 13-16 and 64% in the age group 17-19 are already married.

Among the various problems highlighted in the research studies, were early marriage and motherhood, unsafe abortions, neglected reproductive health problems, exposure to STD/HIV through ignorance about their transmission, pre-marital and extra marital experiences and exposure of adolescent boys to commercial sex workers. Social beliefs, myths and misconceptions have further contributed to these problems. Young girls were found to be poorly informed about menarche and the changes associated with puberty. In comparison, boys had more knowledge, although incomplete or inaccurate, on sexual matters by having better access to reading pornographic material, and through friends. There seemed a great potential to bring about a positive change in the sexual behaviour, atiitudes and social practices to alleviate these problems.

As an outcome of the workshop, recommendations were made to design innovative sex education programmes with greater involvement of students in planning and implementation, to take into account the prevailing adolescent sub-culture, language and their anxieties and to address the prevailing myths and misconceptions. Another important recommendation was to initiate sex education programmes from High School onwards integrating it with the curriculum.

For further details contact: Ms. Kathleen M.Kurz, ICRW, 1717, Massachusetts Avenue, NW Suite 302, Washington DC 20036, USA

World Food Programme (WFP) Jhabua project, Meghnagar, Madhya Pradesh

The Government of Madhya Pradesh and WFP have collaborated on a project in "Community Entrepreneurship for the Local Production of Complementary Food" which is being implemented in Meghnagar block of Jhabua district. CHETNA is an active partner of this project. During the quarter, two critical meetings of all stakeholders were organised in the months of April and May 1998 to finalise the implementing strategy developed by CHETNA to raise the community awareness on complementary feeding and growth monitoring based on the Knowledge Attitude Practice (KAP) study findings. Prototype of the selected Information Education Communication (IEC) material of Counselling Cards book was field tested by the CHETNA team during June and technical inputs from the Government officials, WFP and UNICEF were elicited for finalising the same.

It was decided to organise an orientation training for the block and sector level, Panchayat (village level self government) members and village campaign activities. Lists of trainees, detailed curriculum, and venues for

stipulated trainings have been finalised to begin implementation in the next quarter. CHETNA has also developed formats for monitoring and reporting of the various project activities for all levels and has prepared a note on the roles and responsibilities of the concerned departments, agencies and supervisors in the project. The District Collector will be organising a meeting of all stakeholders to formulate an action plan for convergence of complementary services for greater impact of the project in July, 1998.

For further details contact: Ms.Ila Vakharia, CRC, CHETNA.

A Seminar on Education and Sustainability, Mussoorie, U.P

Society for Integrated Development in Himalayas (SIDH), Mussoorie organised a three day seminar on above mentioned topic from April 11-13, 1998. About 40 participants including CHETNA representatives from concerned Government departments and the NGO community participated.

The workshop aimed to discuss various strategic options for a sustainable education system, specially in the rural context. The discussion was initiated with an overview of the historical background from the Colonial days that brought with it the Western system of education at the cost of the Indian indigenous and traditional methods resulting in a gradual erosion of the rich cultural values attached to it. In the post Colonial era since independence, we have failed to rejuvenate the system except making a few cosmetic changes, which is irrelevant to the present needs, specially of the rural masses.

As one of the strategies, it was expressed that while NGOs cannot replace the State or the community, they can definitely play an intermediary role in short-term interventions that require creative inputs such as in developing appropriate curriculum, training and research in innovative micro level interventions that can be later incorporated at the macro level.

For further details contact: Mr. Pavan Gupta/Ms.Anuradha Joshi, SIDH, Hazelwood, Landaur Cantt., Mussoorie- 248 179, U.P.

Managing Common Ailments in School Children, Ahmedabad, Gujarat

Teachers play a pivotal role in prevention and promotion of health of school children and provide preliminary care during acute illnesses. With an objective to enhance their knowledge base regarding the management of common health concerns, a session was conducted by CHETNA for the teachers forum initiated by Eklavya Educational Foundation on June 11, 1998. 11 Educators participated actively in which diseases like Protein-Energy Malnutrition (PEM), anaemia, respiratory tract infections, gastro intestinal disorders and malaria were discussed. Information on the use of simple herbal remedies and practices as well as some rational allopathic medicines was provided. Emphasis was put on adopting a sensitive and caring attitude towards the sick child. The Educators found the session very useful and felt the need to incorporate this aspect in their day to day activities. A need for information on managing emergencies and accidents was also felt.

For further details contact: Mr.Vivek Prasad, Educational Manager, Eklavya Educational Foundation, Core Emballange, Ambavadi, Ahmedabad-380006, Gujarat.

Source : Our children-our future

Niramay Jeevan Exhibition, Gandhinagar, Gujarat

People are important partners in the process of development. Making the public aware of concerns of development leads to their active participation in the process.

Keeping this objective in view, the Gujarat State Health and Family Welfare Department took an initiative to bring together concerned NGOs and government departments working in the area of health and nutrition on a single platform to share their experiences.

An exhibition was organised from May 1-7, 1998 at Gandhinagar as a part of celebrating the State's Foundation Day, titled 'Nirmay Jeevan' meaning equal opportunity for all to lead a healthy life. The exhibition was declared open to the general public by the National Bharliya Janata Party (BJP)- Chief Mr.Kushabhai Thakare in the presence of the Chief Minister, Gujarat Mr.Keshubhai Patel. Among the important visitors to the week long exhibition were the Health Minister of Gujarat, Delhi and Himachal Pradesh.

CHETNA was invited to contribute in the planning and was also responsible in organising the exhibition stalls. In all, there were 54 stalls put up by the various NGOs and Government departments/agencies. The theme of CHETNA was 'Women and Child Health'. All the materials related to this main theme were displayed in one stall. The second stall was a great crowd puller and had many interactive games, puzzles, mini view master, models displaying human digestive and reproductive systems and other Information Education Communication (IEC) materials where visitors could interact and learn while playing.

About three thousand people including children visited the stalls. The feedback provided by the visitors and those in charge of the stalls was positive and everyone felt a need to replicate the experience.

For further details contact: Dr. R M Patel, Commissioner Health, Block No. 5, Dr. Jivaraj Mehta Bhavan, Old Sachivalaya, Gandhinagar-382010, Gujarat

A Workshop to Promote Dialogue Between the Media and NGOs, Ahmedabad, Gujarat

Several NGOs have expressed a need to develop the strategy for establishing a meaningful dialogue between NGOs and the Communication Media. With this in view, a two day workshop, sponsored by VANI from Delhi was organised by three NGOs 'Janpath','Charkha' and 'Darshan' at the Gandhi Labour Institute, Ahmedabad on April 29 - 30, 1998. About 25 participants from the Media and various NGOs including CHETNA attended the workshop.

Apart from understanding each others' perspective, an objective of the meeting was to constitute a co-ordination committee representing both groups to ensure continuity of dialogue on a long term basis.

Panel discussions were held in different sessions with representatives of the press at the State and district level, and those from weekly and fortnightly magazines. Representatives from Doordarshan and Television channel 'AAJTAK' also participated.

An important outcome of the workshop was that NGO participants became aware of the various programmes related to NGOS work being given coverage through the TV medium. They were also able to share their views on difficulties and constraints faced by NGOs in their interaction with the Media persons and discussed ways to bridge the gap.

It was agreed that inspite of some limitations, Television can play a very significant role in the dissemination of useful information of NGOs' work to the community people.

In the end, a co-ordination committee of 11 members representing NGOs and the Media was constituted and a decision was taken for holding its meetings on a periodical basis to facilitate continued interaction.

For further details contact: Mr. Vijay Jani, Member of the Co-ordination Committee, JANPATH, B-3/1, Sahjanand Towers, Jivraj Park, Ahmedabad- 380051, Gujarat.

Slum Net-work Project Meeting of Ahmedabad Municipal Corporation (AMC) Ahmedabad, Gujarat

Since a few years, AMC has taken an initiative to provide basic services to the slum population of the city under the slum networking project. A meeting to discuss the provision of services under the project was organised on April 22, 1998. The participants included officials from AMC and representatives of NGOs including CHETNA.

The issues discussed in the meeting related to urban partnerships in the network project and activities that can be taken up to address the likely constraints. The case study of Sanjaynagar was presented to initiate discussions followed by individual NGO presentation. It was explained how people of Sanjaynagar were motivated by the Sharda Trust to take keen interest for the successful implementation of the project activities. Presently the work and survey has been started in seven out of ten slums. In all, AMC has plans to operationalise the project in 198 slums of Ahmedabad.

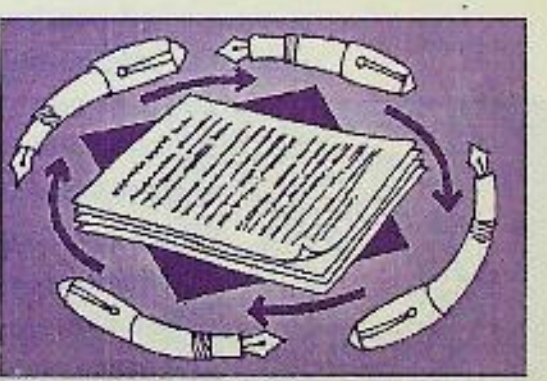
Another important issue that came up for discussion was whether the slums are authorised or not and how to link them to the project. A discussion followed the presentation of the ongoing health project through CHETNA. It highlighted the need to have a greater trust and understanding between the AMC and partner NGOs to have a fixed time line for the project and people's participation in the decision making process. Partnerships could be explored with corporate companies who offer financial assistance to take more interest in this work.

The AMC officials presented the various schemes undertaken by the Corporation.

For further details contact: Mr.Harshadray Solanki, Asstt. Manager, AMC, Slum Network Project, Ahmedabad - 380 001, Gujarat

Management Development Programme on Information Management and Documentation, Jaipur, Rajasthan

In the world of speedy communication, source of information and its dissemination is extremely critical. In this perspective, documentation has became an important tool for development. A training programme for NGOs on Information Management and Documentation was conducted by the Indian Institute of Health Management Research, Jaipur from May 11-16, 1998. About 27 NGO representatives including CHETNA attended the workshop form different states of the country.



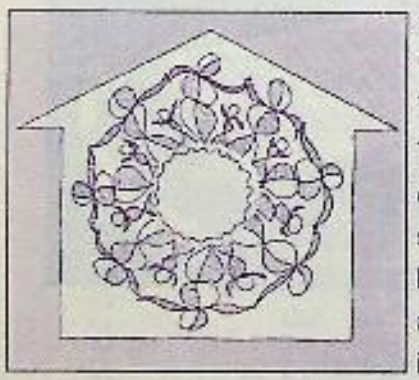
The participants during the workshop were encouraged to share their experiences, through which the concepts were drawn to develop their understanding of the uses of information data, needs assessment, planning monitoring and data analysis, documentation, social communication etc. It was emphasised as to how incorrect information can lead to inaccurate output and documentation.

For further details contact: Dr. P.H.Rao, Fellow in Management, Indian Institute of Health Management and Research, 1, Prabhu Dayal Marg, Sanganer Air Port, Jaipur-302 011, Rajasthan

WAH! Women & Health

Gender Sensitisation Training for significant Family Members of WAH! Participants, Ahmedabad, Gujarat

During 1997, CHETNA successfully completed a comprehensive and gender sensitive Women and Health (WAH!) training programme for the middle level managers of NGOs of Gujarat and Rajasthan states. While incorporating the gender concepts at the personal level, the participants expressed the need to also sensitise their family members on gender. Keeping this felt need in view, during June 16-18, 1998 CHETNA organised a gender sensitive training. The main objective of the training was to sensitise and develop conceptual understanding of the participants on effects of gender biases on the health and development of the family and to develop effective strategies to strengthen the family relations from the gender perspective. About 27 participants enriched the learning process by sharing their experiences.



Through their own personal life experiences the participants were sensitised towards prevailing gender biases in unequal distribution of assets and resources, social discrimination and influence of patriarchal society on women leading to their subordinate role, oppression and exploitation through simulation games and screening of a feature film entitled "Mrityudand". Participants were able to clearly identify the control and domination of men over women in all spheres of life including their sexuality. They also grasped the message that if women took control over the situation through collective action and determination, they could reverse the process.

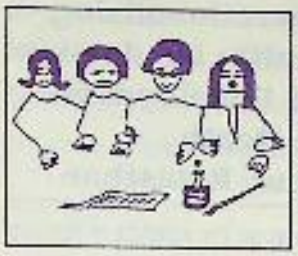
Participants became aware that gender issues if not dealt with firmly, would not only harm women but the whole family and society.

The participants prepared brief action plans at the conclusion of the three days workshop, highlighting the strategies they would adopt once they returned to their places to bring about a change in their own lives, that of their families and society. During the evaluation session they expressed that they will continue sharing of their experiences and participate in future programmes on the subject as they had greatly benefited from attending this training.

For further details contact: Ms.Jyoti Gede, WHDRC-CHETNA

Creating a Forum for Women and Health in Rajasthan Jaipur, Rajasthan

Two major events in the current decade, the International Conference on Population Development (ICPD) held at Cairo in 1994 and the Beijing International Conference on Women's Development in 1995 have greatly influenced Governments and NGOs towards improved health programme all over the world. At the India level, one achievement attributed to this change is the paradigm shift from the earlier vertical target oriented family welfare programme to an integrated Reproductive and Child Health (RCH) approach. RCH also emphasises on decentralised planning and promotion of a holistic gender sensitive perspective as part of its overall strategy. In India a national advocacy network entitled "Health Watch" has been initiated to bridge the gap between policy and implementation of ICPD concepts. Health Watch has taken initiatives to organise national and state field level consultations. The need was felt to start a state level forum at Rajasthan to influence policy and programmes of the state.



With this in view, a two day workshop on the above mentioned topic was organised by CHETNA and Health Watch at Jaipur from April 24-25, 1998. About 30 participants including activists, NGO representatives, doctors, media persons and researchers working in the field of health, development and education for women and children attended the meeting. The objectives of the meeting was to enhance the understanding on health issues related to women, adolescents and children, its present situation in Rajasthan, review efforts made by the Government and NGOs and to discuss the modalities for establishing a Forum in the State for Women.

The participants expressed a desire to have a Forum for Women in the State which would be able to discuss relevant issues, play an advocacy role to bring about strategic policy level changes affecting these programmes and support NGOs and others working in the sector. It was suggested that the forum can also monitor implementation of women's programmes and become a center for dissemination of information for its network partners.

A small committee was set up to draft the vision, objectives and strategy statement to move ahead with the creation of the Forum.

For further details contact: Dr.Vimla Ramchandran (IIHMR)/ Minaxi Shukla (CHETNA), Rajasthan, (IIHMR), 1 Prabhu Dayal Marg, Sanganer Air port, Jaipur-302011, Rajasthan

Media Advocacy on Reproductive Health, New Delhi, Mumbai, Maharashtra and Ahmedabad, Gujarat

As a part of their Media Advocacy Project, the South and East Asia Regional Office of Population Council, New Delhi has taken an initiative to sensitise the media on various issues related to reproductive health and development, with the objective of informing the public about the recent efforts of both government and non government organisations in the area of reproductive health. A series of such advocacy meetings have been organised. The second of the series was organised at New Delhi during April 15-16, 1998.

The 30 participants included senior representatives from the Government, Media and NGOs who discussed the paradigm shift in the field of population and the content and methodology of implementing the reproductive health programmes in India. The meeting also shed light on the constraints leading to the prevailing communication gap between NGOs and the media.

The outcome of the discussion included suggestions for possible ways to link the media with sources of information and for NGOs to take the reproductive health agenda forward. Further progress of the Media Advocacy project depends upon establishing a Working Group to develop the strategy and to identify opportunities to push reproductive health issues forward.

A similar meeting was organised at both Ahmedabad on April 6, 1998 and Mumbai on May 13, 1998.

For further information please contact: Dr.Anjali Nair, Population Council, Zone 5 A, Ground Floor, IHC, New Delhi-110003.

Men as Supportive Partners, In Reproductive and Sexual Health, Kathmandu, Nepal

Since the last few years, the Population Council has taken various initiatives to strengthen the Reproductive and Child Health programme in the country. One of major concerns that the council addressed through the above mentioned workshop organised at Nepal during June 23-26 1998 was on the Male involvement in reproductive and sexual health.

The main objectives of the workshop were to define and develop a common understanding on male

involvement, to share experiences and develop concepts from them and to develop strategies and action plans to strengthen male involvement in reproductive health. The council located NGOs and Government and media representatives researchers who have rich experiences in the area of male involvement. Participants were motivated to document their experiences and present the same during the workshop. The papers were presented under various categories, namely, men as supportive partners, understanding men's reproductive and sexual needs, adolescent sexuality and sexual health and services to men. About 60 participants mainly from India along with few individuals from Nepal, Bangladesh and Philippines participated in the workshop. CHETNA shared its experiences of male involvement under the title of Narrowing the Gap.

At the end of the workshop, an action plan was developed by the participants which put emphasis on networking, sharing of resources and strategic integration of the male in the reproductive and sexual health programme of NGOs and GOs. A need to generate research data on this topic was also expressed.

The workshop proved extremely useful in bringing together important stakeholders on a common platform to discuss the issue and to networking and learning from each other. The workshop was able to generate rich material on the theme of Male involvement from the experiences of various people all over the country.

For further details contact: Dr. Saroj Pachauri, Asia Regional Director, Population Council, South and East Asia, Regional Office, Zone 5A, ground floor, India Habitat Centre, Lodi Road, New Delhi 110003.

A Training on Operationalising Reproductive Health: Leadership and Management Development for Reproductive Heath Programme, Jaipur, Rajasthan

Reproductive Rights has been on the agenda of feminist movements world wide since the beginning of the century. Reproductive Rights espoused by the women's health movement were mainstreamed by the International Conference for Population and Development (ICPD), held at Cairo in 1994. As a follow up, launching of a Reproductive and Child Health (RCH) programme in India has become part of the national agenda in India.

This training was organised with the objective to develop a holistic understanding and relevance of Reproductive Health, to strengthen planning for Reproductive Health Programmes and to identify problems in implementation. 21 representatives from the Government of India and Bangladesh participated in the programme.

Beginning from the concept of reproductive health, topics such as overview of the paradigm shift from family planning to reproductive Health, Utilisation of health care services, and the elements of an ideal reproductive health package were discussed. A panel discussion on Reproductive Health provided insights in to issues like reproductive health of men and infertility, RTIs, STDs, Cancers of the reproductive tract, HIV/AIDS, maternal mortality and abortion.

Theoretical inputs on Strategic Planning and management, followed by group work through various district profiles, facilitated the process of planning a realistic reproductive health programme for the district.

Towards the completion, the participants listed various operational positive and negative issues in RCH. The positive aspects included availability of infrastructure, the political climate, availability of service providers, increased awareness and existing demand for the services etc. The negative aspects included poor quality of the infrastructure, the mindset of individuals involved, quality, outreach and commitment of the service provider,

demand for specific services, lack of awareness on some health issues and limited outreach by media and Information Education Communication (IEC).

For further details contact: Dr.Vimala Ramchandran, IIHMR 1, Prabhudayal Marg, Sanganer Airport, Jaipur, 302 011, Rajasthan

National Workshop on Reproductive Health Problems In Gujarat-Current Status and Future Challenges, Vadodara, Gujarat

To strengthen the Reproductive and Child Health (RCH) programme of the Government of India (GOI), efforts need to be made on all the fronts including research. Multi-dimensional research data can help plan, monitor and evaluate the programme effectively. The centre for Operations Research and Training (CORT) took an initiative to organise a one day workshop on the above mentioned theme on April 6, 1998 at Vadodara to share recent study data on reproductive health. About 50 participants from Gujarat, Maharashtra and New Delhi remained present. CHETNA participated in a panel discussion on Reproductive Health Services in Gujarat; Future Challenges.

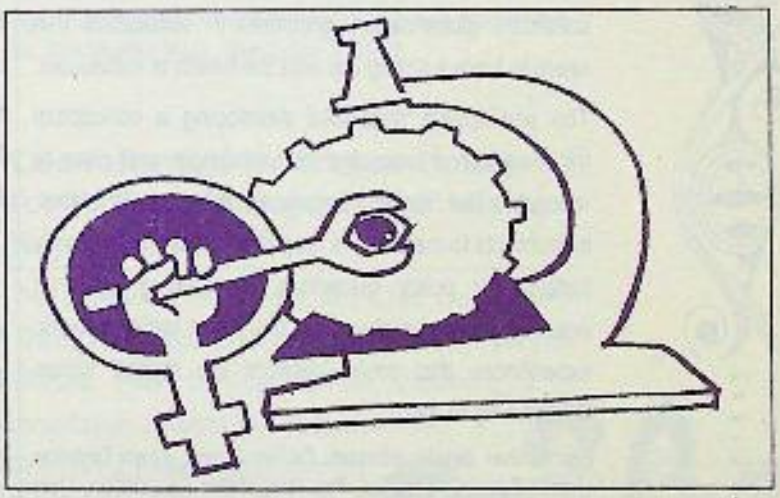
The workshop focused on two sets of studies-the current reproductive health status in Gujarat and current status of reproductive health services. They were namely, reproductive health status in Gujarat-an indepth study of Vadodara district, experiences of a target free approach in Gujarat, are Community Health Centres equipped to function as first referral centres for reproductive health and alternative strategies to address women's reproductive health problems.

The efforts of research were greatly appreciated, however it was felt that the research needs to be holistic in nature while focusing on the gender component and other services of reproductive health rather than emphasising only on family planning services. The copies of the research papers are available from CORT.

For further details contact: Dr.Sandhya Barge, Associate Director, CORT, 402, woodland Apartment, Race Course, Vadodara, 390 007, Gujarat

Workshop on Reproductive Health Care Organised by International Institute for Population Sciences, Mumbai, Maharashtra

The International Institute for Population Sciences (IIPS), Deonar, Mumbai, organised a three day workshop on Reproductive Health from April 6-8, 1998. In conformity with the recent and expanding emphasis on the subject, IIPS has undertaken a major research and teaching initiative in the area of reproductive health. In this direction, the Institute plans to organise a series of workshops to strengthen the research capabilities of the Population Research Centres (PRCs) and to enhance the capacity and involvement of NGOs in Reproductive and Child Health programmes.



CHETNA shared its experiences on "How does the RCH programme Strengthen Current Family Planning Programmes? - Some Evidences." A panel discussion was held on "Operationalising RCH (target free approach); its Feasibility." This was chaired by the CHETNA representative. Some of the topics discussed were, gynaecological morbidity, abortion, quality care, infertility etc. This workshop proved to be a major land-mark in attempting to change the mind-sets of "quantity" driven demographers to seriously consider the "qualitative" concerns of programme management.

For further details contact: Dr. K.B. Pathak, Director, IIPS, Govandi Station Road, Deonar, Mumbai, 400 088, Maharashtra

Understanding the Society and Health Interface: New Opportunities for Improving Health, A Brainstorming Session, Bellagio, Italy

The Rockefeller Foundation of USA in collaboration with the World Health Organisation (WHO), Division of Health Promotion, Education and Communication organised a brainstorming meeting entitled "Understanding the Society and Health Interface: New Opportunities for Improving Health" at Bellagio, Italy from March 30 through April 3, 1998. There were 17 participants from International Donor agencies, NGOs from various countries, including a representative from CHETNA.

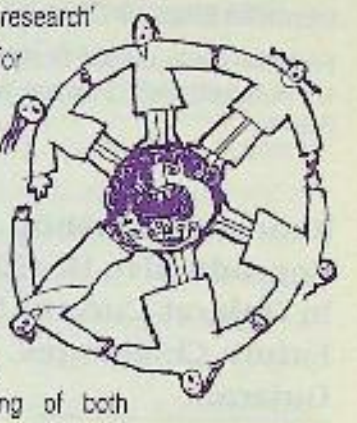
The aim of the meeting was to understand the various social phenomenas such as social capital, social cohesion, globalisation, gradients in occupation that seem to have a strong link with the health of individuals.

The participants discussed developing a conceptual framework in a language that is simple and clear to recognise the 'social' factors affecting health status, instruments to measure its magnitude, identifying priority options for policy guidelines, formulating research agendas based on diverse country and region specific experiences that could highlight the myriad forces determining health.

For further details contact: Dr.Tim Evans, Team Director, Health Sciences Division, The Rockefeller Foundation, New York-10018 2702.

Workshop on Qualitative Research Methodology, Vadodara, Gujarat

Society for Operations Research and Training (SORT) aims to develop the capacity of NGOs in the area of qualitative research methodology so as to make research an integral part of NGOs' regular programmes. One of their major areas of research is reproductive and sexual health. From May 13-14, 1998 one such training was organised at Vadodara. Ten NGO representatives including CHETNA from the State participated in the training.



The Facilitators defined 'research' with its importance for policy makers and programme implementors. Participants were explained the use of qualitative and quantitative methods of data collection, recording of both positive and negative experiences and documentation. Issues related to data management, analysis of data by using computer software were also explained. SORT has planned another workshop on skill development on data management and its analysis.

Two important topics for research: male involvement in reproductive health and domestic and sexual violence were taken up for discussion during the workshop.

For further details contact: Dr.Sandhya Barge, SORT, 405 Woodland Apartments, Race Course, Vadodara-390 007, Gujarat

Women's Health : Monitoring and Implementing the Beijing Platform for Action, Kuala Lumpur, Malaysia

The Asian-Pacific Resource and Research Center for Women (ARROW) being an active organisation on post Beijing activities organised a South East Asian Regional Policy Dialogue on the above topic at Kuala Lampur, Malaysia from June 1-4, 1998. The Dialogue was organised in partnership with the Gender and Development Programme of the Asian and Pacific Development Center (APDC) Malaysia.

The forty five participants included senior Government officials and policy makers responsible for programmes in women's health and family planning, from Ministries of Health, Women's Affairs and population agencies and representatives from NGOs from Cambodia, Indonesia,

Lao PDR, Malaysia, Phillipines, Thailand and Vietnam. Representative from the World Health Organisation's Western Pacific Regional Office, Life Crisis Institute, Canada, and from CHETNA, India were also invited as resource persons.

As a preparatory activity to the workshop, background papers on a seven country study on **"Indicators of Action on Women,s Health Needs and Rights"** were provided as a comprehensive framework to understand women's health needs and status. They provided an insight into statistical health data, gender analysis of other relevant socio-economic indicators and the interaction of women's legal, civil and social rights from a gender perspective.

Participants found the exchange of country experiences in implementing the Beijing Platform for Action on Women,s Health very enriching. The meeting was also successful in establishing inter-country dialogue between GOs and NGOs with senior policy makers in their own countries.

For further details contact : Ms.Rashidah Abdullah, Director, ARROW, 2nd Floor, Block F, Anjung Felda, Jalan Maktab, 54000, Kuala Lumpur, Malaysia.

South Asian Workshop of Gender Trainers, Dhaka, Bangladesh

Gender sensitisation training is becoming an integral part of the NGOs and GOs in South Asian countries. Various efforts are made to develop the modules on gender sensitisation and planning. To share and learn from each other, 27 eminent trainers from South Asian countries and Europe came together at Dhaka, Bangladesh from April 15-21, 1998 to attend the "Workshop of Gender Trainers." It was jointly organized by Proshika Bangladesh and Food and Agricultural Organisation (FAO), New Delhi.

The objectives of the workshop was to share experiences, ideas and materials used in gender trainings, to evolve a broad outline on the duration, size, contents and methodology of gender trainings, and lastly to obtain commitment from gender trainers to act as resource persons at South Asian or National trainings.

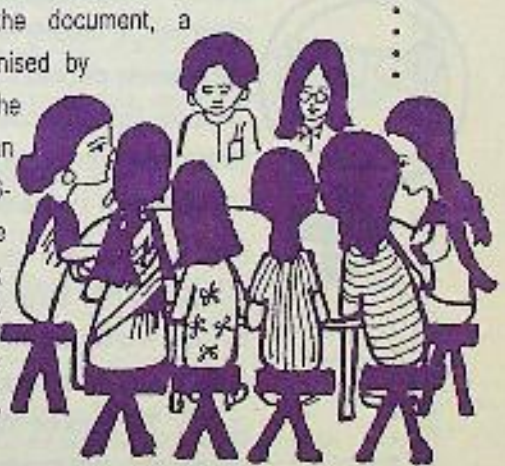
The workshop concluded with a decision to form a gender trainers' network at the South Asia level as well as national and regional levels. At India, it was proposed to initiate four 4 Regional Centers, namely Jagori- New Delhi, Sanhita-Calcutta, CHETNA, Ahmedabad and Initiatives Women In Development (IWID), Chennai.

A training on **"Self development in Gender perspective"** is planned for the first week of September 1998 at Pakistan and gender training for media persons, doctors, lawyers, educationists, fresh trainers, artists etc., by FAO and Proshika during second week of November 1998 at Dhaka, Bangladesh.

For further details contact: Ms.Kamla Bhasin, Food and Agriculture organisation (FAO)- NGO South Asia Programme, 55, Max Mueller Marg, New Delhi- 110 003

Consultation to Review Policy for Women in Rajasthan, Jaipur, Rajasthan

The Department of Women and Child Development (DWCD) Jaipur has taken an initiative to draft a Policy for Women. Prior to finalising the document, a consultation meeting was organised by CHETNA in collaboration with the DWCD, Government of Rajasthan and UNICEF at Jaipur from May 26-27, 1998. The main objective of the workshop was to obtain feedback and comments on the draft document in accordance with the guidelines issues by the DWCD, Government of India.



There were 20 participants who provided meaningful suggestions to improve the policy. The draft policy reaffirms its commitment to work towards the realisation of constitutional guarantee of equality, social justice and non-discrimination on the basis of caste, community,

Source : Asian and Pacific Women's Resource and Action Series Health

sex, religion and language. The policy hopes to create an enabling environment by the Government at all levels which provide support and promotes women's struggle for equality and social justice. It also seeks to provide guidelines for appropriate legislation and allocation of equitable resources.

The participants provided general comments and suggestions for the format, its implementation process and on specific themes.

Formation of a State Commission on Women was also promoted to monitor implementation of the policy. Participation of women from the villages was also considered necessary during planning and implementation.

For further details contact: Ms Sarita Singh, Director, DWCD, Jalpath, Gandhinagar, Jaipur - 302015, Rajasthan

Linkages between Savings/ Credit and Health, Dholera and Ahmedabad, Gujarat

Various efforts made by the government and non government organisations (NGOs) have created women's saving and credit groups in many parts of the country. Though women are the main beneficiaries of these groups, majority of the loans are taken for social and business purpose or for the care of the sick family members. Except for childbirth in rare instances, women seldom take loans for their own health. Women's health continues to be in an abysmal state.

Over the past one year CHETNA and Friends for Women's World Banking (FWWB) is collaborating to sensitise and enhance the knowledge base of leaders of savings and credit groups of different states of the country. Sessions on May 16, 1998 for 25 leaders of savings and credit groups of Gujarat and on July 2 1998, for 27 leaders from Uttar Pradesh were conducted at Dholera and Ahmedabad respectively.

Initially a brainstorming session was conducted to understand the participants perspective on savings and credit activity. It became apparent that women took loans for various family requirements such as repair of house, marriage of daughters, starting a new business etc. Very few loans were taken for their own health.

The participants were made aware on the life cycle approach towards nutritional and health needs. With the help of a educational kit on reproductive health developed by CHETNA,specific health concerns of women were discussed. An important recommendation made during the sessions was to encourage loans with lower interest rates to women seeking loans for their own health problems.

For further details contact: Ms. Reema Kapoor, FWWB, Sakar I, Opposite Gandhigram Railway Station, Ahmedabad-380009, Gujarat

Training for Organisers of Women's Awareness Camps, Ahmedabad, Gujarat.

To empower women to take charge of their own life, the Central Social Welfare Board (CSWB) has taken an initiative to implement Women's Awareness Camps at the village level through field based NGOs. Since 1986, CHETNA has been involved in organising training for organisers of these camps. During this quarter, second organisers training was organised by CHETNA during April 20 to May 2, 1998 at Ahmedabad. About 53 participants of various NGOs joined in the learning process.

Source : LAWG Newsletter/Canada

The training initiated discussion on concept like gender, patriarchy and feminism. Focus was laid on women's movement in Gujarat and India. Special efforts were made to develop skills of organisers to facilitate and conduct participatory sessions at the camp.

For further details contact: Ms.Meena Bhatt, Secretary, Gujarat State Social Welfare Board, 21, Ashoknagar Society, Nr. Bhatta, Paldi, Ahmedabad- 380 007, Gujarat.

MEETINGS AND WORKSHOPS A

Please note address of SAHAY

SAHAY
22/1/1/1 Manoharpukur Road
Calcutta 700 029
Phone : 033 - 4746767/ 4748645

Dates	Meetings/Workshops	Organised by	
April 2-4, 1998	Book Fair of Developmental Literature from India and Saidah, Bangladesh	SAHAY Calcutta	
April 06, 1998	Sustainable Agriculture and Food Security	UNNATI . Ahmedabad	Ms.Alice Morris, UNNATI, G-1200, Azad Society, Ahmedabad-380015, Gujarat
April 06, 1998	Mid Day Meal Programme	The Commissioner, Mid Day Meal, Gandhinagar	Mr.P.M.Acharya, Commissioner, Mid Day Meals Project, Block 9, 1st Floor, Dr.Jivraj Mehta Bhavan, Gandhinagar-382010, Gujarat
April 30,1998	State Resource Group,District Primary Education programme (DPEP)	District Primary Education Programme Gandhinagar	Mr.Sanjay Nandan, State Project Director, DPEP, Sector 17, Gandhinagar, 382 017, Gujarat
May 12, 1998	Session on Sex and Sexuality	Department for International Development (DFID) New Delhi	Mr.Anant Vyas,Programme Support Unit, DFID, Gausala, Gandhi Ashram, Ahmedabad-380027, Gujarat
May 14, 1998	Workshop for designing a strategic plan under AIDS control programme for AMC, 1999-2004	Ahmedabad Municipal Corporation, Ahmedabad	Mr.Pinakin A.Dikshit Dy.Commissioner (Health), AMC Ahmedabad-380 001, Gujarat
May 14, 1998	Session on World Conference for Women held at Bejing-1995	Centre for Environment Education (CEE), Ahmedabad	Mr. Kiran Desai, Programme Director TEE CEE, Nehru Foundation for Development Thaltej Tekra, Ahmedabad-380 054, Gujarat
May 15-16, 1998	Workshop for AIDS Control Programme in Gujarat.	Additional Chief Secretary Health & Family Welfare, Govt. of Gujarat, Gandhinagar.	Dr.D.M.Saxena, Additional Director, State AIDS Cell, E Block, 2nd Floor, Civil Hosp., Gandhinagar-382 010, Gujarat
May 21,1998	Consultation meeting on Supplementary Nutrition in ICDS	Commissioner of Health, Medical Services and of ICDS, Medical Education Gandhinagar	Dr.K.N.Patel, Joint Director Block No.5, Dr.Jivraj Mehta Bhavan, Sachivalaya, Gandhinagar-382010, Gujarat
May 30, 1998	General Body Meeting	Gujarat State Social Welfare Advisory Board (GSSWB), Ahmedabad	Secretary, Gujarat State Social Welfare Advisory Board, 21, Ashok Nagar Society, Paldi, Ahmedabad-380 007, Gujarat
June 20, 1998	State level ECE Co-ordination Committee meeting.	State Institute of Education Research and Training, Udaipur, Rajasthan.	Ms.Sarla Singh, Director,DWCD, Jaipath, Gandhinagar Jaipur-302015, Rajasthan
June 23, 1998	Meeting of NGOs on Cyclone Relief in Gujarat	OXFAM (India) Ahmedabad.	Ms.Rajni Khanna, Regional Representative OXFAM (India) Trust, F/13, Goyal Complex, Nehru Park, Vastrapur, Ahmedabad-380 015, Gujarat
June 24, 1998	Consultation meeting with NGOs working in Central and South Gujarat	Baroda Citizens Council, Vadodara	Mr.Ravi Puranik Action Aid, India, Bhopal Regional Office E/8/23, Arera Colony, Bhopal-462016, Madhya Pradesh.
June 29-30, 1998	State workshop on Community based surveillance of communicable diseases, maternal mortality and social marketing ORS	Janmangal, Jaipur	Dr.Narendra Gupta Co-ordinator, Janmangal State Health and Family Welfare Society for Voluntary sector, Jaipur-302 005. Rajasthan

VISITORS

- Mr. Rau Ram from Janvikas Barmer, with 23 members on April 4th, 1998.
- Dr.D.K.Mangal form The Futures Group International, Washington on April 6th, 1998.
- Dr.Sylvia Marcos from CIPE, Mexico on April 17th to 19th 1998.
- Dr.Gowhar Rizhvi and Ms.Geeta Mishra of Ford Foundation, New Delhi on April 21st 1998.
- Ms.Pushpa B.Shah from Ayurveda College, Ahmedabad on April , 24th 1998.
- Mr.K.Mahajan and Dr.Jayanti Patel of Shakil Productions Mumbai, on April 28 1998.
- Ms.Ragni Deshpande from Women's Features Service, New Delhi on May 1st and 2nd, 1998.
- Mr.Abrar Ahmed Khan from Prema Population Resource Centre, Lucknow on May 2nd 1998.
- Mr.Sudhir Gemawet from Philips Medical Systems, Ahmedabad on May 11th 1998.
- Ms.Geraldine van Kasteren form MUNDO Maastricth, The Netherlands on May 19th 1998.
- Dr.Jos C.G.M.Weel from Hogeschool van Amsterdam, Amsterdam, The Netherlands on May 19th 1998.
- Six students from DNHE, IGNOU, Ahmedabad on May 29th 1998.
- Ms.Varshaben Patel from Gujarat Vidyapith, Ahmedabad on June , 16th 1998.

PUBLICATIONS

Low Cost IEC Materials Developed by Abhivyakti

The Media Resource Center of Abhivyakti has developed several low cost audio-visual Information Education Communication (IEC) materials that can be very useful to Non-Government Organisations (NGOs) as teaching aids. 'Chakori', a flannel story developed last year on the status of women in English is now available in Hindi and Marathi languages as well.

For further details contact : Mr.Nitin Paranjpe, Abhivyakti, Omkar Bungalow, Opp.Wagh Guruji Vidyalaya, Pumping Station Road, Nashik, Maharashtra. 422 005

Life Size Model of Uterus

IDEAL organization has developed a life size model of the uterus which can be used to explain the anatomy of the reproductive system to adolescent girls and women .

For further details contact: Mr.Ashok Bhargava, IDEAL, B 4/1, Sahjanand Towers, Jivraj Park, Ahmedabad-380051, Gujarat.

Hot Line Counselling on HIV/AIDS by South India IADS Action Programme (SIAAP)

The rapid spread of HIV infection in our region and the enormous amount of media publicity given to AIDS have created a climate of anxiety, confusion and fear among our people. Although all of us acknowledge the fact that Indians are vulnerable to HIV infection to some extent, not many of us have the access or the ability to reduce this activity.

South India AIDS Action Programme (SIAAP), a voluntary organization, offers an HIV/AIDS dedicated telephone service.(Phone No.416185). The main objective of this telephone service is to provide a non-judgmental and confidential environment which allows individuals to freely discuss their fears and anxieties, and empowers them to make decisions about their personal lives.

For further details contact : Ms.Shyamala, Project Director, South India AIDS Action Programme, 65, 1st Street, Kamaraj Avenue, Adyar, Chennai. 600 020, Tamilnadu

TAKE NOTE

10TH SOUTH ASIAN FUND RISING WORKSHOP

The South Asian Fund Raising Group (SAFRG) is organizing its 10th workshop at Kathmandu during September 13-16, 1998. The theme of the workshop is "Fund Raising and Beyond" - attempts to explore ways as to how the resource mobilisation activity can help in bringing about social change and facilitate the process of establishing sustainable partnerships with socially concerned individuals and organisations.

For further details contact : The Executive Officer, South Asian Fund Raising Group, D 66/13, Vasant Vihar, New Delhi- 110057.

THE INTERNATIONAL FUND RAISING WORKSHOP

The 18th International Fund Raising Workshop is being organised at Leeuwenhorst Congrescentrum, near Amsterdam Netherlands from October 20 - 23, 1998. The workshop will provide an opportunity to learn and discuss new fund raising skills from respected international speakers.

For further details contact: Rhian Burton, Alan Bird or Alison Cooper at the London office : 295 Kennington Road, London SE11 4 QE, UK.

COMPUTER APPLICATION IN HOSPITAL MANAGEMENT

The Indian Institute of Health Management Research, Jaipur is organizing its sixth programme on Computer Application in Hospital Management from September 21-26, 1998 at their Institute.

The programme aims at giving Hospital Managers an exposure to the use of computers to track, sort and analyse hospital management information. It has been specifically designed for hospital administrators and executives engaged in the management of hospitals.

For further details contact : Mr.Hitesh Gupta, Co-ordinator, IIHMR, 1, Prabhu Dayal Marg, Sanganer Air Port, Jaipur- 302 011, Rajasthan

TRAINING OF TRAINERS IN GENDER DEVELOPMENT

The Netherlands based Gender and Development Training Center is conducting a three week course for experienced trainers in gender and development. The course is to conducted from October 25 - November 07, 1998.

For further details contact : Gender and Development Training Centre, Wilhelmiastraat 18 2011 VM Haarlem, The Netherlands

FINANCING HEALTH CARE IN DEVELOPING COUNTRIES

A twelve week course from September 17 - December 11, 1998 is being planned by the Center for International Health of Boston University School of Public Health. It will focus on practical methods for financial management of health programmes and the economic evaluation of health policy and programme options.

For further details contact: International Health Certificate Programmes and Seminars, 715 Albany Street, T-4W Boston, MA 02118-2526, USA

COURSES IN NETHERLANDS

The International Water and Sanitation Center is organising a course on " Environmental Sanitation Activities in Rural Low-Income Urban Areas" from September 07-25, 1998 and a course on " Hygiene Education and Promotion : Planning and Management for Behavioural Change" from October 12-30, 1998 at their Institute.

For further details contact: Ineke van Hooff, Head of Training, International Water and Sanitation Center, Vuurtorenweg 37, The Hague, Netherlands

CONVENTION ON FOCUS THE CHILD

A Convention on Focus the Child '96 is scheduled to be held from August 20-22, 1998 at the Science City, Calcutta. This year the focus is on problems of Middle School with the theme being "Is the curriculum for Upper Primary stage relevant today"? As before, it is being organised by New Wave Display Services Private Limited and supported by the Teachers' Center, Calcutta with technical input from the National Council of Educational Research and Training (NCERT).

For further details contact: The Convenor, Focus the Child, New Wave Display Services Private Limited, 207 AJC Bose Road, Calcutta- 700 017, West Bengal

PRINTED MATTER BOOK-POST
(For Private Circulation Only)

CHETNA
Centre for Health Education Training and Nutrition Awareness
Lilavatiben Lalbhai's Bungalow, Civil Camp Road, Shahibaug, Ahmedabad - 380 004, Gujarat, India.
Ph. : +91(79) 2868856, 2866695, Fax : +91 (79) 2866513, E-mail:indu.capoor@lwahm.net (or) chetna@adinet.ernet.in

Ben Lilavati Lalbhai Holistic Health Centre, Ahmedabad, Gujarat

Holistic Health Centre, an initiative of CHETNA, as an activity of Ben Lilavati Lalbhai Trust, is committed to the holistic development of women and children of the urban slums situated around the Lilavatiben's Bungalow in the Shahibaug slums. The centre, in the last three years has been able to establish a rapport with the community members. Providing health care is used as an entry point to facilitate the process of development.

During the last three months, 264 women and children took advantage of the curative health services provided by the centre. On April 23, an immunisation camp was organised in collaboration with the Ahmedabad Municipal Corporation. As regular effort of CHETNA, 7 new children were enrolled in the Municipal primary school. 50 women from the slum actively participated in the 'Niramaya Jeevan' Exhibition organised at Gandhinagar. The adolescent girls participated as volunteers at CHETNA exhibition stall to explain the health messages to the general public. Health education classes on maternal health, environmental sanitation, malaria were organised for women and children. The women now also regularly save money which is deposited in the SEWA Bank. The women visited two organisations Jyoti Sangh and Majur Mahajan this quarter to learn about their activities.

The centre also celebrated May 28, as an International Day of Action for Women's health by organising the women's gynaecological health camp to show their solidarity to the International Campaign on Access to Health Care. .

For further details contact: Vd. Laxmi Bhatt, WHDRC, CHETNA

WR-11:9

(सीमित वितरण हेतु)

●ाठवाँ अंक उत्तराखण्ड में महिला स्वास्थ्य एवं विकास सम्बधित त्रैमासिक पत्रिका जुलाई १९९८

आमने-सामने

तीन साल पहले हमने महिला स्वास्थ्य के मुद्दे को जन स्वास्थ्य के दायरे में शामिल करने के लिए एक प्रयास शुरू किया था। इस प्रयास के अन्तर्गत हमने उत्तराखण्ड की महिलाओं के स्वास्थ्य की स्थिति को समझने के लिए एक अध्ययन किया। साथ-साथ मातृशिशु केन्द्रित जन स्वास्थ्य कार्यक्रमों में महिलाओं के स्वास्थ्य के लिए संवेदनशीलता व जगह बनाने के लिए अलग-अलग स्तर पर प्रशिक्षण कार्यक्रम भी किये। इसी बीच भारत सरकार के स्वास्थ्य व परिवार कल्याण कार्यक्रमों में भी कई सारे परिवर्तन आये। परिवार कल्याण कार्यक्रम को लक्ष्य मुक्त किया गया तथा मातृशिशु कार्यक्रम में प्रजनक स्वास्थ्य को शामिल किया गया।

●हिलाओं के स्वास्थ्य के मुद्दे को हर स्तर पर उठाने की दृष्टि से हमने स्वास्थ्य सखी की शुरूआत की। इस अंक के साथ स्वास्थ्य सखी ने दो साल का सफर तय किया है। हमें काफी खुशी है कि इस बीच हम इसे लगभग नियमित रूप से प्रकाशित करने में सक्षम रहे। शुरू में हमने केवल उत्तराखण्ड की संस्थाओं के बीच ही इसे वितरित करने की सोची थी। लेकिन पहले अंक के बाद ही पाठकों के आग्रह देखते हुए हमने इसे अधिक व्यापक रूप से बाँटना शुरू किया। आज स्वास्थ्य सखी की १००० प्रतियाँ छपती हैं और हमें कहने में खुशी है कि प्रथम चार अंकों की हर प्रति बँट चुकी है। हमारे देश के दूसरे क्षेत्रमें रहने वाले मित्रों से माँग आई, कि यदि सम्भव हो तो हम स्वास्थ्य सखी का अंग्रेजी अनुवाद करायें। इस माँग को ध्यान में रखते हुए हमने स्वास्थ्य सखी का अंग्रेजी में अनुवाद भी शुरू किया। बीच में नेपाल और गुजरात में कार्यरत मित्रों ने इसका स्थानीय भाषा में अनुवाद भी किया। इन सारी प्रतिक्रियाओं ने हमें बहुत बल दिया। हम चाहेंगे कि आप इसी प्रकार अपने अनुभव, सवाल व जवाब हमारे साथ भविष्य में भी बाँटते रहेंगे।

इस अंक में हमने 'स्त्री रोग' को विषय बनाया है। 'स्त्री रोग' से हमारा आशय महिलाओं की उन परेशानियों से हैं जो उन्हें महिला होने के नाते होती हैं। इनमें मुख्यत: जननांगों व स्तन की तकलीफें शामिल है। स्वास्थ्य सखी के अगले अंक का विषय -'यौन संचारित रोग व एड्स' है। कृपया अपने सुझाव व लेख हमें १५ अक्टूबर तक अवश्य भेजने का कष्ट करें।

इस अंक में.....

चुप रहकर सब कुछ सहने की परम्परा

कुछ समय पहले जब हम गाँव की महिलाओं के साथ स्वास्थ्य पी०आर०ए० (सहभागी ग्रामीण अध्ययन) कर रहे थे, तब हमने महिलाओं से पूछा : 'आपके गाँव में महिलाओं की मुख्य बीमारियाँ क्या है?' इसके जवाब में वे बताने लगी- सिर दर्द, आँख दर्द, साँस की परेशानी, कमर दर्द, घुटनों में दर्द, खट्टी डकार आदि-आदि। मुझे हैरानी हुई कि महिलाएँ कमर से घुटनों के बीच कोई परेशानी बता ही नहीं रही थी। बार-बार पूछने पर भी ऊपर दी गयी बीमारियाँ ही बतायी जा रही थीं। अन्त में मैंने अलग-अलग बीमारियों का नाम लेना शुरू किया : सफेद पानी, माहवारी में तकलीफ, बच्चेदानी खिसकना, पेशाब में जलन, गर्भावस्था में परेशानी। तब महिलाएँ धीरे-धीरे शर्माती हुई स्वीकारने लगी। इसके बाद हमने प्रश्न रखा- 'कौन सी बीमारियों से अधिक तकलीफ होती है?' इस समय प्रजनन तंत्रकी इन्ही बीमारियों के बारे में अधिक महिलाओं ने बताया। फिर हमने आखिरी प्रश्न रखा- 'कौन सी बीमारियों का हम इलाज पहले कराते हैं?' अब महिलाओं का कहना था कि ज्यादातर इन बीमारियों का इलाज कराया ही नहीं जाता है, मुँह बन्द कर सहन किया जाता है। जब सहने लायक नहीं रहता है, तब ही इलाज के लिए जाते हैं।

अन्य गाँवों में, अन्य क्षेत्रों में भी यही स्थिति हमें देखने को मिली। आखिर ऐसा क्यों? महिलाओं के प्रजनन तंत्रों में ऐसी कौन सी गन्दगी होती है कि इस पर बातें करना ही गलत और शर्मनाक माना जाता है? यहाँ तक कि तकलीफ होने पर भी वे इसके बारे में बता नहीं सकती है? महिलाओं ने कैसे मान लिया कि उनके शरीर के एक चौथाई हिस्से को पूरी तरह नकारना है, जैसे कि वह है ही न? और कब तक महिलाएँ अपने प्रजनन तंत्रके स्वास्थ्य को इस तरह अनदेखा करती रहेंगी?

यदि हम बहुत पुराने इतिहास में ढूँढें, तो हम यह पाते हैं कि महिलाओं की उर्वरता या प्रजनन क्षमता को एक दैविक शक्ति के रूप में पूजा जाता था। यह शायद इस बात का संकेत है कि उस समय महिलाओं के प्रजनन तंत्रको महत्व दिया जाता था। परन्तु वेद-आधारित हिन्दू धर्म की उत्पत्ति से स्थितियाँ बदलने लगी। इसमें अन्य दैविक शक्तियों को महत्व दिया गया और आदिकालीन दैविक शक्तियों का प्रभाव घटता गया। जिसका उदाहरण है कि आज उनके बहुत कम मंदिर मिलते हैं। फिर धीरे-धीरे पुरूष-प्रधान समाज की संरचना हुई, और धर्म व संस्कारों का ऐसा ढाँचा खड़ा किया गया जिसमें महिला को हमेशा महिला होने की गलती महसूस हो। इस विचारधारा में महिला प्रजनन अंग को शर्म, घृणा व गंदगी फैलाने वाले विचारों से जोड़ा गया ताकि वह सशक्तता का प्रतीक कभी न बने। इसका एक जबरदस्त तरीका था महिला को समय-समय पर 'अछूत' बनाना। समाज में जिनको सबसे निचला दर्जा दिया जा रहा था, महिलाओं को अक्सर उन्हीं के बराबर बनना पड़ता था। जैसे- हर महीने माहवारी के पाँच दिन अछूत रहना, गर्भावस्था में अछूत रहना, प्रसव के बाद भी अछूत रहना। इन दिनों में महिला इतनी अपवित्र है कि वह भगवान के मंदिर में भी नहीं जा सकती है भले उसी भगवान ने उसके शरीर का गठन क्यों न किया हो।

इन सामाजिक नियमों के चलते महिलाओं ने भी अपने प्रजनन तंत्रके कारण अपने को हमेशा हीन महसूस किया, उसे घृणा व नकारात्मक नजरिए से देखा, और उसके अस्तित्व को छुपाने की कोशिश में रही। फलस्वरूप, उसमें तकलीफ होने पर भी बताने से वे शर्माती रही।

पुरूष प्रधान समाज की एक और विशेषता है कि उसमें महिला के शरीर को एक वस्तु के समान माना गया और उस पर मालिकाना हक किसी पुरूष का होता है, जैसे पिता, बड़े भाई, पति, बेटा आदि। महिला के प्रजनन तंत्रको विशेषकर उसके पति की सम्पत्ति माना जाता है। इस सम्पत्ति को हमेशा सुरक्षित एवं आम नज़रों से दूर रखना आवश्यक माना जाता है। इसलिए प्रजनन तंत्रको छिपाना पड़ता है, उस पर खुलकर बात करने या उसे कहीं दिखाने पर शर्म महसूस होती है। इसलिए कोई तकलीफ शुरू होने पर महिलाएँ बताती ही नहीं हैं, और इलाज भी कराने से शर्माती हैं। इन हालातों में हम क्या करें?

सबसे पहले तो इस 'चुप रहने की' परम्परा को तोड़ना है। हर महिला को अपने अन्दर प्रयास करना है कि वह अपने प्रजनन तंत्रव उसकी प्रक्रियाओं पर खुलकर बात कर सके। कम से कम किसी एक निकट मित्रके साथ। इसके अलावा अपने प्रजनन तंत्रके प्रति हमारी जो शर्म और घृणा है उसके स्थान पर लगाव व गर्व की भावना को बढ़ाना है। हमारा अगला कदम होगा नई पीढ़ी को इस रूढ़ीकरण से बचाना जिसमें महिलाओं को सब कुछ घुट-घुट कर सहने की सीख दी जाती है। आज तक अपने बेटे व बेटियों को जिन सवालों के जवाब हम दे नहीं पाते थे, या किसी तरह टाल देते थे आज उन्हीं सवालों पर हमें खुलकर स्वाभाविक ढंग से जानकारी देना होगा ताकि उनके मन में महिला शरीर के प्रति वही शर्म और घृणा घर न कर पाए। स्वयं और परिवार से आगे चलकर समाज में उन प्रथाओं को बदलना है जो महिला प्रजनन तंत्रों व उसकी प्रक्रियाओं

(शेष भाग पृष्ठ ५ पर)

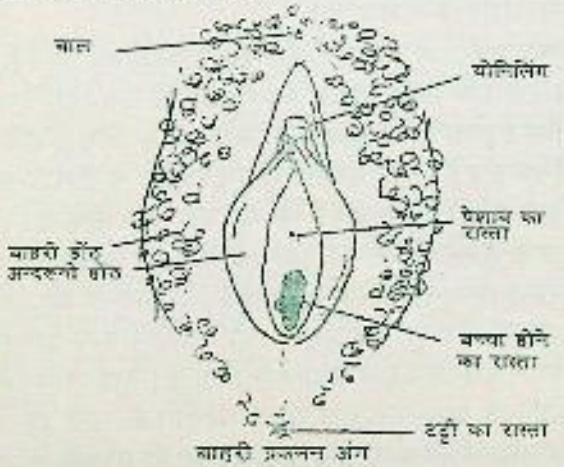
जनन अंगों की बनावट व सामान्य प्रक्रियाएँ

स्त्री रोगों को समझने से पहले आवश्यक है कि महिलाओं के जनन अंगों के गठन व उसकी सामान्य प्रक्रियाओं के बारे में हम थोड़ी सी जानकारी लें। वयस्क महिलाओं के जनन अंगों की बनावट कुछ इस प्रकार होती है-

*जननांग के बाहरी हिस्से में बालों से ढ़के दो होठ होते है जिन्हें बाहरी होठ कहा जा सकता है यह छूने में नरम होते है क्योंकि इनके अन्दर वसा है।

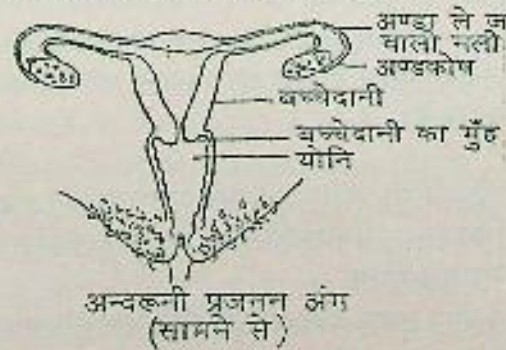
*बाहरी होठों को फैलाने पर अन्दर दो और होठ है। इन्हें अन्दरूनी होठ कहा जा सकता है। इनकी बनावट कुछ अलग है। यह पतले होते है और यह मुँह के अन्दर के जैसी खाल से ढ़के होते है। ऊपर की ओर जहाँ अन्दर के दोनो होठ आपस में मिलते हैं वहीं पर एक छोटा सा छेद होता है जो पेशाब का रास्ता है।

*पेशाब के रास्ते के ऊपर माँस की छोटी सी एक गुठली होती है, जो यौन उत्तेजना के समय सख्त हो जाती है और सम्भोग के समय का आनन्द यहीं महसूस होता है। इसे योनिलिंग कहा जा सकता है। जननांगों का इतना हिस्सा हम बाहर से देख या छू सकते है।



*अन्दरूनी होठों के अन्दर का हिस्सा एक नली जैसा है। यही बच्चा पैदा होने का रास्ता है।

*इस रास्ते के अन्दर एक नरम माँस की गुठली है जो छूने में नाक जैसी सख्त है। इसके बीचों-बीच एक गड्ढा जैसा है यह बच्चेदानी का मुँह है। आमतौर पर यह बन्द ही रहता है *बच्चेदानी के मुँह के ऊपर बच्चेदानी है जो कमर के बीच की हड्डी के ठीक पीछे रहती है और सामान्य स्थिति में पेट दबाने से नहीं पता चलती। बच्चेदानी के ठीक सामने और कमर की हड्डी के पीछे पेशाब की थैली है।



अन्दरूनी प्रजनन अंग
(सामने से)

सामान्यत: महिलाओं के बच्चे होने के रास्ते एक गीला चिपचिपा सा पदार्थ रहता है। इस पदार्थ का गीलापन और चिपचिपाहट मासिक चक्र के अनुसार बदलती रहती है। यहाँ पर जो बात महत्वपूर्ण है वह यह है कि इस गीले स्राव में कीटनाशक क्षमता भी होती है आमतौर पर इस गीलेपन से महिलाओं को कोई परेशानी नहीं होनी चाहिए और न ही उससे कपड़े गीले होने चाहिए। अन्दर के होठों के नीचे कुछ और भी ग्रन्थियाँ है जिनसे यौन उत्तेजना के समय एक गीला चिपचिपा पानी निकलता है। इस पानी की चिकनाहट के कारण यौन सम्भोग के समय पुरूष के लिंग को बच्चा होने के रास्ते के अन्दर जाने में आसानी रहती है।

प्रिय मित्र
स्वास्थ्य सखी के पिछले अंक मानसिक स्वास्थ्य व हिंसा में जल्दबाजी के कारण सम्पादन में हुई गलतियों के लिए हमें खेद है। भविष्य में ऐसी गलतियां न दोहराने की हमारी कोशिश रहेगी
धन्यवाद
सम्पादक मण्डल

(एक २५ का शेष भाग)
इस नये नाम वाले कार्यक्रम में दाईयों, पंचायत प्रतिनिधियों, महिला स्वास्थ्य संघों व आँगनबाड़ी कार्यकर्ताओं आदि की भागीदारी से परिवारों का सर्वेक्षण करने की बात कही गयी है ताकि समुदाय की जरूरत को पहचाना जा सके। लेकिन ज्यादातर जगहों पर महिला स्वास्थ्य संघ व आँगनबाड़ी कार्यकर्ता नहीं है तो लोगों की यह शंका वाजिब लगती है कि ऊपर दिये गये तरीके से प्राप्त जानकारी में गलती होने की पूरी सम्भावना है।

इन सभी तथ्यों के मद्देनजर लोगों को यह संदेह है कि कार्यक्रम सफल होने के लिए जिस इच्छाशक्ति की आवश्यकता होती है वह इसमें नहीं झलकती । परन्तु आज भारत की महिलाएँ सिर्फ परिवार नियोजन को ही अपनाने के लिए तैयार नहीं है क्योंकि उनमें प्रजनन स्वास्थ्य सम्बन्धी जागरूकता बढ़ रही है। अत: बदलती परिस्थितियों में भारत सरकार को भी परिवार नियोजन के साथ प्रजनन स्वास्थ्य सम्बन्धी अन्य सारी सेवाएँ भी हर जगह उपलब्ध करानी चाहिए ताकि प्रजनन एवं बाल स्वास्थ्य कार्यक्रम के अन्तर्गत किये गये वायदे पूरे हो सकें।

जनन अंगों से जुड़ी कुछ परेशानियाँ

जनन अंगों की आम परेशानियों में मुख्य है- खुजली, अधिक सफेद पानी जाना, गाढ़ा दही जैसा, पीला या खून से मिला हुआ पानी जाना, पेशाब के रास्ते में जलन, अन्दरूनी होठों में फोड़ा, सम्भोग के समय दर्द, खाँसने या छींकने में पेशाब की बूँद निकलना, बच्चा होने के रास्ते कुछ नीचे खिसक रहा है महसूस होना आदि। इसके अलावा माहवारी से जुड़ी परेशानियाँ जैसे अधिक खून जाना, कम खून जाना, अधिक समय तक खून जाना या महीने में एक से अधिक बार खून जाने की समस्याएँ तो हैं ही। ये तो रही जनन अंगों की शारीरिक परेशानियाँ लेकिन इससे जुड़ी जो एक और परेशानी है वह है सामाजिक। इस परेशानी के चलते महिलाएँ अक्सर इन परेशानियों के बारे में किसी को नहीं बताती और जब तक स्थितियाँ बहुत बिगड़ न जायें तब तक इलाज के लिए कहीं नहीं जाती। जनन अंगों से जो शर्म का राज जुड़ा है उससे महिलाओं को पता नहीं कितनी परेशानी चुप होकर झेलनी पड़ती है। अब हम जनन अंगों से जुड़ी शारीरिक परेशानियों के बारे में यहाँ पर जानेंगे-

खुजली

खुजली सफाई से जुड़ी एक समस्या है। कभी-कभी जननांगों के बालों में जूँ भी लग सकते है। अन्यथा बच्चा होने के रास्ते संक्रमण (छूत) फैलने के कारण भी खुजली होती है। याद रखने की बात है कि अगर महिलाएँ नियमित रूप से अपने जननांगों को नहीं धोती या माहवारी के दौरान उचित सफाई नहीं रखती तो छूत का फैलना आसान है। हमारे गाँव घरों में महिलाओं को पूरे कपड़े उतारकर नहाने या रोजाना अन्दर के कपड़ों को बदलने के अवसर व सुविधाएँ न मिल पाने के कारण यह समस्या पैदा होती है।

अधिक सफेद पानी जाना

इस परेशानी के विषय में पत्रिका के अन्य पन्नों में दिया गया लेख देखें।

पेशाब के रास्ते में जलन

यह महिलाओं की एक आम समस्या है। महिलाओं के पेशाब का रास्ता पुरुषों की तुलना में बहुत ही छोटा होता है। जिसके कारण कीटाणु आसानी से पेशाब की थैली तक पहुँच जाते है। इस छूत का नतीजा यह है कि न केवल पेशाब करते वक्त काफी जलन होती है बल्कि बार-बार पेशाब लगती है, रुक-रुक कर पेशाब होती है। पेशाब नहीं हुआ ऐसा भी महसूस होता है। व्यक्तिगत सफाई की कमी या सम्भोग के समय पेशाब के रास्ते में अधिक घिस जाने से या अपने पुरुष साथी से यह छूत फैलता है। पर्याप्त मात्रा में पानी नहीं पीने से यह परेशानी बढ़ती है। आमतौर पर गाँवों में यही पाया जाता है कि महिलाएँ कम पानी पीती है क्योंकि उन्हें पेशाब करने के लिए पर्याप्त और सुलभ जगह नहीं मिलती है। फलस्वरूप उनकी यह तकलीफ रह जाती है। यदि किसी को इस प्रकार की तकलीफ हो तो उन्हें अधिक पानी पीने की सलाह देनी चाहिए। रात में एक कप पानी में २ चम्मच साबुत धनियाँ भिगोकर सुबह पानी पीने को कहें। कई बार इसी से आराम मिल जाता है। यदि तब भी परेशानी कम नहीं हो तो डॉक्टर को दिखाए।

अन्दरूनी होठों में फोड़ा

यह आम समस्या नहीं है पर जब होता है तो बहुत ही दर्दनाक होता है। इसके कारण चलने, बैठने में बहुत तकलीफ होती है और किसी को बताना भी मुश्किल है। इस परिस्थिति में गुनगुने पानी से सेंक तथा किसी भी दर्द निवारक गोली (एस्पीरीन या पेरासिटामोल) से आराम हो सकता है। फोड़े के फूटने तक दर्द कम नहीं होता। इससे अच्छा तो यह है कि किसी दवाखाने में जाकर फोड़े पर चीरा लगवालें। इससे तुरन्त आराम मिलता है।

सम्भोग के समय दर्द

कुछ महिलाओं को सम्भोग के समय काफी दर्द होता है। सम्भोग के समय महिला के जननांगों से एक चिपचिपा पानी तैयार होता है यह स्राव यौन उत्तेजना के दौरान अधिक निकलता है। यदि सम्भोग से पूर्व महिला में यौन उत्तेजना कम हुई हो तो सम्भव है कि यह स्राव कम निकला हो। इससे सम्भोग के समय पुरुष के लिंग को बच्चा होने के रास्ते में जाने में परेशानी होती है और महिला को दर्द। यदि महिला और पुरुष आपस की यौन उत्तेजना के बारे में ध्यान रखें तो यह समस्या कम होती है। कुछ महिलाओं में योनि के आस-पास घाव या बच्चा होने के रास्ते छूत या बच्चेदानी की कोई बीमारी के कारण भी सम्भोग के समय दर्द हो सकता है। कभी-कभी मानसिक कारण जैसे पहले यौन हिंसा का अनुभव या यौन सम्बन्धों के बारे में शर्म या अपने साथी के साथ उचित मानसिक आराम न महसूस करने पर भी ऐसा होता है। खेद की बात तो यह है कि हमारे समाज में यह समस्या कभी स्वीकारी ही नहीं जाती है और अधिकतर महिलाएँ इस समस्या को झेलती रहती है। जबकि ज्यादातर समय इस परेशानी को कम किया जा सकता है।

छींकने या खाँसने के साथ पेशाब की बूँद निकलना, बच्चा होने के रास्ते कुछ खिसकने जैसा महसूस होना

ये दोनो लक्षण बच्चेदानी के नीचे खिसकने के साथ जुड़े है।

बच्चादानी अपनी जगह पर कुछ नसों के भरोसे टिकी रहती है। किसी भी कारण इन नसों पर अधिक दबाब आने से बच्चादानी नीचे खिसकने लगती है। इनमें मुख्य है- ज्यादा बच्चे होना, बच्चों के बीच में अन्तर कम होना, बच्चेदानी का मुँह पूरी तरह खुलने से पहले बच्चा पैदा करने के लिए जोर लगाना, बच्चा पैदा होने में जल्दी करने के लिए ऊपर से पेट दबाना या बच्चा होने के बाद तुरन्त भारी काम करना। यदि हम ध्यान से देखें तो हमारे गाँव में यह सभी परिस्थितियाँ मिलती है। स्वाभाविक है कि हमारे गाँव में बच्चेदानी खिसकने की शिकायत भी कम नहीं है। लेकिन यह भी एक ऐसी परेशानी है जो महिलाएँ कभी बताती नहीं हैं। हमारे अनुभव में हमने ऐसी महिलाओं को भी देखा है जिनकी बच्चेदानी पूरी बाहर लटकती है, लेकिन महिलाएँ फिर भी चुप है। यह एक ऐसी परेशानी है जिसमें बचाव ही इलाज है। क्योंकि एक बार बच्चेदानी बाहर निकलने में डॉक्टर उसके ऑपरेशन की ही सलाह देते है। इससे पहले एक छल्ला पहनाने का इलाज था लेकिन आजकल डॉक्टर इसे कम उपयोग में लाते है।

अधिक खून जाना

माहवारी से जुड़ी खून जाने की गड़बड़ियों/परेशानियों के बारे में स्वास्थ्य सखी के दूसरे अंक में जानकारी दी गई है। यहाँ पर एक खास प्रकार की परेशानी पर ध्यान दिया जाएगा, वह है सम्भोग के बाद थोड़ा खून जाना या खून के धब्बे कपड़ों पर लगना। यह एक खतरनाक लक्षण है क्योंकि यह बच्चेदानी के मुँह में कैन्सर का लक्षण है। बच्चेदानी का कैंसर भारत में महिलाओं में पाये जाने वाले कैंसरों में सबसे अधिक पाया जाता है। इसके जो मुख्य लक्षण है वह है खून जाना और अधिक सफेद पानी। लेकिन इन लक्षणों के उभरने से पहले ही जाँच द्वारा इस बीमारी को पकड़ा जा सकता है।

बाहर के देशों में ३० साल या उस से कम उम्र की महिलाओं की नियमित जाँच की जाती है ताकि कैंसर होने से पहले ही बीमारी पकड़ में आये और लाईलाज बनने से पहले उसका इलाज हो। इस जाँच का नाम 'पैप स्मियर' है और इसमें बच्चेदानी के मुँह से कुछ पदार्थ निकालकर जाँचा जाता है। यह जाँच काफी सरल है।

बच्चेदानी का कैंसर कुछ परिस्थितियों में अधिक पाया जाता है जैसे- कम उम्र में यौन सम्भोग, कम उम्र में पहला बच्चा होना, अधिक बच्चे या कम समय के अन्तर में बच्चे होना, गरीबी, व्यक्तिगत सफाई की कमी आदि। हमारे गाँव की महिलाओं में यह सारी परिस्थितियाँ मिलती है। पर हम सही बता भी नहीं सकते कि हमारे गाँव में कितनी महिलाओं की बच्चेदानी के कैंसर के कारण मृत्यु हो रही है क्योंकि अधिकतर महिलाएँ इलाज से पहले ही चल बसती है। सर्तक रहने की बात यही है कि यदि किसी को अधिक सफेद पानी की शिकायत हो या सम्भोग के बाद खून के छींटें जाने की शिकायत हो तो उन्हें तुरन्त डॉक्टर के पास जाना चाहिए। इससे भी बेहतर होगा यदि महिलाएँ अपनी नियमित जाँच करायें।

पैप टेस्ट

पैप टेस्ट या पैपेनकोलस टेस्ट बच्चेदानी के मुँह के कैंसर के बारे में जाँच का एक सरल उपाय है। यह जाँच बहुत ही सरल है और इसमें खर्च भी बहुत कम आता है। इस जाँच के लिए न भर्ती होना पड़ता है और न ही कोई तकलीफ होती है। इस जाँच के दौरान डॉक्टर दवाखाने में ही महिला को लेटाकर उसके बच्चेदानी के मुँह की कुछ कोशिकाओं को एक लकड़ी के पतले पट्टे और ब्रुश से एक शीशे के स्लाईड में ले लेती है।कोशिकाओं को फिर उचित रासायनिक तत्वों से तैयार करने के बाद सूक्ष्मदर्शी (माईक्रोस्कोप) के माध्यम से बारीकी से देखा जाता है कैंसर होने पर इन कोशिकाओं में कुछ खराबी आ जाती हैं जो आसानी से दिखाई देती है।

(पृष्ठ २ का शेष भाग)

को हीन नजरों से देखती हैं। उदाहरण के लिए माहवारी में महिला को अपवित्र व अछूत कहना या फिर गर्भावस्था, प्रसव व उसके बाद महिला को अछूत मानना आदि। हॉलाकि महिला के प्रजननतंत्र के भरोसे ही समाज अपने को बनाए रखता है, अगली पीढ़ी सुनिश्चित होती है लेकिन उसी प्रजनन तंत्र को लेकर सामाजिक तिरस्कार महिला पर लादना घोर अन्याय है। खासकर इसलिए क्योंकि महिलाओं को इस प्रजनन तंत्रकी बनावट के कारण वैसे ही काफी तकलीफ उठानी पड़ती है। अतः महिला प्रजनन के तंत्र व उसकी स्वाभाविक प्रक्रियाओं को एक सम्मानजनक तरीके से समाज को स्वीकारना आवश्यक है।

सरकार व प्रशासन को भी कदम उठाना है। औपचारिक शिक्षा व्यवस्था द्वारा हमें प्रजनन तंत्र सम्बन्धी एक स्वस्थ नजरिये को बढ़ावा देना होगा। इसके लिए ज़रूरी है कि सबसे पहले हम इस विषय को लेकर अध्यापकों के अन्दर की ग्रन्थियों को ही सुलझायें। उसके साथ उपयुक्त पाठ्यक्रम व सामग्री उन्हें देना है। शिक्षा व्यवस्था के अलावा स्वास्थ्य व्यवस्था में भी परिवर्तन लाना है। महिलाएँ अपने प्रजनन अंग पुरूष स्वास्थ्य कर्मियों को दिखाना नहीं चाहती है इसलिए अस्पताल की नर्स तथा गाँव की ए०एन०एम० की क्षमता-वृद्धि करना है जिससे वह प्रजनन स्वास्थ्य की प्राथमिक सेवाएँ महिलाओं को दे सकें। इससे महिलाओं को समस्याओं के लिए थोड़ी राहत तो मिलेगी। वे महिला स्वास्थ्य कर्मियों से अपनी बात खुलकर बता भी सकेंगी। इस तरह हर स्तर पर कदम उठाकर हम महिला प्रजनन तंत्र की समस्याओं का सही समय पर इलाज के लिए एक माहौल बना पाएँगे और इस चुप रहकर सब कुछ सहने की परम्परा को तोड़ सकेंगे।

उत्तराखण्ड की महिलाएँ : एक झलक

इस स्तम्भ के माध्यम से हम आपके साथ सहयोग एवं अन्य साथी संस्थाओं द्वारा उत्तराखण्ड की महिलाओं के स्वास्थ्य की स्थिति पर अध्ययन की जानकारी बाँटते रहे है। इस बार पिछले अंकों की तरह महिलाओं के आम स्त्री रोगों के बारे में प्राप्त जानकारी की एक झलक हम यहाँ पर प्रस्तुत कर रहे है। यह जानकारी महिला बैठकों, साक्षात्कार व चिकित्सा शिविर के माध्यम से प्राप्त हुई। यहाँ पर हम एक बात बहुत स्पष्ट रूप से कहना चाहते है कि महिलाओं के स्त्री रोगों के बारे में हमें जो भी जानकारी मिली वह महिलाओं की आम स्वास्थ्य समस्याओं के साथ ही मिली। स्त्री रोगों पर अलग से खुलकर चर्चा करने के लिए महिलाएँ तैयार नहीं थी। इसलिए जिन भी महिलाओं ने अपनी समस्या बतायी वे शायद उस समस्या से बहुत परेशान रही होंगी क्योंकि महिलाओं का कहना है कि जब तक ये समस्याएँ सहने लायक होती है तब तक वे इनके बारे में किसी को बतातीं भी नहीं है। अत: यहाँ पर दिये गये आँकड़े इसी सामाजिक पृष्ठभूमि में समझे जाने की ज़रूरत है।

*चिकित्सा शिविर में आई महिलाओं में से ३.३% ने स्वयं बच्चेदानी बाहर आने की तकलीफ बतायी और गहराई से पूछने पर १६.९% ने इसको स्वीकारा। जबकि डॉक्टरी जाँच के दौरान १७.१% महिलाओं की बच्चेदानी बाहर पायी गयी । घरों पर व्यक्तिगत साक्षात्कार के दौरान १.२% महिलाओं ने इसकी परेशानी बतायी ।

*शिविर में आयी महिलाओं में से २६.२% ने स्वयं सफेद पानी की शिकायत की और डॉक्टरी जाँच के दौरान ७९% में सफेद पानी पाया गया। घरों में २९.१% ने स्वत: सफेद पानी की तकलीफ बतायी।

*इसके अलावा जिन परेशानियों के बारे में महिलाओं ने बताया उनमें प्रमुख रहीं पेशाब में जलन (२%) अनियमित माहवारी (१०%)व माहवारी के समय दर्द (५.५%) ।

प्राथमिकीकरण के आधार पर जब महिलाओं से पूछा गया कि वे उन ६ बीमारियों (महिलाओं की बीमारियाँ एवं स्त्री रोग) के बारे में बतायें जो सबसे ज्यादा तकलीफ देती है और सबसे ज्यादा होती हैं उनका उत्तर निम्न प्रकार से था–

सबसे ज्यादा तकलीफ देने वाली बीमारियाँ	सबसे ज्यादा होने वाली बीमारियाँ
सफेद पानी	सफेद पानी
कमर दर्द	कमर दर्द
बच्चादानी बाहर	माहवारी में अनियमितता
चक्कर	सिर दर्द
पेट में गोला	पेट दर्द
माहवारी में अनियमितता	बच्चादानी बाहर आना

इस सूची से यह स्पष्ट होता है कि ६ बीमारियों में ३ तो स्त्री रोग ही हैं और सूची के दोनों स्तम्भों में सफेद पानी सबसे ऊपर है। इस प्रकार इसकी गम्भीरता को समझा जा सकता है। इस सूची में जो बात ज़्यादा खतरनाक लगती है वह है कि बच्चादानी बाहर आना ६ मुख्य बीमारियों में है और पहले सतम्भ में यह तीसरे स्थान पर है तो दूसरे स्तम्भ में पाँचवें । इसका मतलब है कि महिलाओं को प्रसव के बाद उचित आराम व खुराक नहीं मिलती जिससे वे इस तकलीफ का शिकार इतनी आसानी से हो जाती है।

बैठकों में महिलाओं से पूछे जाने पर कि वे इन बीमारियों के इलाज के लिए क्या करती है? उनके उत्तर निम्न थे-

बीमारी का नाम	कुछ नहीं	घरेलू	एलोपैथिक
सफेद पानी	६	२	१
माहवारी में तकलीफ	६	६	२
बच्चादानी बाहर	६	–	१
कमर दर्द	३	८	४
सिर दर्द	२	८	२

इस सारणी से यह स्पष्ट होता है कि हालांकि ये बीमारियाँ महिलाओं को इतना तकलीफ देती है फिर भी ज्यादातर महिलाएँ इन बीमारियों का कुछ भी इलाज नहीं कराती। कारण पूछने पर उन्होंने कहा कि वे बीमारियाँ छुपाती है इसलिए न ही बताती है और न इलाज ही कराती है।

इलाज या बीमारियों की चर्चा करने के सम्बन्ध में यह स्थिति तो उन तकलीफों की है जो महिलाएँ बहुत परेशान होने पर एक दूसरे से कहती हैं या फिर यह कहिए कि समाज उनके बारे में चोरी-चोरी बात करने की थोड़ी छूट देता है। लेकिन उन व्यक्तिगत तकलीफों की कहीं कोई बात नहीं है जो प्रजनन अंग से और किन्हीं कारणों से जुड़ी है जैसे बच्चेदानी में गाँठ, सम्भोग के समय दर्द या खून गिरना, अन्दरूनी होठों में फोड़ा आदि।

(इस जानकारी को इकट्ठा करने में हमने निम्न संस्थाओं से मदद ली- पर्वतीय पर्यावरण संरक्षण समिति, पिथौरागढ़आरोही, नैनीताल; सदन, चमोली; गोपेश्वर प्रखण्ड जन कल्याण परिषद, चमोली; जनविकास संस्थान, टिहरी; मंसूरी ग्रामीण विकास समिति, मंसूरी; न्यार घाटी ग्राम स्वराज्य समिति पौड़ी; जय माँ लोक विकास संस्थान, उत्तरकाशी; उत्तरांचल विकास संस्थान, ऊधमसिंह नगर)

अगले अंक का विषय:

यौन संचारित रोग/एड्स

(कृपया अपने लेख १५ अक्टूबर तक भेजने का कष्ट करें)

सामान्य सफेद पानी

कैरवा (शतावरी)

एक अँगुली के बराबर
जड़ को पीसकर १
गिलास दूध से लें।

लहसुन

रात में पे
होने के
बिना लह
रखे लें अ

माहवारी अधिक दिन तक होती है

सौंफ

एक चम्मच सौंफ और एक
चम्मच मिश्री एक कप पानी

माहवारी के साथ दर्द

पतकुँआर (धृतकुमारी)

डेढ़ अँगुली के बराबर पत्ती

माहवारी के सम

बासिंग (अड़ूसा)

अधिक सफेद पानी की शिकायत

सफेद पानी क्या है?

महिलाओं का बच्चा होने का रास्ता थोड़ा सा गीला रहता है क्योंकि वहाँ पर एक चिकना गीला पानी तैयार होता है। अण्डा पक कर फूटने के समय इसकी मात्र व प्रकार बदल जाता है। इस चिकने गीले पानी से महिला को न कोई परेशानी होती है और न ही उसके अन्दर के कपड़े गीले होते है। जब किसी कारण से इसकी मात्र बढ़ जाती है और उससे महिला को परेशानी हो रही हो या उसका रंग, प्रकार बदल कर दही जैसा, पीला या खून के छींटे के साथ हो तो उसे सफेद पानी की बीमारी कह सकते है। इस समस्या के होने पर इस पानी में बदबू भी आती है और साथ में खुजली भी होती है।

सफेद पानी क्यों होता है?

सामान्य सफेद पानी कुदरती है और होना आवश्यक है। सफेद पानी बढ़ जाना बीमारी का संकेत है। सफेद पानी ज्यादा जाने का सबसे मुख्य कारण है बच्चेदानी के रास्ते संक्रमण। बच्चेदानी में संक्रमण के साथ-साथ कमजोरी व उचित आहार की कमी से भी सफेद पानी बढ़ जाता है। सफाई की कमी सफेद पानी होने का एक महत्वपूर्ण कारण है जैसे- नियमित रूप से जननांगों की साबुन से सफाई नहीं होना नियमित रूप से कपड़े नहीं बदलना, माहवारी के दौरान सफाई न रखना, पेशाब करने के बाद जननांगों की सफाई नहीं होना टट्टी करने के बाद टट्टी का रास्ता ठीक तरह से न धोना आदि। कभी-कभी पुरूषों से भी महिलाओं को सफेद पानी पैदा करने वाले कीटाणु मिलते है। बच्चेदानी में कैंसर से भी सफेद पानी बढ़ जाता है।

सफेद पानी के प्रकार

अगर सफेद पानी बढ़ गया है तो वह दही जैसा, पीला, खून मिला, बदबूदार व झागदार हो सकता है। सफेद पानी के साथ कभी-कभी अन्य समस्या भी उत्पन्न होने लगती है जैसे जनन अंगों में जलन, दर्द, सूजन, पेशाब में जलन, पेट के नीचे के हिस्से में दर्द आदि ।

सफेद पानी की रोकथाम

(१) रोज़ाना सुबह व रात में सोते समय साफ पानी व साबुन से जननांगों को धोना।

(२) रोज़ाना चड्ढी बदलना, अगर सम्भव हो तो सोने से पहले धुली चड्ढी पहनना।

(३)माहवारी में ३-३ घंटे के अन्तर में खून सोखने वाला कपड़ा बदलना। यह कपड़ा साफ धुला, धूप में सूखा होना चाहिए।

(४)पुरूषों को लिंग की खाल हटाकर सुबह-शाम साबुन से धोना चाहिए।

(५) टट्टी के बाद टट्टी का रास्ता आगे से पीछे की ओर धोयें न कि पीछे से आगे की ओर। यह आदत हमें बच्चों में बचपन से ही डालनी चाहिए।

(६) अगर सम्भव हो तो पेशाब के बाद जनन अंगों को धोयें

(७)महिला-पुरूष सम्भोग से पहले और बाद में पेशाब करें व जनन अंगों को पानी से धोयें ।

(८) पर्याप्त मात्रा में पौष्टिक आहार लें। हरी सब्जी का सेवन करें।

(९) बार-बार एन्टीबायोटिक दवायें न लें।

(१०) पति-पत्नी में से किसी एक को शिकायत होने पर दोनों लोग अपना-अपना इलाज करायें।

सफेद पानी का इलाज

घरेलू इलाज

* शतावरी की जड़ ५० ग्राम, १० ग्राम जीरा मिलाकर पीस लें। एक कप दूध के साथ एक चम्मच चूर्ण रोज सुबह खाली पेट एक महीने तक लें।

* नीम की पत्तियाँ पानी में उबालकर गुनगुने पानी से अंगो की सफाई करें या गुनगुने पानी में नमक डालकर जननांगों को धोयें।

* १/२ चम्मच ताजा बना हुआ दही लेकर योनि की दीवार में साफ अँगुलियों से लगायें। ऐसा लगभग १०-१५ दिन तक दिन में दो बार करे।

*लहसुन की गाँठ से एक साफ सुथरी कली अलग करें। इसका छिलका न उतारें। इस कली को बच्चा होने के रास्ते में रखे। पहले तीन दिन में एक-एक कली तीन बार रखें तथा बाद में १०-१२ दिन के लिये दिन में १-१ कली को दो बार रखें। जब नयी कली रखे तो पुरानी निकाल दें।

*लहसुन की २-३ कली को कूटकर साफ सूती कपड़े में पोटली बनाकर रात में योनि में रखें तथा सुबह निकालें यह १०-१५ दिन तक करें। इस दौरान सम्भोग न करें।

* अपने पुरूष साथी को कच्चा लहसुन तब तक खिलायें जब तक कि उसके पसीने से लहसुन की महक न आये।

एलोपैथिक इलाज

*मेट्रोनिडाजोल ४०० एम०जी० की १-१ गोली दिन में तीन बार पति-पत्नी दोनो को लेना है। दवा खाली पेट न खायें।

* योनि के रास्ते में रखने वाली गोली केनिस्टान को रात में सोते समय योनि में रखते है। इस समय सम्भोग न करें।

एलोपैथिक इलाज डॉक्टरी जाँच के बाद ही शुरू करें।

कुछ महत्वपूर्ण स्त्री रोग : सतर्कता की ज़रूरत

*पेशाब और बच्चा होने के रास्ते के बीच छेद होना । यह तकलीफ तब पाई जाती है जब बच्चा होने के समय माँ को काफी तकलीफ हुई हो और बच्चे का सिर काफी देर तक फँसा हो। इन महिलाओं में पेशाब लगातार चूता रहता है। यहाँ तक कि इनके बदन और कपड़ों से पेशाब की महक आती रहती है। समाज में इन महिलाओं को एक कोने में ढकेल दिया जाता है। ऑपरेशन से यह छेद बन्द करना सम्भव है।

*अन्दर के जननांगों में छूत या संक्रमण। बाहरी जननांगों से छूत आसानी से अन्दर के जननांगों (बच्चेदानी, नली, अण्डाशय) तक पहुँच जाती है। इसमें हल्का बुखार, पेट के निचले हिस्सा में लगातार दर्द, कमर दर्द, अधिक सफेद पानी, सम्भोग के समय दर्द आदि शिकायत रहती है। इसका इलाज यदि जल्दी नहीं हुआ तो महिला निःसन्तान्ता का शिकार बन जाती है।

*माहवारी में अनियमित खून जाना। कभी -कभी अनियमित खून जाने के लिए कोई कारण जाँच के बाद भी नहीं मिलता। यह खून या तो माहवारी के दौरान अधिक गिरता है या माहवारी की अवधि लम्बी हो जाती है या फिर दो माहवारियों के बीच भी खून जाता है। ऐसी परिस्थिति में डॉक्टरी सलाह लेना आवश्यक है क्योंकि हमारे गाँव की महिलाएँ पहले से ही खून की कमी की शिकार रहती है और अगर इस प्रकार भी उनका खून बर्बाद होता रहा तो वे मौत की शिकार हो जायेंगी ।

*बच्चेदानी में गाँठ अनियमित माहवारी का एक मुख्य कारण है। यह गाँठ अन्दर की जाँच के दौरान डॉक्टर को पता चल जाती है। ऑपरेशन से इन गाँठो को निकाला जा सकता है। यह गाँठ कैंसर की गाँठ नहीं है। अक्सर इन गाँठों से कोई तकलीफ नहीं होती लेकिन कई महिलाओं में इन गाँठों के कारण निःसन्तान्ता पाई जाती है।

*बच्चेदानी के बाहर बच्चेदानी की परत होना। यह अवस्था कभी-कभी पाई जाती है और बच्चेदानी के अन्दर की परत अण्डाशय, बच्चेदानी को सम्भालने वाली नसें, बच्चा होने का रास्ता और टट्टी होने के रास्ते के बीच में पाई जाती है। जो माहवारी चक्र बच्चेदानी के अन्दर की परत में चलता है वही मासिक चक्र इन दूसरी जगहों पर पाई जाने वाली परतों में भी चलता है। कुछ महिलाओं में कोई तकलीफ नहीं होती पर अधिकतर महिलाओं में माहवारी के समय दर्द, अधिक खून जाना, निःसन्तान्ता, सम्भोग के समय दर्द आदि की शिकायत रहती है। इस तकलीफ का इलाज आसान नहीं है।

*जननांगों की टी०बी०। यह एक सामान्य बीमारी नहीं है पर फिर भी इसके बारे में सतर्क रहना उचित होगा। जननांगों की टी०बी० से जो परेशानी सबसे अधिक होती है वह है निःसन्तान्ता। इसके अलावा माहवारी में अनियमितता (कम या कभी-कभी ज्यादा खून जाना) भी कुछ महिलाओं में पाई जाती है। इलाज से बीमारी ठीक हो जाती है। लेकिन निःसन्तानता की शिकायत दूर नहीं होती ।

महिलाओं में स्तनों की कुछ परेशानी

महिलाओं के स्तनों (छाती) में कई सारी समस्याएँ होती है। यहाँ पर तीन मुख्य समस्याओं के बारे में चर्चा की जाएगी।

छाती पकना

दूध पिलाने वाली माँ को अक्सर छाती में दर्द, भारीपन साथ में बुखार और बगल में गिल्टी की शिकायत होती है। यह सारे लक्षण छाती पकने के संकेत है। छाती पकने के पीछे मुख्य कारण निप्पल की खाल फटना या छाती में अधिक दूध उतरना व दूध जमना है। इन कारणों से कीटाणु आसानी से छाती में घुस जाते है। दूध कीटाणुओं का बहुत ही प्रिय भोजन है जहाँ वे संख्या में खूब तेज़ी से बढ़ते है। इसके चलते छाती पकने लगती है और उसमें धीरे-धीरे मवाद भर जाती है। अगर जल्दी से इसका इलाज न हुआ तो पूरी छाती ही मवाद से भर सकती है।

क्या करें- छाती में दर्द, अधिक गर्मी, भारीपन या उसके सख्त हो जाने पर तुरन्त उसका दूध निकालना चाहिए। दूध बच्चे को पिलाया जा सकता है अगर छाती को हाथ से दबाकर दूध निकालने में दर्द के कारण बहुत ही मुश्किल है तो तौलिये को गरम पानी में भिगोकर उस से छाती पर सेंक लगाते हुए धीरे-धीरे दूध निकालने की कोशिश करें। तौलिये से सेंक देते समय बाहर से धीरे-धीरे अन्दर निप्पल की ओर दबाएँ। दूध निकालने से छाती हल्की हो जाएगी व दर्द भी कम होगा। यदि माँ को बुखार आने लग जाए या बगल में गिल्टी हो या सेंक व दूध निकालने से कोई आराम न हो तो तुरन्त डॉक्टर को दिखाए। एक बार छाती में मवाद बन जाने पर ऑपरेशन के सिवा कोई इलाज नहीं है। याद रखें किसी भी हालत में दूध निकालना न बन्द करें। दूध निकालना बन्द करने पर समस्या बढ़ जाएगी।

छाती में गाँठ

यदि हम महिला की छाती को हथेली से हल्का दबाकर देखें

तो उसमें कोई गाँठ महसूस नहीं होती। उसी छाती को यदि हम अँगुलियों के बीच में दबाकर देखें तो एक गाँठ महसूस होती है- यह सामान्य है। यदि हथेली से छाती को दबाने से गाँठ महसूस हो तो चिन्ता की बात है। अक्सर छाती की गाँठ कैंसर भी हो सकती है। इसी कारण महिलाओं को महीने में एक बार अपनी छाती की नियमित जाँच करनी चाहिए। छाती की जाँच करने का सबसे सही समय माहवारी के एक सप्ताह बाद होता है क्योंकि तब छाती न तो बहुत मुलायम होती है और न ही व सख्त होती है। इसलिए इस दौरान जाँच ज्यादा ठीक होने की सम्भावना रहती है। छाती के स्वयं जाँच का तरीका चित्रों के माध्यम से समझाया जा रहा है-

(१) एक शीशे के सामने खड़ी होकर अपनी दोनों छाती को ध्यान से देखें उसके आकार में अन्तर या उसकी खाल में कोई ढीलापन तो नहीं है। यह जाँच करते समय पहले दोनों हाथ नीचे की तरफ लटकायें फिर सिर के पीछे।

(२) अब लेट कर बाँये हाथ को सिर के नीचे रखें और दाँये हाथ (अँगुलियों के बीच का हिस्सा सिरा नहीं) से छाती को बाहर से अंदर की ओर गोलाई में घुमायें। हाथ से इतना दबाव डालें ताकि छाती में हुई किसी भी गाँठ का पता चल जाये। इस प्रकार दूसरी छाती की भी जाँच करें। लेकिन अबकी बार दाँया हाथ सिर के नीचे होगा और बाँये हाथ से जाँच की जायेगी।

(३)अब अपने हाथ से निप्पल व आस-पास के हिस्से की जाँच करने के लिए उसे दबायें देखें कि ऐसा करते समय कहीं कोई स्राव तो नहीं निकल रहा। यह जाँच दोनों छाती की करें।

छाती का कैंसर

छाती के कैंसर के कुछ लक्षण नीचे दिये जा रहे है-

*निप्पल से खून मिला हुआ पानी निकलना
*छाती में गाँठ शुरू हुई है और वह बढ़ रही है
*छाती की गाँठ बहुत (पत्थर की तरह) सख्त है
*गाँठ निप्पल से या उपर की खाल से चिपकी हुई है
*अचानक निप्पल धीरे-धीरे अन्दर की तरफ धँसने लगता है
*छाती के उपर की खाल पर दाने, छोटे गड्ढे आने लगते है या तो खाल खुरदरी होने लगती है
*अक्सर कैंसर की गाँठों में शुरू में दर्द नहीं होता।

छाती का कैंसर महिलाओं में काफी पाया जाता है। इस कैंसर का इलाज सम्भव है लेकिन उसके लिए बीमारी को शुरू में पकड़ना होगा और तुरन्त इलाज करवाना होगा। शुरू की स्थिति में ऑपरेशन ही उचित इलाज है और महिलाएँ इस ऑपरेशन के बाद सालों तक जिन्दा रहती है। यदि बीमारी फैली न हो तो बीमारी पकड़ने के लिए छाती की स्वयं जाँच करना आवश्यक है।

छाती की अन्य गाँठे

छाती की हर गाँठ कैंसर नहीं होती। इन गाँठों की पहचान खुद न करके डॉक्टर पर छोड़ना ही उचित होगा। सामान्य गाँठों को पहचानने के कुछ चिन्ह निम्न प्रकार है-

*यह गाँठ लम्बे समय से मौजूद रहती है
*यह गाँठ बढ़ती नहीं है या फिर बहुत ही धीरे बढ़ती है
*यह गाँठ छूने में बहुत सख्त नहीं होती
*यदि इन गाँठों को पकड़ने की कोशिश करे तो यह गाँठ अँगुलियों से फिसल जाती हैं
*कभी-कभी यह गाँठ माहवारी के समय बढ़ती हैं और उनमें दर्द भी शुरू हो जाता है।

छाती की गाँठ कैंसर है या नहीं यह निर्णय खुद कभी न लें। यदि छाती में गाँठ होने का पता चले तो डॉक्टरी सलाह अवश्य लें।

महिलाओं की व्यक्तिगत सफाई

आमतौर पर गाँव में महिलाओं की व्यक्तिगत सफाई को महत्व नहीं दिया जाता है जिसके कारण महिलाओं व किशोरियों को बहुत सारी स्वास्थ्य समस्या का सामना करना पड़ता है। लड़कियों को बचपन से ही बताना चाहिए कि-

*टट्टी, पेशाब व बच्चा होने के रास्ते को नहाते समय साबुन से साफ करना चाहिए।

*टट्टी करने के बाद टट्टी के रास्ते की सफाई पीछे से आगे न करके आगे से पीछे धोना चाहिए।

*पेशाब करने के बाद भी योनि को साफ पानी से धोना चाहिए।

जब लड़की जवान हो जाती है तो उसे इन सफाईयों के साथ-साथ कुछ विशेष सफाई रखने की भी आवश्यकता होती है। जैसे माहवारी के दौरान रोज नहाना, जननांगों को साबुन पानी से धोना, दिन में दो-तीन बार कपड़ा बदलना, गीली चड्ढी या कपड़े नहीं पहनना, कपड़े को अच्छी तरह धूप में सुखाने के बाद प्रयोग में लाना, माहवारी के दौरान सूती कपड़े का उपयोग करना आदि ।

इसी के साथ महिलाओं को प्रसव के दौरान व प्रसव के बाद की सफाई पर विशेष ध्यान रखने की आवश्यकता होती है। प्रसव को हमेशा साफ जगह में करवाना चाहिए, बच्चा होने के रास्ते को साफ रखना चाहिए, बार-बार गंदे हाथों से जाँच नहीं करना चाहिए, पेटीकोट साफ पहनना चाहिए। बच्चा पैदा होने के बाद माँ को रोजाना गुनगुने पानी से नहाना चाहिए, नहाते समय जननांगों की साबुन से सफाई करनी चाहिए, पेटीकोट व अन्दर पहनने वाले कपड़े रोज बदलने चाहिए, खून सोखने के लिए हमेशा सूती कपड़े को धूप में अच्छी तरह सुखाकर उपयोग में लाना चाहिए। यदि इस प्रकार किशोरियाँ व महिलाएँ व्यक्तिगत सफाई को बचपन से महत्व देकर अपने व्यवहार में लायें तो बहुत सारी स्वास्थ्य समस्याओं से बचा जा सकता है।

आम स्त्री रोगों में पुरुषों की भूमिका

यह पढ़ने और सुनने में थोड़ा अजीब लगेगा कि बात तो स्त्री रोगों की हो रही है तो उसमें पुरुषों की क्या भूमिका हो सकती है? नीचे दिये गये कुछ बिन्दु असमंजस की इसी स्थिति को हल करने का प्रयास है ताकि पुरुषों की मदद से महिलाओं को कुछ हद तक इन तकलीफों से बचाया जा सके-

पिता होने के नाते

१) छोटी उम्र में बेटी की शादी न करें ताकि वह कच्ची उम्र में यौन सम्भोग व माँ बनने के बोझ से बची रहे। ऐसा करके आप उसे बच्चेदानी खिसकने, बच्चेदानी के कैंसर व सम्भोग के समय दर्द जैसी तकलीफों से बचायेंगे।

२) बेटी को पढ़ायें जरूर ताकि वह अपने शरीर व उसकी प्रक्रियाओं को समझ कर अपनी सेहत का ध्यान रख सके।

३) शारीरिक बदलाव सम्बन्धी प्रश्नों का सीधा व सरल उत्तर देकर बेटी को सही जानकारी दें।

पति होने के नाते

४) पत्नी की इच्छा न होने पर उससे सम्भोग न करें ताकि आप उसे यौन सम्भोग के समय दर्द से छुटकारा दिला सकते है।

५) पत्नी को जल्दी-जल्दी व बार-बार माँ बनने के लिए मजबूर न करें।

६) प्रसव के बाद पत्नी के आराम व भोजन का पूरा-पूरा ध्यान रखें ताकि वह कमजोरी व बच्चेदानी खिसकने की समस्या से बच सके।

७) पत्नी को अधिक सफेद पानी की शिकायत होने पर आप इलाज कराने व सफाई बरतने में पूरा-पूरा सहयोग दें। आप स्वयं भी इलाज करायें।

८) पत्नी से उसके शरीर व शारीरिक प्रक्रियाओं सम्बन्धी जानकारी बाँटे। पत्नी को अपनी प्रजनक अंगों सम्बन्धी तकलीफों को कहने के लिए प्रोत्साहित करें ताकि वह घुट-घुट कर सब कुछ सहने की बजाय इलाज करायें।

९) पत्नी को स्त्री रोग होने पर तुरन्त इलाज के लिए ले जायें।

१०) खुद को या पत्नी को प्रजनन अंग सम्बन्धी कोई भी तकलीफ होने पर उपचार होने तक पत्नी से शारीरिक सम्बन्ध न रखें।

पुरुष होने के नाते

११) छोटी उम्र की लड़की से शादी न करें।

१२) अपने लिंग की ठीक प्रकार से सफाई रखें। उसके आगे की खाल हटाकर रोज़ाना धोयें। सम्भोग के पहले भी लिंग की सफाई करें। इस प्रकार आप अपनी यौन साथी को बच्चेदानी की छूत व सफेद पानी से बचा सकते है।

१३) अपने यौन संचारित रोग का इलाज करने के लिए कुँआरी कन्या से सम्भोग के मिथक पर विश्वास न करें क्योंकि इससे कभी भी आपका रोग ठीक नहीं होगा। इसको जगह आप डॉक्टरी इलाज करायें।

प्रिय साथी,

स्वास्थ्य सखी को निकलते हुए २ साल हो गये हैं । इस बीच अलग-अलग व्यक्तियों व संस्थाओं ने इसकी माँग की। जिससे हमें एहसास हुआ कि आप लोगों को हमारा यह छोटा सा प्रयास काफी पसन्द आ रहा है। हमारा यह प्रयास हमेशा जारी रहे इसके लिए जरूरी है कि स्वास्थ्य सखी अब अपने पैरों पर खड़ी होने की दिशा में प्रयास करे। इसी उद्देश्य से अब इस स्वास्थ्य सखी के लिए आप सभी से कुछ सहयोग राशि चाहेंगे जिसकी दरें निम्न प्रकार से हैं-

एक प्रति	रू० ८/-
वार्षिक सदस्यता (४ अंक)	रू० २५/-
५ से अधिक प्रतियों	रू० ४/- हर प्रति
*१ से अधिक प्रतियाँ लेकिन ५ तक	रू० ५/- के लिए

(* एक अंक की ५ प्रतियाँ मँगाने पर २५ रू० देने होंगे)

प्रजनक एव बाल स्वास्थ्य क्या है?

अप्रैल १९९६ से चालू भारत सरकार का प्रजनक एवं बाल स्वास्थ्य कार्यक्रम जो पहले मातृशिशु कार्यक्रम कहलाता था, उन सभी जरूरतों को पूरी करने का आश्वासन देता है जो कि वर्षों से चलाये जा रहे परिवार कल्याण कार्यक्रम के दौरान महसूस की गयीं । लेकिन इस प्रजनक एवं बाल स्वास्थ्य कार्यक्रम को समझने के लिए जरूरी है कि हम प्रजनक स्वास्थ्य को समझें ताकि हम कार्यक्रम का नाम बदले जाने के कारणों को समझ सकें। साथ ही दूसरी बात जो यहाँ पर महत्वपूर्ण है वह यह है कि नये कार्यक्रम में बाल स्वास्थ्य के अन्तर्गत तो वही सेवाएँ प्रदान की जा रही है जो मातृशिशु स्वास्थ्य कार्यक्रम के अन्तर्गत दी जाती थीं। सेवाओं या सोच के स्तर पर जो भी बदलाव हुआ है वह प्रजनक स्वास्थ्य वाले हिस्से में हुआ है। इस परिवर्तन की कड़ी कहाँ और क्यों शुरू हुई इसको हम यहाँ समझने का प्रयास करेंगे।

प्रजनक स्वास्थ्य : उत्पत्ति एवं अर्थ

काहिरा में आयोजित 'जनसंख्या एवं विकास पर अन्तर्राष्ट्रीय सम्मेलन' १९९४ के कुछ वर्ष पहले से ही नारी आन्दोलन में प्रजनक स्वास्थ्य पर सोच विचार शुरू हो चुका था। इसका मुख्य कारण यह था कि हर जगह महिलाएँ गर्भनिरोधन के अलावा अपनी विभिन्न स्वास्थ्य समस्याओं को व्यक्त कर रहीं थी। पर उनके लिए कहीं भी स्वास्थ्य की सरकारी प्राथमिक सेवाएँ तक उपलब्ध नहीं थी। दूसरी तरफ सरकार मातृ-शिशु स्वास्थ्य की तुलना में परिवार नियोजन पर बहुत अधिक खर्च कर रही थी। इस परिवार नियोजन कार्यक्रम में महिलाओं को 'बच्चा पैदा करने वाली मुसीबत' के नजरिए से देखा जाता था। सेवाओं का स्तर काफी असंतोषजनक था एवं महिलाओं की प्रजनक स्वास्थ्य सम्बन्धी विभिन्न आवश्यकताओं की पूर्ति बिल्कुल नहीं हो पा रही थी। इन सारे कारणों के चलते महिलाओं ने अपनी आवाज बुलन्द की और इस प्रकार से प्रजनक स्वास्थ्य के मुद्दे पर नीति निर्माताओं का ध्यान गया। काहिरा सम्मेलन के दौरान प्रजनक स्वास्थ्य का अर्थ निम्न प्रकार से समझाया गया-

१) प्रजनक स्वास्थ्य का मतलब न केवल बीमारियों का अभाव है बल्कि प्रजनन तंत्र एवं उसकी प्रक्रियाओं सम्बन्धी हर आयाम से सम्पूर्ण शारीरिक, मानसिक एवं सामाजिक खुशहाली/स्वास्थ्य,

२) सुरक्षित एवं संतोषजनक यौनिक सम्बन्ध, प्रजनन की क्षमता तथा दम्पत्ति को बच्चा पैदा करने न करने की छूट एवं संख्या तय करने की आजादी,

३) महिला एवं पुरूषों को अपनी प्रजनन क्षमता के नियंत्रण हेतु अपनी पसन्द की सुरक्षित, प्रभावी, कम खर्च वाली पद्धतियों तक पहुँच, व

४) सुरक्षित गर्भावस्था एवं प्रसव हेतु स्वास्थ्य सेवाओं तक पहुँच पाने का अधिकार ।

काहिरा सम्मेलन में प्रजनक स्वास्थ्य एवं प्रजनक अधिकारों को महिलाओं के मानव अधिकार के रूप में माना गया । सन् २०१५ तक इस अधिकार को जन-जन तक पहुँचाना कार्यक्रम का लक्ष्य रखा गया। इस कार्यक्रम के अन्तर्गत निम्न सेवाएँ दी जाने की बात कही गयी-

१) अच्छे गुणात्मक स्तर पर परिवार नियोजन सलाह, शिक्षा/जानकारी/संचार एवं सेवाएँ,

२) गर्भावस्था, सुरक्षित मातृत्व तथा प्रसव पश्चात् देखरेख तथा रक्तदान के बारे में जानकारी,

३) निःसन्तानता की रोकथाम एवं इलाज,

४) असुरक्षित गर्भपात की जटिलताओं की रोकथाम एवं इलाज तथा सुरक्षित गर्भपात सम्बन्धी सेवाएँ,

५) प्रजनन अंगों के संक्रमण, यौन संक्रामक बीमारियों की रोकथाम, पहचान व समय पर इलाज,

६) यौनिकता, यौनिक व प्रजनक स्वास्थ्य, जिम्मेदार मातृत्व-पितृत्व व यौन संक्रामक बीमारियों एवं एड्स की रोकथाम पर जानकारी/शिक्षा/संचार,

७) कैंसर एवं प्रजनन अंगों के संक्रमण के खतरे को बढ़ाने वाली चीजों पर महिलाओं की जानकारी,

८) उन लड़कियों व महिलाओं के लिए चिकित्सा एवं मानसिक स्वास्थ्य सेवाएँ जिनको किसी प्रकार की हिंसा का शिकार बनना पड़ा,

९) परिवार नियोजन, गर्भावस्था, प्रसव, गर्भपात, निःसन्तानता, कैन्सर, एड्स, यौन संक्रामक रोग एवं प्रजनन अंगों के संक्रमण आदि सेवाओं के लिए संदर्भन (रिफरल) की सुविधा एवं उपलब्धि।

हालाकि भारत ने इन सेवाओं को अपने देश में प्रदान करने की बात की लेकिन जून १९९६ में प्रकाशित जिला-स्तरीय प्रशिक्षण नियोजन मार्गदर्शिका के अन्तर्गत विभिन्न स्तरों पर निम्न सेवाएँ प्रदान किये जाने की बात लिखी है-

१) अनचाहे गर्भ की रोकथाम, प्रबंधन गर्भनिरोधन व गर्भपात,

२) मातृत्व देखभाल : गर्भावस्था, प्रसव व प्रसव पश्चात् सेवाएँ,

३) यौन-संक्रामक रोग व प्रजनन तंत्र के संक्रमण का प्रबंधन,

४) युवकों, महिला-पुरूषों व किशोर-किशोरियों के लिए यौनिकता व लिंगभेद पर सलाह/जानकारी व शिक्षा।

इसके अलावा यह भी सोचा गया कि कार्यक्रम को लागू करते समय सेवाओं की गुणवत्ता, ग्राहकों की सन्तुष्टि व अतिरिक्त सेवाएँ प्रदान करने पर ध्यान दिया जायेगा। इसके लिए सेवा प्रदान करने वाले कर्मचारियों के पर्याप्त प्रशिक्षण की भी बात की गयी। फिर भी यदि अन्तर्राष्ट्रीय मंच पर प्रजनक स्वास्थ्य के अन्तर्गत प्रदान की जाने वाली सेवाओं और भारत के राष्ट्रीय कार्यक्रम के अन्तर्गत प्रदान की जाने वाली सेवाओं की तुलना करके देखें तो स्पष्ट होता है कि भारत के प्रजनक स्वास्थ्य कार्यक्रम को कई मायने में सीमित बनाया गया है। प्रजनन स्वास्थ्य की कई महत्वपूर्ण समस्याओं के लिए नीति में कहीं पर किसी भी प्रकार की सेवा का प्रावधान नहीं है। ये समस्याएँ हैं- निःसन्तानता, बच्चादानी खिसकना, बच्चेदानी का कैंसर व गाँठ, लिंग जाँच एवं भ्रूण हत्या तथा यौनिक हिंसा। इसके अतिरिक्त जिन सेवाओं को प्रदान करने का

इरादा भी है उन्हें प्रभावी रूप से करने के लिए काफी अभिमुखीकरण व प्रशिक्षण की आवश्यकता है। लेकिन इस प्रकार की कोई भी तैयारी व क्षमता उ०प्र० स्वास्थ्य विभाग में कम ही नज़र आती है।

ये सारी कमियाँ तो इस कार्यक्रम में महसूस हुई ही और इससे पहले कि इन सीमाओं को ध्यान में रखते हुए कार्यक्रम लागू किया जा सकता इसी बीच नीतियों के स्तर पर एक और बदलाव हो गया। आमतौर पर लोगों की यह मान्यता हो गयी कि 'लक्ष्य मुक्त' कार्यक्रम का मतलब है 'कार्यमुक्त' कार्यक्रम, कार्यक्रम के संचालन में समुदाय की कोई भागीदारी नहीं हो पा रही है तथा विभाग में दी जाने वाली रिपोर्ट भी उचित नहीं है। इसलिए १९९८ में कार्यक्रम का नाम लक्ष्य मुक्त दृष्टिकोण से बदलकर समुदाय की ज़रूरत को पहचानना रखा गया। (कुछ ज़िलों की खराब कार्य प्रगति रिपोर्ट को देखते हुए उ०प्र० सरकार के स्वास्थ्य एवं परिवार कल्याण विभाग ने उन चिकित्साधि-कारियों पर दण्डात्मक कार्यवाही किये जाने का आदेश जारित किया जो कि खराब प्रगति दिखाते है।)

प्रजनक एवं बाल स्वास्थ्य कार्यक्रम में पहले से जिन सेवाओं को दिये जाने की बात कही गयी थी समुदाय की ज़रूरत पहचानने वाले कार्यक्रम में उन वायदों में भी कमी आयी है। उदाहरण के लिए अब एस०टी०डी/आर०टी०आई की पहचान मातृ एवं शिशु कल्याण कार्यक्रम का हिस्सा है। जिसका मतलब है कि इन बीमारियों से पीड़ित वे सभी महिलाएँ छूट जायेंगी जो कि शारीरिक व सामाजिक कारणों से माँ नहीं बन सकती। इसके अलावा स्वास्थ्य शिक्षा देना कार्यक्रम का ज़रूरी हिस्सा न होकर ए०एन०एम० के कार्यों का हिस्सा है(यानि कि इसको करना अनिवार्य नहीं है) ।

(शेष भाग पृष्ठ ३ पर)

आपकी बात

प्रिय मित्र

हमने आपके द्वारा प्रकाशित स्वास्थ्य सखी पत्रिका का अध्ययन हमारी साथी संस्थाओं में किया था। उक्त पत्रिका में स्वास्थ्य सम्बन्धी काफी अच्छी-अच्छी जानकारियाँ दी गई थी। अत: आपसे निवेदन है कि उक्त पत्रिका की प्रति हमारी संस्था को भी भिजवाने की कृपा करावें क्योंकि हमारी संस्था भी ग्रामीण क्षेत्र में स्वास्थ्य सम्बन्धी गतिविधियों का संचालन कर रही है।

ए०आर शर्मा
ए०टी०एम०ए०
जयपुर

प्रिय मित्र

आपकी पत्रिका स्वास्थ्य सखी देखने का सौभाग्य प्राप्त हुआ हम लोग यहाँ पर मातृ एवं शिशु कल्याण कार्यक्रम चलाते है। कृपया अपनी पत्रिका की १-२ प्रति भेजने का कष्ट करियेगा।

नवीन कृष्ण गोयल
हिमालयन इंस्टीट्यूट ऑफ मेडिकल साइन्स
देहरादून

प्रिय मित्र

संस्था को आपके द्वारा प्रकाशित स्वास्थ्य सखी पत्रिका ग्रामीण महिलाओं के लिए अत्यन्त उपयोगी लगी है। अत: आपसे अनुरोध करना है कि आप हमारी संस्था को इस पत्रिका को भिजवाने की कृपा करेंगे।

आर०एस० बोहरा
हिमालियन ग्राम विकास समिति
गंगोलीहाट

प्रिय मित्र

आपके द्वारा सम्पादित स्वास्थ्य सखी में महिलाओं के स्वास्थ्य पर दी जाने वाली जानकारी महत्वपूर्ण है। हमारी संस्था स्वास्थ्य सखी से लाभ उठाना चाहती है। आशा करता हूँ आप मुझे उक्त पत्रिका अवश्य भेजेंगे।

पी०के० त्रिपाठी
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लखनऊ

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इस पत्रिका के प्रकाशन के लिए हम मैकार्थर फाउन्डेशन के आभारी है।

bsh-11;9

REVIVING... UNDERSTANDING... USING

INDIGENOUS HEALTH PRACTICES

IHP

... PART OF BECOMING EMPOWERED

Indigenous Health Practices (IHP) refers to the knowledge, experience and practices possessed by people in traditional rural societies. Customarily in women's hand, IHP encompass all kinds of health-sustaining and healing practices including midwifery skills.

IN TRADITIONAL RURAL SOCIETIES

- Production is governed by human need
- Reproduction is under the same roof
- Goods are exchanged locally
- Health outlook is holistic & healing practices are woven into daily life
- Fertility is seen as women's strength
- Women's hands hold skills and wisdom
- Care comes from community & environment.

IN INDUSTRIALISED URBAN SOCIETY

The impact of the changing economic and social scenario on IHP is grave. Diverse traditional rural societies give way to uniform urbanised industrial society. Evolved over thousands of years, our indigenous health practices face extinction.

PROCESS OF CHANGE

industrialisation
commercialisation
privatisation
women's subjugation
medicalisation

PRODUCTION

- Production is driven by market demand.
- Market economy governs plans & policies.
- Cash crops replace sustenance crops.
- Resources & environment are depleted.
- Mechanisation marginalises women & poor.

ECONOMY AND SOCIETY

- Migration uproots culture & traditions.
- Disparity increases between rich & poor.
- Women are viewed as mothers or sex objects.

HEALTH AND MEDICINE

- Control of health is out of people's hands. People's outlook on health is fragmented & short-sighted.
- Medicine's outlook is mechanistic, curative, commercial and male-structured.
- Health care has become an industry.
- Industry patents people's herbs & knowledge.
- Pollution & change in foods threatens health.

REPRODUCTION

- Women are kept at home to reproduce for society and industry.
- The medical system claims control.
- Childbearing is a source of women's weakness, & fertility a liability.

Are you aware that...

* IHP spans many areas like nutrition, first aid, fractures, skin and eye problems, bites of snakes, insects & animals, dental & gum care, and mental disorders. Most of the healers recognised for skills in these areas are men.
* Yet, women are the most numerous carriers and practitioners of IHP. Within India's six lakh villages, countless women possess indigenous knowledge of healing. Some are healers with community recognition.
* Dais (traditional midwives, or TBAs) attend 70 to 80 percent of childbirths and more in remote rural areas where health centres and hospitals may not be accessible. They number about 6 lakhs.
* Likewise, there are women bone-setters, herbalists, faith-healers, snake-bite curers, and so on.
* Women healers use herbs to relieve gynaecological ailments, like menstrual disorders, vaginal discharge, bleeding and womb prolapse.
* About 465 adivasi tribes and 4500 other caste and ethnic communities in India are the carriers of IHP going back many thousands of years. Over four thousand years ago, the physician Charaka advised vaidyas to go and learn from healers among the forest dwelling people.
* More than 7000 plant species are being used medicinally in India.

It is important to know that...

* India is one of the few countries besides China and Sri Lanka to have a living indigenous health care system as ancient as five thousand years old.
* Regional floral bio-diversity - trees, shrubs, grasses, ferns, climbers, runners, tubers, orchids - forms the major natural resource base of IHP. In dry desert climates, animal and mineral substances play a greater role.
* Common ailments - about 70 percent of health problems - like diarrhoea, worm infestations, respiratory conditions, skin and dental problems can be treated effectively with IHP.

SUPPORT IHP AND STRENGTHEN COMPREHENSIVE PRIMARY HEALTH CARE!

For more information about IHP, contact:
Information & Publications Unit, LSPSS
(Lok Swasthya Parampara Samvardhan Samiti)
P.O.Box 7102, Ramanathapuram P.O.
Trichy Road, Coimbatore 641045 INDIA
Phone: 91-0422-214132 FAX: 91-0422-214953

Towards Women's Empowerment...

Although health services are inadequate for most people, women's access to formal health care is even more restricted. The Government health services provided within programmes affecting women and children - whether 'MCH', 'safe motherhood', 'child survival' or 'family planning' - do not touch most of women's health problems. Unmarried and non-reproducing women are excluded. Private health care is exploitative, or not within reach at all - and it may be hazardous.

Women have limited control over their own bodies, over their health and over resources at home and in their communities. Many people are working to change this through women's development initiatives and programmes. Among health and development workers, there is a growing attempt to understand and revive IHP as part of empowerment of women and local communities.

How can IHP help?

IHP can help improve the health of women. Part of day-to-day living, indigenous health practices are accessible, available, affordable and culturally acceptable. They help meet the health-sustaining and healing needs of women. They reduce women's tendency for self-neglect.

IHP help to enhance women's control over their bodies. Women understand their bodies according to a familiar world-view supported by their experience and new information. The gap between self and body reduces.

IHP promote self-reliance. Women themselves identify causes of ailments and decide about steps of healing. They grow and prepare medicines. They can manage local herbal pharmacies.

IHP can build women's self-esteem. Promoting indigenous health practices re-affirms knowledge and healing skills of women passed down from countless generations.

IHP can raise women's self-confidence at community level. Sharing experiences, knowledge and skills women can unite and build mutual support across barriers of caste and class.

IHP can help in encouraging gender equality and justice. Promotion of IHP can provide an enabling environment for women and men healthworkers to come together for the common purpose of healing and sustaining health. It fosters recognition of women healers and of the role of women in healing.

IHP can help change perceptions of women's roles. Women's roles of nurturing and caregiving are perceived differently at home and outside. Women's health service and action in the community brings recognition and validation.

How can IHP promote Women's Health and Empowerment ?

PROMOTION OF IHP

HEALTH BENEFITS

- Health care is available, accessible, affordable and acceptable to women.
- Avoids delay in attending to gynaecological & other illnesses of women.
- Helps demystify health care.
- Fosters improvement in nutrition & health.

SOCIAL BENEFITS

- Recognises women's knowledge and skills.
- Collective sharing of IHP can cut across gender, caste and class.
- Challenges stereotypical healthcare roles.
- Strengthens self-reliance in the community.

Control over body, resources & health Self-esteem & self-confidence Solidarity among women Rise in women's status increased decision-making for health

Empowered Women, Strong Local Communities & Healthy Society

Empowerment of women around health issues also concerns accountability of Government health services and regulation of unethical private medical practice. All health services must be accountable to the public and to women's needs. The medical system should pay due recognition and respect to IHP, as the people have been relying on them traditionally for effective primary health care of common ailments.

A BOOK ABOUT WOMEN'S IHP ...HER HEALING HERITAGE.....

HER HEALING HERITAGE brings to light women's traditional practices concerning the health of women and children. It is based on a collaborative survey by LSPSS and CHETNA involving 24 rural areas in eleven states of India. Over 2000 women including dais (traditional midwives) shared their understanding and practices relating to pregnancy, childbirth, breast-feeding and infancy.

Compiled and written by Vd. Smita Bajpai and edited by Dr. Mira Sadgopal, it includes the topics of pregnancy confirmation and care, abortion, the dai tradition, making childbirth easier, care of woman and infant after childbirth, and childcare. Major issues arising from the survey are highlighted along with some recommendations relevant to national health policy.

Written in simple and clear English, extensively illustrated, women's healing practices are documented within their cultural context with a feminist perspective. Comment is added from Ayurvedic as well as allopathic medical viewpoints.

HER HEALING HERITAGE will be useful to doctors, vaidyas, health policy makers and other interested people involved in health care who plan and implement women's health programmes. Likewise it will interest social scientists and academicians.

- Pages: 216 • Size: 6.25"x9" • Contributory Price: Rs.150/$15

What you can do...

As an individual
identify, learn about IHP; use IHP yourself and in your home for greater control over body & health; recognise women healers & support the strengthening of IHP; discuss the importance & role of IHP with others.

As a development worker
recognise & understand IHP within the total context of development; work on integrating IHP into health & development programmes; promote IHP for women's empowerment and community self-reliance .

As a healer or healthworker
value, share and utilise your knowledge of IHP; link with others to strengthen and protect IHP & the natural resources base in the environment; explain IHP to the people; learn more about IHP in your region and elsewhere.

As a physician
keep informed and up-to-date on the scientific basis of IHP. Select, use & promote sound practices.

As a health programme planner
incorporate IHP into health & development programmes, stressing women's empowerment; identify & include women healers in programmes; enlarge the number of women in decision-making roles.

As a health policy maker
allocate resources for research, promotion & use of IHP; formulate pro-people and pro-woman policies which will preserve the country's rich base of healing knowledge; make efforts to prevent unjust exploitation from within or without, such as by export or patenting.

As a media person
provide coverage on IHP, giving a positive, gender-sensitive, informative & balanced view; disseminate information through media networks; report on struggles to protect & promote the IHP base for sustainable development.

As a researcher
conduct research on the use of particular herbs & practices to help meet the health needs of women & communities; become familiar with the IHP database; support and guide local and regional groups to carry out, document and analyse findings from participatory research projects.

As an educationist
bring IHP into schools & other institutions of learning; build up a positive attitude towards IHP in the present development context; update and revise text-books in friendly format, publishing in regional languages; recognise & strengthen IHP in academic & scientific bodies.

What CHETNA does...

CHETNA is involved in various activities to promote IHP as part of women's empowerment.

1. **Training:** CHETNA incorporates IHP in the perspective and content of TOT (Training of Trainers) workshops addressing the health and nutrition of women and children.

2. **Information and Documentation:** CHETNA develops and produces educational materials to spread information and awareness about IHP - booklets, charts & posters, scrolls, training kits, exhibitions and reports. Dissemination is local, regional, national and international.

3. **Building Capacities of NGOs:** Mainly in the states of Gujarat and Rajasthan, CHETNA brings IHP into training and consultation with NGOs. This enables them to increase the effectiveness of their health programmes and add an edge to women's empowerment strategies.

4. **Networking and Advocacy:** CHETNA collaborates with others to develop IHP, to empower women and to protect the environment at local and policy levels.

CHETNA **Women's Health and Development Resource Centre** Chaitanyaa

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Phone : 7868856, 7866695 Fax: 91- 79-7866513 and 91- 79-6420242. CHETNA'S Email Address Indu. Capoor@ Lwahm. Nancanet. Com

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WH-11:9

WOMEN'S WORK AND HEALTH

Women's Work and Health

Most people, whatever their race, nationality, or the stage of development of their country, spend most of their lives working for a living (The World Development Report 1995).

As work is coventionally measured, the definition of work conveys two different meanings for men and women. Oten it mischaracterises relative effort. While men's work is limited to only income generation, for women, in addition to income-generating activities, it encompasses household work, preparing food, fetching firewood and water, child care and nurturing of family and community needs.

Ironically, while men's work is considered to be productive, women's work is greatly undervalued in economic terms and time allocated to household activities other than agriculture is rarely recognised and rewarded.

Indian women walk on a tight rope. The traditional patrilineal family system confines their role mostly to the domestic sphere, allocating them to a subordinate status. A majority of them need to go out to work for economic reasons yet still have to continue to shoulder domestic responsibilities without any support. Even if they work outside the home, **lack of education, skills and gender based discrimination** restricts them from securing higher paying jobs.

According to the 1991 Census, in India, only 6% women work in the organised sector such as government offices, industries, public undertakings, or as entrepreneurs. Given the labour market conditions and the existing socio-economic environment, there has been a phenomenal growth of the unorganised sector where about 80% of women are employed. This sector is characterised by discriminatory hiring practices, low wages, long and strenous work hours, total lack of job and social security benefits and occupational health hazards. Even among the minority of those working in the organised sector, very few constitute of administrators and menegers.

Non-recognition and **undervaluation** of women's work both at home and outside, has an adverse effect on their health. With time-a scarce resource relative to the tasks that need to be done, the frequent alternative is to heighten the intensity of work. Hours for leisure activities or even sleep are reduced. The strenous physical tasks allocated to women, combined with limited food intake further exacerbates malnutrition among Indian women. As a result, about 70 percent of them suffer from Anaemia and hence are more prone to infections.

Productive responsibilities are hardest on child bearing women, who typically work until late in their pregnancies and resume work before they have fully recovered from childbirth.

Besides, women are also expected to maintain social relations and responsibilities, the pressure of which often affects their mental status.

Poor physical and mental health of women directly affects their productivity, work output and wage earning capacity. Due to these socio-economic interlocks, a vicious cycle of poverty, poor health and lower wages is set in motion.

To improve this situation, women's work, both at household as well as an occupation, needs to be duly recognised and rewarded within our social, economic and political contexts. It is essential to identify and address the factors affecting women's health due to work in a holistic manner.

Work at Home

At the family level, with inadequate food intake, women perform a number of activities, which adversely affects their health status. For example,

- They walk long distances everyday to fetch water, firewood and fodder and carry the load back home. This may cause backache, bodyache, abortion and prolapse of uterus. Sexual abuse, snake and scorpion bites are also not uncommon among such women.
- Household chores such as washing clothes and utensils with detergent and soap often may cause skin diseases/allergy. Sweeping and mopping work may cause bodyache and backache.
- In our patriarchal society, it is mostly the women who do the cooking. The heat and smoke generated especially from cowdung cake and firewood used as fuel for cooking are very harmful for health. They may affect the heart and lungs to a great extent and may also cause burns, allergy and eye disorders.
- During pounding of certain spices, the particles may affect the lungs causing cough and watering of eyes due to an allergy. It may also result in bodyache and backache.
- Regular cattle care and milching creates a possibility of infection, due to the insects on the cattle.
- Use of insecticides at home is harmful to women's health.
- Long working hours, monotony of work and lack of nutrition create a number of physical and psychological problems.

Health Hazards of Different Occupations

As mentioned earlier, a majority of women are employed in the unorganised sector and hence they are more likely to work in situations where there is no protection against exposure to potential health hazards.

- Women working in the agriculture sector, often suffer from repeated abortion, backache and bodyache (due to bad posture) and infertility, allergy and respiratory problems due to pesticides and chemicals used in agriculture. Working in the slushy water often results in skin diseases, hook worm manifestation and Anaemia.
- In the construction work, women being considered as unskilled labour, are given the brick or load carrying work, which is relatively lower paid and may affect their general as well as reproductive health, resulting in abortion, still birth and/or heavy bleeding etc.
- In food processing units, extensive heat may cause dehydration while in the fish processing unit due to constant handling of ice and preservatives, frost bite, cold, muscular pain and skin diseases may affect women's health.
- The use of dye, acid, solvents and fumes in chemical industries may cause Bronchitis, allergy, abortion, menstrual irregularities, still birth, Anaemia, eye disorders and psychological problems.
- The repetitive work in electronic and packaging industries may result in restlessness, allergy, pain in the fingers, backache and bodyache.
- Secretarial and typing work which is usually performed by women in different offices, may cause pain in fingers, shoulders, back or bodyache.
- Self employed women are engaged in various activities such as rag picking, domestic work, needle work, papad (thin crisp cake made out of flour mixed with spices) making, etc. These activities lead to back and bodyache, infections, skin diseases, eye problems etc.
- Women health workers especially nurses and midwives regularly face the danger of serious infections, such as Hepatitis B, Tuberculosis etc. In addition, they face health hazards due to pathological, radiological and disinfection work.
- Sexual abuse exists in every occupation and at all levels. It greatly affects women psychologically and physically. So far this aspect has been neglected and overlooked and it needs to be considered as occupational health hazard.

Women engaged as commercial sex workers are frequently exposed to sexually transmitted diseases including HIV/AIDS due to forced unsafe sexual practices by the clients, leading to reproductive tract infections. In addition, these women and their children suffer from mental agony due to constant humiliation and social boycott.

For Action...

As a Woman:

- Some of your health concerns may be work related. Be aware of the health hazards related to various occupations/work. Seek medical advice/treatment before your problems get aggravated or repeated.
- Be aware of the rules and regulations at your work place. Unite to demand basic facilities including safety measures, equal work hours, creche facilities and wages etc. Raise your voice against sexual abuse or harassment at your work place.

As a Family Member:

- **Recognise** household chores and child care responsibilities as "work". **Distribute** the household responsibilities equally among men and women.
- **Enable** women to improve their technical skills and pursue careers/professions of their choice.
- **Extend** active support and co-operation to ensure women's development.

As a Policy Maker:

- **Ensure** development and implementation of policies enabling life useful education and technical skill development training for women. Ensure the development of safer and appropriate tools for women. Plan strategies to train women to use these tools and ensure employment for them.
- **Ensure** regular provision of food grains and vegetables at a cheaper rate through the public distribution system. Adjust the time of distribution such that women do not loose a day's wage to procure the same.
- **Introduce and ensure** implementation of comprehensive laws to regulate work hours for women in all sectors. Provide creches, other basic facilities and safe equipments at work places and training centres.
- **Introduce and ensure** strict enforcement of laws and severe punishment to its violators.
- **Introduce and ensure** implementation of a health monitoring system to regularly assess the effects of various occupations on health, provide safety measures and free medical services.
- **Develop** a quick and easy compensation system for workers who are injured while at work.

As an Employer:

- **Extend** equal job opportunities, wages, work hours, training and protective equipments to women. Ensure adequate compensation in case of casualty.
- **Ensure** provision of basic facilities such as safe drinking water, separate toilets for men and women, rest rooms, breaks for breast feeding to nursing mothers. Provide creche facility to the women workers at the work place.
- **Ensure** provision of paid maternity/paternity leave and medical check-up to all workers.
- **Ensure** harassment free work environment for women workers.

As a Doctor/Medical Professional:

- Before initiating any treatment, take the complete history of the patient including details about her/ his work/profession.
- **Provide** counselling and guidance on occupation related health hazards to patients while treating them, if required.

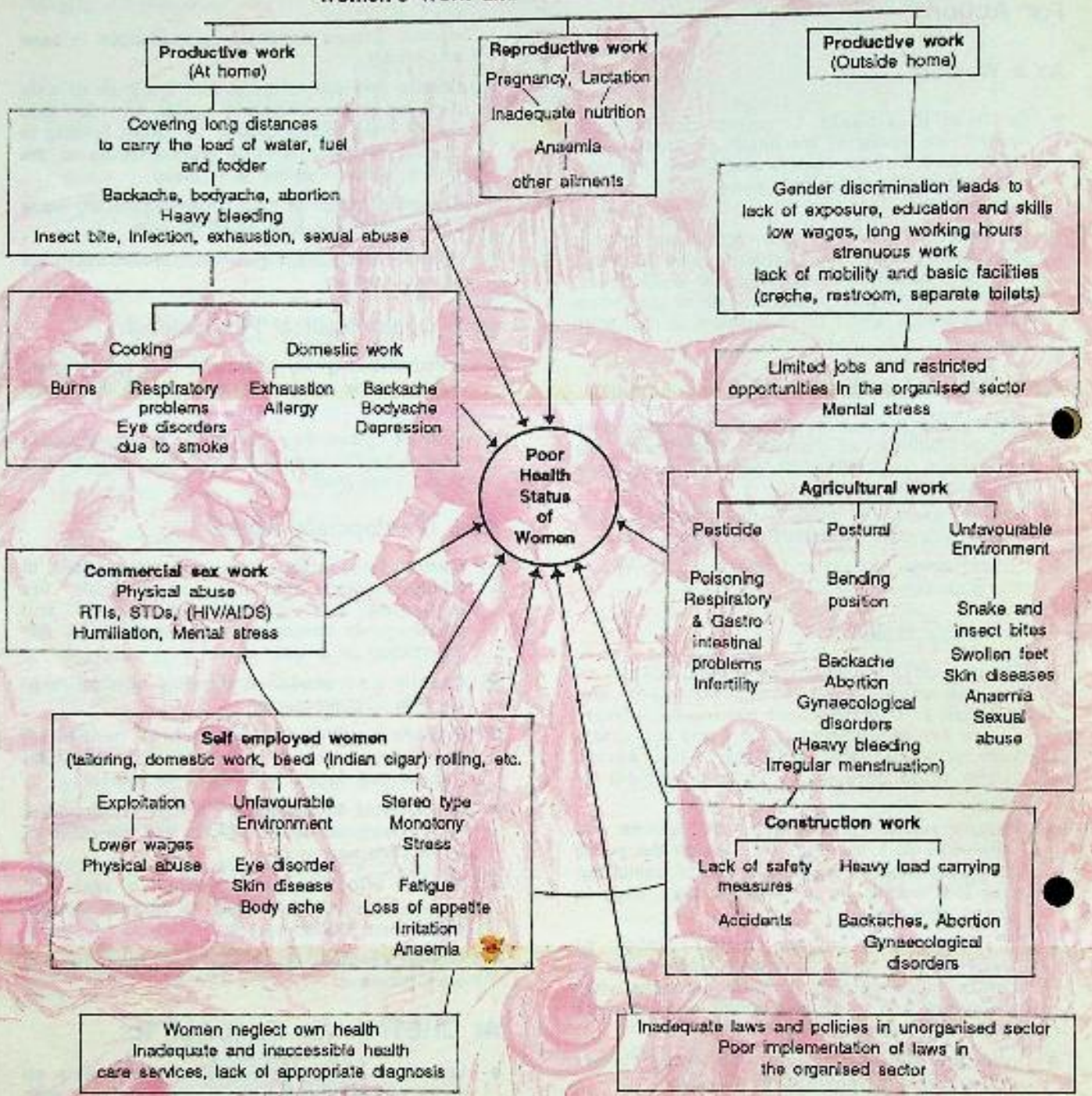
As a Development Worker:

- **Conduct** research on various occupations in which women are engaged in both, the organised and unorganised sectors and systematically document the findings. **Share** this information on a wider scale.
- **Create** awareness of various occupational hazards through media.
- **Ensure** development of income generation programmes which take into account the possible occupational health hazards of the workers.
- Make efforts to **sensitise** medical professionals on occupational health aspects and the need for a sensitive approach.
- **Ensure** effective implementation of laws and provision of basic facilities to women at work places and training centres.
- **Ensure** effective implementation of safety rules at work places.

At CHETNA We Envisage To:

- **focus** on the adverse effects of overwork on women's health as a part of our women's health and development programmes.
- **sensitise** the government and non-government organisations about women's health concerns related to work so they can empower women and build their capacities to demand basic facilities and equal opportunities at home and at work place through their programmes.
- **develop and disseminate** educational and training material on women's work and its adverse effect on their health.

Women's Work and Related Health Hazards



CHETNA Women's Health and [illegible] elopment Resource Centre Chaitanyaa

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WOMEN AND HIV/AIDS

To know.....

The chances of HIV infection through infected blood transfusion are almost hundred percent.

The major signs of AIDS are, at least 10% loss of body weight, chronic diarrhoea (for more than one month), prolonged fever (for more than one month).

There is a high prevalence of RTIs (Reproductive Tract Infections) including STDs (Sexually Transmitted Diseases) among Indian Women.

In the presence of STDs the chances of HIV infection increase by 10 to 30 times. Due to social stigma, very few women avail STD treatment.

In the presence of HIV, response to STD treatment may be slow. It also works both ways by increasing the infection chances of one in the presence of the other.

The chances of HIV infection from men to women are 2 to 10 times higher than women to men. Because there is an increased risk of infection for the receptive partner and women are at the receiving end in sexual intercourse.

Biologically women are 10 to 30 times more prone to HIV infection due to larger exposed surface of virus penetrable.

HIV positive women may experience irregularities in menstruation and complications during pregnancy due to heavy medication while treating opportunistic infection.

And act.....

As a doctor:

To educate and counsel people about HIV/AIDS

To adopt unbiased, sympathetic, humane approach towards the HIV infected and maintain absolute confidentiality about them.

To use only sterilised syringes, needles and surgical instruments.

To transfuse HIV free certified blood and use it only when absolutely necessary.

As an educationist :

To impart HIV/AIDS information to adolescents and relate it to women's socio-cultural status.

As a development worker:

To sensitize men and women through extensive AIDS awareness campaign.

To help women in empowerment and device specific interventions to enable them to protect themselves and receive appropriate care against HIV/AIDS.

As a citizen :

To spread AIDS messages and maintain unbiased, non-judgmental approach to the HIV positive and treat them with compassion not discrimination.

To provide a support system within the family and community.

To donate blood and insist on the use of HIV free certified blood.

To use condoms for reducing the risk of infection.

As a woman :

Being able to say no to your partner against unsafe sex behaviour, since you have a right to live a STD and HIV free life.

Realities of HIV/AIDS .....

AIDS (Acquired Immuno Deficiency Syndrome) is not a disease in itself. It is a condition created by a virus called HIV (Human Immuno-deficiency Virus). HIV infection progressively weakens the body's immune system, leaving the victim vulnerable to a host of life threatening opportunistic infections like Diarrhoea, Tuberculosis, and Pneumonia, which otherwise usually may not result in fatal consequences.

AIDS can be transmitted through body fluids like blood, vaginal secretion and semen.

The sources of HIV infection are unprotected and unsafe sexual intercourse with infected partner, contaminated blood, blood products and transplanted organs and tissues of infected persons.

It can be transmitted by using unsterilized syringes and needles.

An infected mother can pass on the infection to her foetus or new born baby (there is 50 to 70 percent chances of the foetus being born normal and breastfeeding by such a mother is considered safe).

Anyone can be infected by HIV. There is no cure for AIDS and no effective vaccine or medicine has been developed till date. Prevention is the only protection.

Except for the use of condom, no other contraception can prevent the infection.

The infection does not spread by touching and kissing an infected person, sharing food, bed, clothes and toilet seats or swimming pool with him/her.

It does not spread through mosquito bites.

What makes women more vulnerable to HIV/AIDS.....

Due to social and sexual subordination, women find it difficult to negotiate and prevent men from practising unsafe sex at home and at workplace as well.

Lack of control over sexuality, in addition to, the culture specific submissiveness increase the chances of HIV infection in women.

Poverty, unemployment and lack of education might force them to accept sex work, increasing chances of HIV infection through forced unsafe sexual practices.

Inadequate information, lack of mobility and poor health services increase the chance of HIV infection by manifold.

Rape or early marriage expose women to HIV/AIDS at an early age.

Inadequate laws aggravate her HIV status. For example, Rape law and PITA (Prevention of Immoral Traffic Act) are inadequate and more often the violators go unpunished due to the lapses in the Act.

Immature cervix in adolescents and less mucus production in the genital tract of post-menopausal women may cause injury during sexual intercourse increasing their susceptibility to HIV infection.

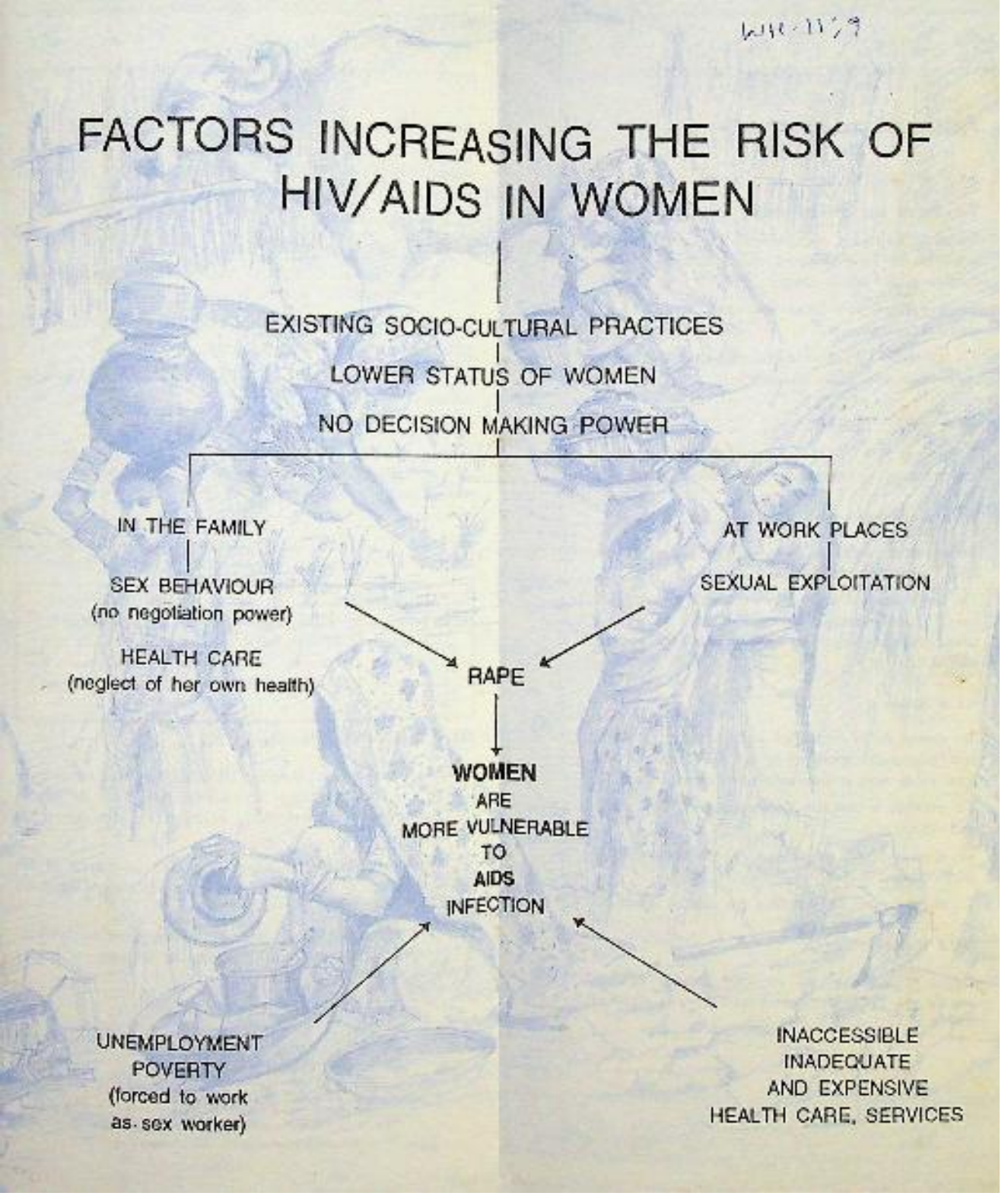
Since female birth passage is not visible to the naked eye, any lesion that may occur is not easily recognised and treated.

Since foetus can acquire HIV from the infected mother, infected women often have to deal either with a tremendous sense of guilt and grief about infecting their children or the loss of their child bearing potential.

At present male condoms, on which women do not have a control, are the only means to prevent AIDS.

WH-11/9

FACTORS INCREASING THE RISK OF HIV/AIDS IN WOMEN



As a media person :

To give accurate and correct information and publish responsible, well researched, unbiased gender articles in relation to HIV/AIDS.

As a policy maker:

To ensure safe blood supply.

To promote female controlled barrier methods and provide quality condoms.

To empower women through development programmes.

To ensure stringent law enforcement.

To publish and promote HIV/AIDS education materials from women's perspective.

At the State level :

To deal with HIV/AIDS, conduct special training programmes for government health functionaries, including the doctors to provide technical information related to AIDS and medico-social aspects.

To integrate AIDS/STD programmes within the existing programmes focusing on women's health and development.

AIDS education will be most effective if the whole community is aware and encourages safer lifestyle. HIV positive people need support both within and outside the community. Unless women are in position to control their own lives, it is difficult to prevent HIV spread.

What CHETNA envisages to do.....

CHETNA envisages to develop HIV/AIDS related educational materials in local languages and disseminate it for the benefit of the community, particularly highlighting it's effects on women.

CHETNA would also incorporate AIDS education in the health programmes for women and in sex education campaign for adolescents.

It would make strategic training interventions at different programme levels on gender issues to improve women's status in society.

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A Bird's Eye View on Breast Cancer

Do You Know ?

- Breast Cancer is the third commonest cancer in the world, and it is the commonest cancer among women in world.
- In India one in twelve women during her age up to 65 years has a chance to get a Cancer.
- The rate of breast cancer in India is rising. It is estimated that in year 2001 there will be 80,000 new breast cancer cases in India.
- Breast Cancer is more common among urban women, compared to rural women. The rate of breast cancer in urban women is 22-28 per 100,000. In rural women it is 6 per 100,000.
- In India breast cancer is second commonest cancer in women, however in cities like Ahmedabad and Mumbai breast cancer is the leading cancer among women.
- Men too can develop breast cancer, but it is very rare.
- Early diagnosis and prompt treatment can give better results and may cure the breast cancer.
- Breast cancer surgery includes removal of axillary lymph nodes. If they are not removed, the treatment remains incomplete & disease may become fatal.

Your Contribution in Fight Against Breast Cancer

As a Patient of Breast Cancer

- Do not consider breast cancer as a stigma. Enjoy and move freely in society.
- Do not avoid questions related to breast cancer by friends & relatives, provide them clear & correct information on breast cancer.
- Meet other breast cancer patients and exchange experiences and information.

As a Doctor

- Acquire scientific information on breast cancer regularly.
- Discuss breast cancer with patient and provide timely and correct guidance.
- Sensitise yourself with social factors related to breast cancer.
- Create facilities and provide congenial atmosphere (privacy) for diagnosis of breast cancer
- Assure future cooperation to patient during treatment of breast cancer.
- Do not treat breast cancer if you cannot remove axillary lymph nodes. Refer the patient to a cancer specialist.

As Corporate Sector

- Provide information your breast cancer in simple local language to all men and women workers. Arrange regular diagnostic camp and talk on breast cancer.
- Allocate some part of your profit for fight against breast cancer.

As a Manufacturer of Cosmetics

- Include pamphlet of breast cancer with cosmetics or print messages about breast cancer on the cover of your products.

As a Voluntary Organisation

- Organise seminars and discussions on breast cancer.
- Print and widely disseminate educative information through booklet or pamphlets in local languages.
- Establish links with organisations working against breast cancer.
- Sensitise various strata of society towards women's health and start movement for women's health rights.

As a Media Person

- Print lead articles presenting social attitude and positive outlook on breast cancer.
- Popularise self breast examination by providing information regularly.
- Broadcast and telecast breast cancer related messages.

As a Policy Maker

- Give special attention to breast cancer in programmes related to women's health and medical education.
- Create facilities & allocate budget for breast cancer detection and treatment.
- Provide information on breast cancer in simple local language.
- Join hands with organisations working against breast cancer.

As a Woman

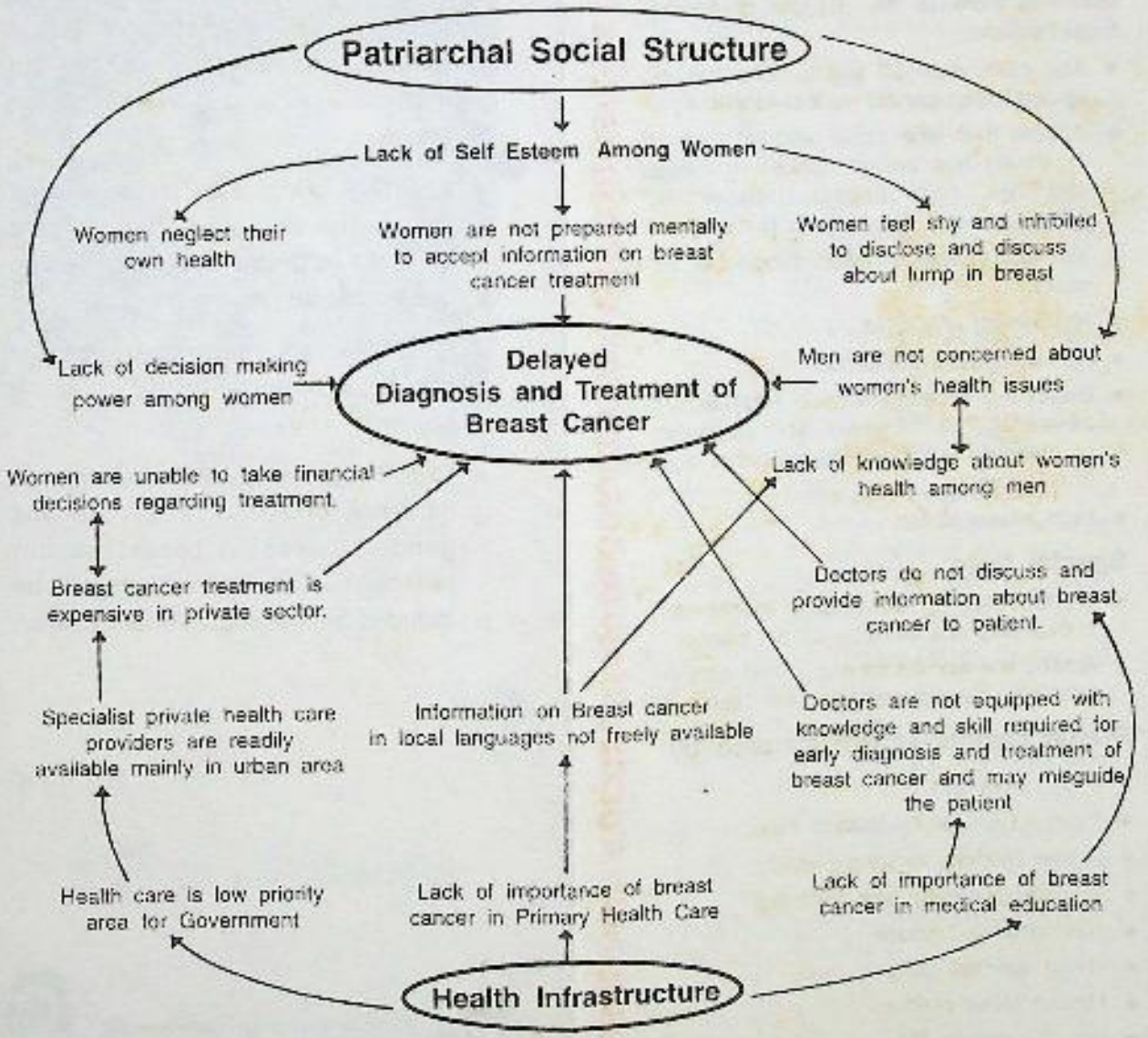
- Do not neglect your health.
- Perform breast self examination every month after age of 20 years.
- Get mammography and examination of breast by a trained doctor or nurse regularly after age of 50 years.
- If you feel a lump in breast, do not hesitate and go for early diagnosis.

As a Man

- Women are pillars of any society. Take interest in women's health issues.
- Be aware about breast cancer.
- Your informed and positive attitude is necessary for early diagnosis and correct treatment.

WH-114

Factors Responsible for Delayed Diagnosis and Treatment of Breast Cancer



Risk Factors of Breast Cancer

The exact causes of breast cancer are not yet known, however some risk factors are known to increase the chances of getting breast cancer.

- Age more than 50 years. The risk of having breast cancer increases with age.
- If more than one close relative (mother or sister) has breast cancer. If these relatives had breast cancer in premenopausal age the risk is more.
- The first delivery is after the age of 30 years.
- Not having any child.
- Not breast fed the child.
- Beginning of menstruation (menarche) before age of 12 years and stoppage of menstruation (menopause) after age of 50 years.
- High intake of fat.

Special Note

- Women having risk factors mentioned above may not develop breast cancer.
- Among the women having breast cancer only 30% have presence of risk factors.

Breast Cancer is Not Caused by

- Injury to breast
- Injury to breast by infant's head
- Breast feeding for long period
- Wearing synthetic and tight bra
- Having large breasts
- Using scented soap
- Having more children
- Sin of previous life

What CHETNA Aims to Do ?

- CHETNA will disseminate important and essential information on breast cancer, and will function as an information and dissemination centre.
- CHETNA will create awareness of link between social factors and medical infrastructure facilities in breast cancer treatment.
- CHETNA will incorporate breast cancer concerns in its ongoing trainings.
- CHETNA will undertake research on influence of social factors on and gender biases in breast cancer treatment. This information will be included in the educational material.

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HEALTH OF WOMEN IN INDIA'S FAMILIES

Did You Know...

Women in India contribute 53%
of all hours worked,
while men contribute 31%.

Women require an average of
2200 calories per day
and yet receive only about 1400.

Girls are less likely to be vaccinated than boys,
or to receive medical care when needed.

Women are more likely to fall ill
than men, yet less likely to receive
preventive or curative care.

Overall, the health status of Indian women
ranks among the lowest in the world.

The family has a role to play in perpetuating this situation. But it can also be an important source of improvement in women's health.

Women's Health in India's Families

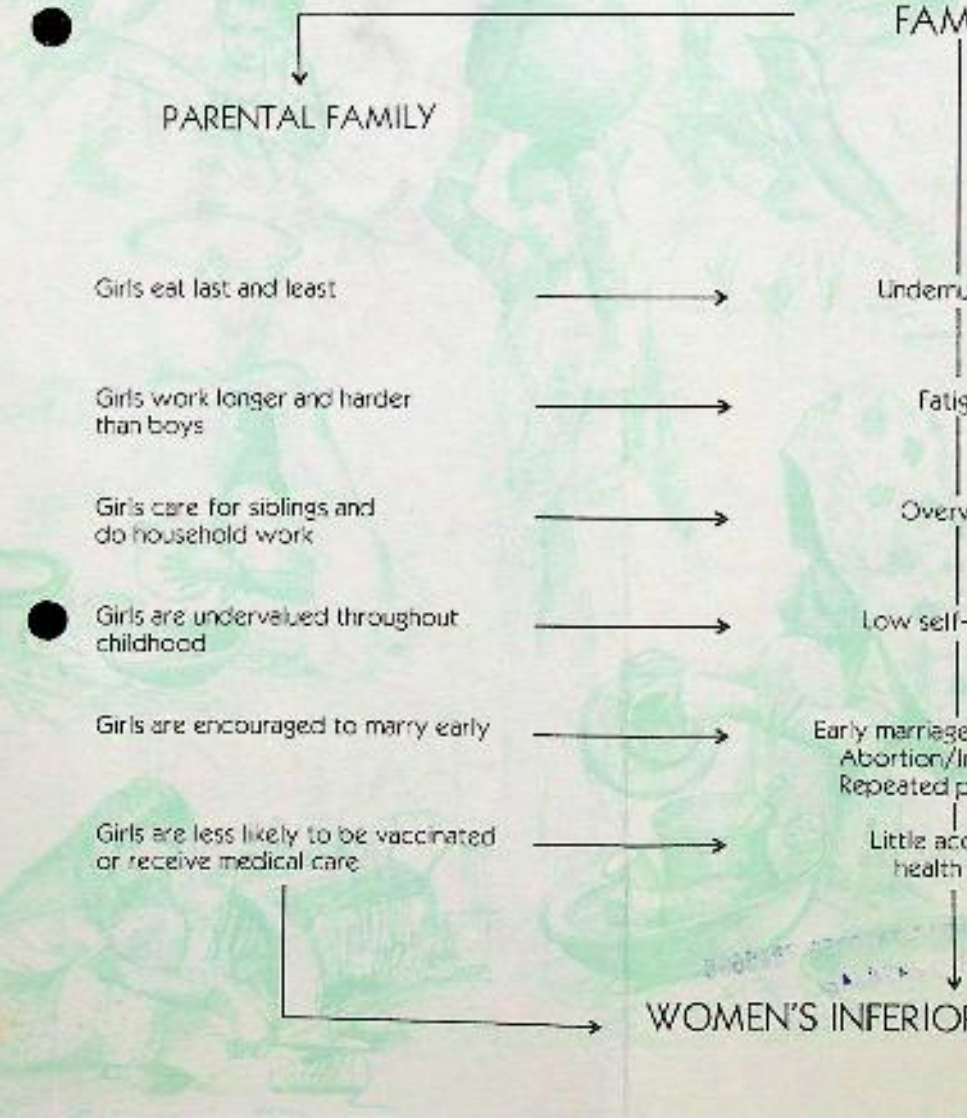
Throughout their lives, Indian women suffer from poor health, in part because of the lifelong discrimination within their parental families and their families by marriage.

Through childhood, in their parental homes, girls are considered less valuable than boys. Deprived of nutrient and calorie-rich foods, they are often overworked, shouldering responsibilities for child-care and domestic tasks. Girls are trained early to expect exclusive responsibility for reproductive labour, in addition to contributing to 'productive' work.

Discrimination often continues in a woman's new family. Under-valued, and viewed as a labourer in her new home, the daughter-in-law eats last and least, yet works longest and hardest, often combining both reproductive and productive tasks. She is likely to suffer enormous pressure to give birth to a son to 'continue the family line'.

The cumulative effect of this familial discrimination is women's lifelong inferior health status. Undernutrition, fatigue, and low self-esteem, combined with early and repeated pregnancies leave women anaemic, at high risk of dying during childbirth, and susceptible to disease. Their lower access to preventative and curative health care aggravates this situation.

THE INDIAN FAMILY AND



What CHETNA Does?

CHETNA undertakes awareness-raising activities surrounding issues of women's overall inferior status and condition in Indian society.

CHETNA actively advocates and lobbies to bring the issue of women's inferior health status to the fore, and encourages India's Central and State governments to act not only to improve women's health, but their overall status and condition.

CHETNA's programming takes a life-cycle approach to women's health, considering a woman's needs and the discrimination against her from birth until old age.

CHETNA encourages change to begin at home, within the family.

What You Can Do...

The family can take concrete actions on a daily basis to improve the lives of their daughters, daughters-in-law, sisters, wives, and mothers. Distributing food equitably, sharing workloads and domestic responsibilities, being conscious of women's health concerns -- each of these will help to improve the health status of India's women.

As a woman:

Be aware of your health needs, and recognize your need for adequate food, rest, and health care. Physical pain and discomfort need not be part of everyday living. They are a cause for concern and treatment.

As a mother or mother-in-law:

Ensure that your daughter or daughter-in-law receives enough food and rest. Try to distribute the workload equally between your daughter and your son.

As a father or father-in-law:

Recognize that your daughter or daughter-in-law's health needs are as important as those of your son. Sharing housework will help to see that her needs are met.

As a brother or brother-in-law:

Notice whether your sister or sister-in-law is receiving ample food, rest, and care, and stand up for her if she isn't. Help to ensure that she is not over-burdened with work.

For more information about CHETNA, please contact...

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CHETNA: TRAINING FOR WOMEN'S EMPOWERMENT

CHE-TNA

Training For Women's Trainers Empowerment

CHETNA's Training of Trainers strategy helps to empower women. With participatory approaches, trainers are equipped with the knowledge, skills, and awareness to contribute more effectively in their work at the community level, to the empowerment of women.

Based on a fundamental respect for people's knowledge and abilities, CHETNA designs participatory TOTs which are learner-centred, and geared to the needs of participants themselves. Drawing on the experiences of participants, using an activity and group-based approach, CHETNA's TOTs focus on learning which is relevant to daily living.

Participants gain an *awareness* of the broader social, economic, and political issues affecting women and men, and an understanding, both intellectual and emotional, of gender discrimination. They acquire new *skills* on the basis of needs which they themselves identify, skills which will improve their work at the field levels. Building on pre-existing knowledge, participants gain new *knowledge*. Ultimately they achieve a synthesis of the two, and gain a sense of 'ownership' over that which they know.

The awareness, skills and knowledge generated through CHETNA's Training of Trainers programmes increase the self-confidence of participants, strengthen their ability to articulate their interests and analyze their situations, and motivate them to take collective action to work for change.

Work at the field level is strengthened and improved, as trainers adopt participatory approaches. They share the knowledge, skills, and awareness gained through CHETNA training. In the long term, CHETNA's TOTs lead not only to empowerment of trainers, but to the empowerment of women at the community level.

Training of Trainers at CHETNA...

CHETNA undertakes Training of Trainers in Gujarat and Rajasthan as part of its capacity-building strategy in both non-governmental and governmental organizations. With over ten years of experience, CHETNA specializes in TOTs on women's health, traditional birth attendant training, traditional medicine, and women's development.

Over the years, many middle and upper level professionals have been trained to sensitize their own trainees, and to raise awareness of social and gender issues affecting the daily lives of women and men throughout India.

They have learned to better share knowledge, increase skills, develop educational and training materials, as well as conduct needs assessments, baseline surveys, and qualitative and participatory research.

CHETNA places the utmost priority on conducting *participatory* trainings, creating warm and supportive learning environments, and encouraging participants to recognize that which they already know. CHETNA equips trainers with the tools to conduct their own trainings in the same way.

If you would be interested in attending or having your staff attend a TOT conducted by CHETNA, please let us know.

TRAINING FOR WOM

TRAINING C

Participatory

Needs-based ar
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Group as fo

Awareness

Issues considered in their social, cultural, political, economic and gender context
Understanding underlying causes of problems affecting oneself

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Participants learn n
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Ability to articu
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Motivation to tal

WOMEN'S EM

GENDER AND WOMEN'S HEALTH

Did You Know...

Every year, in India, 12 million girls are born. 1.5 million die before their first birthdays, another 850,000 die before their fifth birthdays, and only 9 million will be alive at the age of 15.

The average nutritional intake for women in India is only 1400 calories daily. The requirement is approximately 2200.

70% of women in India suffer from anaemia, and 92% suffer from gynaecological diseases.

More deaths due to pregnancy and childbirth occur in India in one week than in all of Europe in one year.

A woman's likelihood of dying during pregnancy or childbirth in India is 1 in 18, as compared with 1 in 9850 in Northern Europe.

The sex-ratio in India is only 929 women per 1000 men. This means that 22.5 million Indian women are currently 'missing'.

What CHETNA Does?

CHETNA is working for education, awareness, and empowerment of women, by strengthening the efforts of grassroots NGOs, teachers, traditional birth attendants, health care workers, and government functionaries.

Not only by attuning these workers to the specific health concerns of women, but also by raising awareness regarding the social imbalances which underlie these concerns, CHETNA is tackling head on the situation of women in India today.

Chaitanyaa, the Women's Health and Development Resource Centre has grown out of CHETNA's commitment to women. Chaitanyaa recognizes that efforts to improve women's health must be linked to an understanding of the underlying issues and causes, and sees efforts to improve women's health as part of the broader struggle to improve women's overall status and condition.

Gender and Women's Health

Women, like men, have basic physical health needs including adequate food, rest, and access to health care. But, because of their reproductive capacities, women's bodies have particular biological needs over and above those of men. Menstruation, pregnancy, lactation, menopause, and overall gynaecological health require higher nutritive intakes -- more iron, more protein -- throughout a woman's life.

Implications of Gender...

For social reasons, that is, by implication of their *gender*, women's physical needs are often not met. The higher social value accorded to boys and men, women's lack of decision-making power, the unequal division of labour, and various traditional beliefs leave women working harder than men, for longer hours, while consuming inadequate quantities of nutritious food.

The results...

For women's health, the results of this imbalance are startling. In India, girls and women have poorer health than their sisters in other parts of the world: lower life expectancy, higher levels of morbidity, and maternal mortality among the highest in the world.

The solution...

Clearly, women's health cannot be improved with only the use of vaccines, medicines, or tablets. Real improvement in women's health requires that India address the social inequalities and discrimination underlying women's overall inferior status.

GENDER AND W

HEALTH NEEDS OF WOMEN

THROUGHOUT A WOMAN'S LIFE
Adequate food, rest, and health care

DURING MENSTRUATION:
5 times as much iron

DURING PREGNANCY:
Extra rest
Food
20 times as much iron
Pre-natal care

DURING LACTATION:
More food, especially dairy products

DURING MENOPAUSE
Emotional support

DURING OLD AGE:
Calcium and iron rich foods
Emotional support

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Sex and Gender

SEX...

The sex of a person refers only to biology, to physical traits such as chromosomes, hormones, genitalia, and secondary sex characteristics leading to the determination of people as *male* or *female*.

GENDER...

A person's gender refers to the system of socially-ascribed roles and relations between women and men, neither determined by sex nor biology, but by the cultural, social, political and economic context in which they live. Gender roles are learned through the complex process of socialization whereby *masculine* and *feminine* characteristics and qualities are defined. Gender roles vary from culture to culture and can change over time.

Analysis of these gender roles and relationships reveals imbalances in power, wealth, decision-making responsibilities, workload, and obligations.

These imbalances have very serious repercussions for women, especially for women's health.

For more information about CHETNA please contact...

CHETNA

Chaitanyaa

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ANAEMIA: SYMPTOM OF A SOCIAL ILL

Did You Know...

More than half of the Indian population suffers from anaemia.

70% of Indian women are anaemic.

Anaemia leaves many women vulnerable to diseases, less likely to be able to fight them.

Anaemia is the major cause of maternal mortality in India, where women have a 1 in 18 chance of dying during pregnancy. This compares with a 1 in 9850 chance for women in Sweden.

30% of newborn children in India suffer from anaemia.

Children born to anaemic mothers are likely to be undernourished from birth, and if they are girls, this may continue throughout their lives.

What CHETNA does?

CHETNA is actively fighting anaemia in many ways:

CHETNA's 'Training of Trainers' strategy familiarizes health workers with the issues surrounding anaemia as well as its social and physiological causes, and gives them the tools to fight it in their own families and communities.

CHETNA actively advocates and lobbies to bring the issue of women's inferior health status to the fore, and encourages the Central and State governments to act to improve not only women's health but their overall status and condition.

CHETNA has developed and disseminates an 'Anaemia Women's Health Kit', a multi-media educational package of flip-charts, stories, songs, and posters which teaches health care workers and women at the grassroots level how to fight anaemia.

Anaemia is...

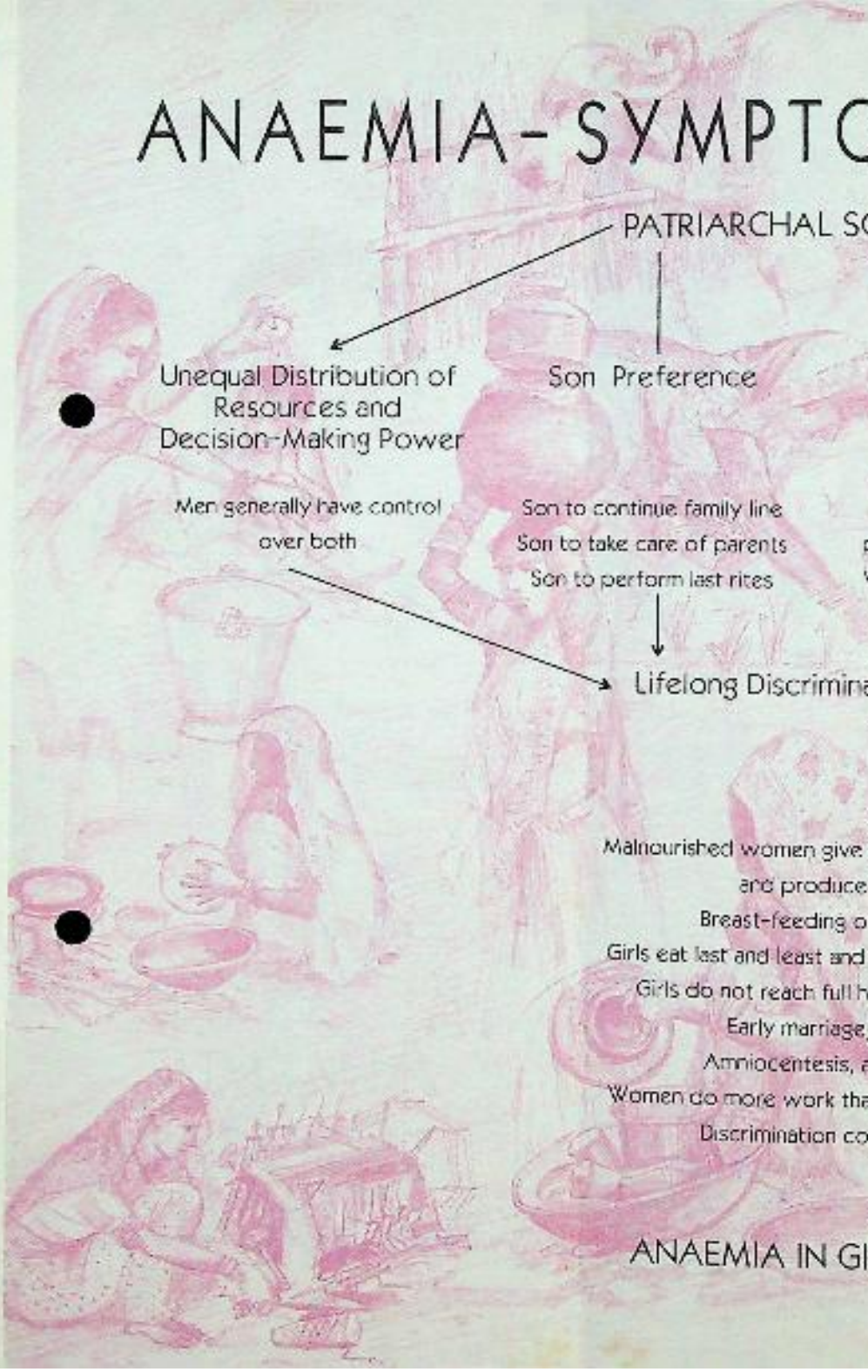
one of the most common disorders among girls and women in developing countries. In fact, in India, upwards of 70% of women are anaemic.

On the surface, anaemia seems to be simply a physical ailment, the result of low iron and protein intake, perhaps aggravated by hookworm, malaria, or haemorrhage.

But anaemia is much more complex, not only a physiological disease, but a symptom of serious social illness. Anaemia results from systematic discrimination against women from birth until old age, and is a product of a patriarchal social structure which has for centuries relegated women to the sidelines of social, economic, and political life.

Son preference, the unequal distribution of labour, resources and decision-making power, and traditional beliefs and taboos: aggravated by poverty, these lead to abortion, infanticide, halted breast-feeding, early marriage and pregnancies, and women's inadequate food intake. Women are left tired, physically weak, and undernourished. And, more often than not, they become anaemic.

The results of anaemia are tragic: women die in childbirth more often in India than anywhere else in the world; their babies have a higher chance of dying and are often born undernourished; women become vulnerable to other diseases, and are less able to fight them; and they spend the majority of their lives fatigued, thinking that weakness and pain are just a regular part of day-to-day life.



What You Can Do...

As a Teacher or Principal...

You can incorporate gender and health issues into your teaching, both in the classroom, and in your community.

As a Health Care Worker or Physician...

You can take a life-cycle approach to women's health, recognizing that anaemia, as well as the discrimination which causes it, affects women from birth to old age. Recognize that many of your female clients may be anaemic.

As a Traditional Birth Attendant...

You can undertake awareness-raising activities in your own community to ensure that anaemia is treated not just as a problem of pregnancy, but as the result of lifelong inadequate intake of nutrients.

As a Journalist or Writer...

You can use your writing skills to raise awareness, through newspapers and other publications, not only of women's inferior health status, but also of their overall inferior status and condition in India.

As a Concerned Citizen...

You can take steps within your own life to balance work with your spouse and ensure that all of your family eats adequately and gets plenty of rest. Remember, anaemia can affect your wife, daughter, sister, or even you.

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for more information about CHETNA please contact...

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Fax-91-079-7866513-0420242

CHETNA

Chaitanyaa

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CHETNA

The Beginning

CHETNA, which means 'awareness' in several Indian languages, is an acronym for Centre for Health Education, Training and Nutrition Awareness. It was established in 1980 as a project to improve the impact of supplementary feeding programmes for women and children, in Gujarat, India.

Mission : CHETNA's mission is to contribute towards the empowerment of disadvantaged women and children so that they become capable of gaining control over their own, their families' and communities' health.

Presently, CHETNA works for **education, awareness** and **empowerment,** by supporting and strengthening the work of functionaries of Government and Non-Government Organisations (NGOs), Individuals and Educators working to improve the health of women and children.

Geographical Outreach

CHETNA primarily works in the States of Gujarat and Rajasthan, in India.

CHETNA's Ideology

- **Strengthening existing efforts prevents duplication...**

CHETNA supports ongoing efforts of Government and Non-Government Organisations, health professionals and community groups to improve their work related to health and development concerns of the community.

- **Information leads to empowerment...**

CHETNA realises that information is an indispensable input in the process of development and is critical in terms of policy making and programming.

CHETNA makes efforts to bridge the communication gap that exists between the grassroots and policy makers, funders and programme implementors ensuring that information on experiences of innovative, viable and relevant development is disseminated widely.

- **A participatory approach is the cornerstone of empowerment and it is particularly essential at the field level...**

Participation enables people to take greater control over their lives, over the problems which confront them and the solutions which challenge them. Community based development requires that people define their own health needs, and that solutions come from their own context. Focusing on health and nutrition, CHETNA uses participatory methods to empower women and children.

- **Drawing from the knowledge of the community...**

CHETNA makes efforts to demystify modern health knowledge and share factual information with the community. Strengthening existing health systems, it also draws on the richness of traditional health knowledge and practices and encourages people to use the knowledge they already possess to address their health concerns.

- **Need-based education respects people's differences...**

CHETNA plans and develops need-based education and training modules and materials which are responsive to priorities of the people themselves. Every training session, each information package, and every activity is tailored to meet people's felt needs.

- **A life cycle approach...**

CHETNA addresses the health concerns of women from infancy to old-age including, early childhood, school age, adolescence, adulthood and old-age through the activities of its two Resource Centres namely, **Child Resource Centre (CHEITAN) and Women's Health and Development Resource Centre (Chaitanyaa).**

CHEITAN Committed to Children...

- **A child centred and gender sensitive perspective...**

CHEITAN works with a child-centred, gender sensitive perspective, valuing each child and recognising her/his right to blossom and grow as an unique individual not merely as an investment for future but, for what s/he is today.

- **Giving children a choice in learning...**

Curious and creative, children quickly grasp health and nutrition messages and can be assisted to take control of their own health, that of their families' and communities'. Using a 'cafeteria approach' to health education, CHEITAN encourages children to select the information most useful to them.

- **Learning by doing...**

Through games, puppet shows, songs, drawing, painting, story telling, children are encouraged to take part in shaping their own health and nutrition messages. To make learning interesting, CHEITAN develops and uses activity-based, innovative approaches.

- **Children as partners in health...**

CHEITAN does not consider children as passive recipients of health care. Instead, it realises that children are capable and have a right to be considered as partners in health. It recognises that they are effective change agents for the health and development of the community.

Vision

CHEITAN envisages empowered, healthy and happy children who can contribute to the development of the Nation.

Mission
To empower children to become active partners of their own health, that of their families' and communities', by equipping adults working with them.

Areas of intervention
Early childhood care and development (0-6 years)
Health and education of school age children (6-14 years)
Health & development of adolescents (15-18 years)

CHAITANYAA, Committed to Women...

- **Health in the social context...**

Women's health problems reflect the diversity of social, cultural, economic and physical environment. Efforts to improve the health of women must be linked with an understanding of the underlying issues and causes. Chaitanyaa's efforts to improve women's health are a part of the broader struggle to improve their overall status and condition.

- **Empowerment through awareness...**

Chaitanyaa works to raise women's awareness, by providing opportunities and tools to reflect on their social, political and cultural status and encouraging them to take action to improve the quality of their lives.

- **An integrative and holistic approach...**

Chaitanyaa recognises that women's health encompasses their social, physical and psychological well being and these need to be addressed in an integrative manner.

Chaitanyaa does not see women merely in their role as mothers. As a holistic approach, it considers focus on all stages of women's lives important.

- **A gender sensitive and realistic perspective...**

Chaitanyaa recognises that gender discrimination is one of the important determinants of women's low health status. Therefore, understanding and addressing the implications of gender relations and enlisting the participation of men and the community, is central to its efforts in enhancing women's health and development.

In its analysis and approach, Chaitanyaa considers the totality of the political, economic and social factors that shape women's environment particularly, which affect womens' ability to control and improve their health status.

Vision
Chaitanyaa envisages an egalitarian and just society where empowered women live healthy lives.

Mission
Its mission is to enhance women's health status by empowering them to gain control over their own health and development concerns.

Areas of Intervention
Health and development of adolescents (12-19 years).
Nutritional status of women (20 years and above).
Maternal Health, Reproductive Health, Psychological Health, Occupational Health and Promotion of Beneficial Traditional Health Practices.

Activities of CHETNA

- **Training :** Trainings are conducted by CHETNA as a strategy for sensitisation, capacity building, information sharing and networking. Capacity building is done through conducting 'Training of Trainers', workshops on specific concerns of children and women from time to time, depending on the felt need.

- **Documentation of innovative efforts, development and dissemination of IEC materials:**
Innovative methods of imparting health education are tried out by both the resource centres of CHETNA at the field level. Such efforts are documented to enable sharing of experiences and replication.

From time to time, education and training materials are designed and developed after extensive field testing for creating awareness at the community level and for sensitising policy makers.

CHETNA has also developed innovative and creative health and nutrition communication materials such as flash cards, flip charts, booklets, manuals, pamphlets, learning kits and audio-visual material. These have been found to be effective to impart health and nutrition messages to children and women particularly, among the illiterate community.

* **Networking** : Networking to share experiences, exchange materials and ideas with individuals and organisations at the regional, state, national and international level is facilitated through :

— **A quarterly newsletter**
— **Trainings**
— **Exhibitions**
— **Organising and participating in issue-based events/meetings/work-shops/ seminars/conferences.**

With the growing organisation and user needs, CHETNA is now preparing to supplement its traditional channels of communication such as, personal contacts, reports, newsletter, meetings and press releases with computer based communications.

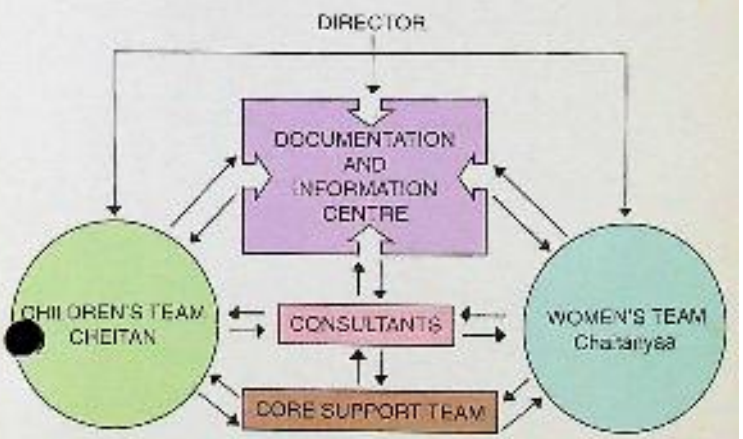
* **Advocacy** : CHETNA advocates on concerns/issues critical to health and development of women and children through-sharing of views, experiences and documents at the state, national and international forms, eg.
  — contributing in policy documents of Government of India or in country papers to be presented at International forums.
  — providing input during appraisal and evaluation missions in Health, Education and Development Programmes of Women and Children.

Newsletter : CHETNA publishes a quarterly newsletter, CHETNA News, in English. The objectives of this newsletter are to provide readers with information useful for strengthening service delivery, to share field level experiences of the CHETNA team, advocate and promote innovative programme interventions related to health education, training, nutrition awareness and above all serve as a tool for networking. It covers all major activities of CHETNA and some other organisations, information on new resources and sources for further information.

CHETNA's Documentation and Information Centre

A Documentation and Information Centre has also been established at CHETNA specifically, to address the information needs of individuals, Government and Non-Government organisations, working in the field of women's health and development and child health and education.

CHETNA'S ORGANISATIONAL CHART



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http://www.undp.org/cairo.html

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5. The Earth Times/**POPULATION**: India's made some progress, says head of UN populati - **POPULATION** zimanhp2_10_22.jpg Wasim Zaman India's made some progress, says head of UN **population** wing redarrow.gif - 0.1 K By VIR SINGH (c) Earth Times News Service n.gifEW DELHI--After heading the la
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7. 9.12.97 World **conference** on racism to be convened by UN - today/ news/ markets/ cyber/ money/ mining/ companies/ forum/ africa/ headlines/ columns/ search/ prices/ jobs/ unit trusts/ broking/ property/ woza/ archive WOZA December 9, 1997 World **conference** on
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8. EMF - United Nations Fourth World **Conference** on Women in Beijing - **UN** 4th World **Conference** logo BYTES FROM BEIJING... Among the 35,000 plus women gathered in Beijing and Huairou in September 1995, ten were from The Feminist Majority. Here are on-site accounts that Fe
http://www.feminist.org/other/b/bytes.html

9. Population Resources on the Web - Return to Population home pageReturn to Population home page Population Resources on the Web Horizon Solutions Site Provides cases studies of population solutions worldwide and an opportunity to discu
   http://www.weadapt.org/resources/page1/resources.html

10. UN birth control plan - UN birth control plan TOKYO (UPI) -- An action plan drawn up by a U.N. affiliate calls for worldwide birth control by the year 2015 in line with a drastic reduction in infant and maternal mortality.
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