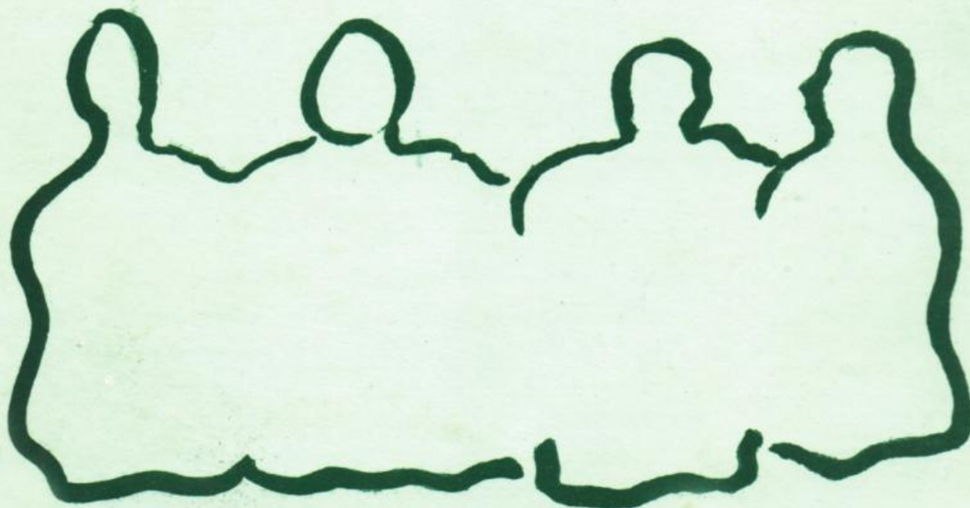
WOMEN AND HEALTH POLICY IN SOUTH ASIA STRATEGIES FOR CHANGE

November 9-13, 1999.
New Delhi

Workshop Proceedings



Organised by

SANGAT
South Asian Network of Gender Activists and Trainers
and
JAGORI
A Women's Resource Centre

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WOMEN AND HEALTH POLICY IN SOUTH ASIA

Introduction to Sangat

The countries in South Asia share close historical, political and cultural links and there are broad similarities in the causes and nature of poverty and situation of women. There is therefore a need to create common forums for learning from varied experiences and joint policy making across boundaries. The situation of women in South Asian countries is characterized by gender inequity and subordination. Women lag behind men in all indicators of social and economic development – sex ratio, education, health, nutrition and so on. Women are concentrated in low paid and unskilled jobs, earn lower wages and generally do not own property and economically productive resources. They are largely excluded from structures of governance and justice and from processes of economic, social and political decision making.

Women are also excluded from and adversely affected by present models and trends of development, which have resulted in increasing impoverishment and hunger, landlessness, environmental degradation and marginalization of the poor. Issues of women's development cannot be seen in isolation from other issues such as militarization, increasing communal and ethnic violence, religious fundamentalism and the impact of marketization and globalization on the economies of these countries. These forces act collectively to further constrain women's spaces and roles and reinforce existing patriarchal institutions, relationships and values. The socio-economic variables involved in the developmental processes need to be looked at from the women's point of views.

The South Asian Network of Gender Trainers (SANGT) was created in April 1998 during a South Asian workshop of gender trainers in Koitta, Bangladesh. The founders of this network were 27 women and men from the five countries in the region. The main objectives for creating this network were as follows:

* to keep in touch in order to expand and strengthen bonds of solidarity
* help evolve a South Asian perspective on issues related to gender and development.
* to bring to centrestage women's concerns and issues in all development debates
* help lobby for a gender perspective on all issues at the South Asian and national levels

It was decided that the network should have a rotating secretariat and for the year 1998-1999 it was with Bedari in Pakistan. In April 1999 the secretariat moved to Jagori in India. At that time the name of the network was changed to SANGAT (South Asian Network of Gender Activists and Trainers) so as to include a wider constituency. Three workshops have been organized under the banner of SANGAT:

* **Workshop on Self Awareness and Self Growth** held in Islamabad in April 1999.
* **Workshop on Women and Health Policy** in New Delhi in November 1999
* **Workshop on Information and Know how** held in Pune in February 2000.

This network has now grown to over 300 organizations. SANGAT also brings out regular newsletters which include contributions from its members in all the countries. The newsletter has been conceived of as a space for dialogue on issues of concern to all of us.

Background to the Workshop

With increasing globalization and privatization, health has become a commodity. The role of the state in providing health services is changing and international development agencies, non-government organizations and pharmaceutical companies amongst others are more actively involved in the health sector than ever before. Thus we decided that the focus of the workshop would be on health policy.

We wanted the workshop to be progressive and provide concrete grounds to build upon, rather than just a critique of policies of the state and international agencies. The truth is that we have all been struggling to find alternatives and women/people - friendly ways of delivering and accessing health. We therefore felt that it might be useful to bring together some of these different initiatives and collectively reflect and build upon them.

Having decided this, the next step was to plan the format of the workshop. We met several people during this formulation stage who gave us valuable input. We finally decided to go in for a format where case studies of different initiatives linked to the understanding, provision and delivery of health care and services would be presented by groups and individuals who had been working in the field for at least five years. The case study format enabled us to have detailed presentations on several issues and also build on experiences of different organizations and groups who have been doing rich work on the field and at the grassroots level.

One of the main critiques from women's groups and health activists has been that women's health has been translated only to reproductive health, and often more narrowly to family planning. It is imperative for us to broaden the canvas of women's health issues and that was one of the factors in planning the workshop. The effort was to have a wide range of issues relating to women's health to situate the broad framework within which we need to address women's health issues. In addition, there was a presentation of the overall health status and concerns of each country in order to set the stage for the following papers and discussions.

As the focus was on policy, it was decided that the workshop should also provide space for a dialogue with people in positions of power and decision

making. A symposium was organized at the end of the workshop where policy makers in the governments and international and donor agencies were invited.

We hope that this workshop leads to more dialogue between the different sets of actors who have a stake in women's health issues –the state, donor and international agencies, women's groups, health activists and most importantly, women.

The Workshop

The workshop was held in the sylvan surroundings of the Sanskriti Kendra at the outskirts of New Delhi. It is a creative and sensitively designed artists village which has been the host for many of Jagori's workshops. The staff was courteous and non-interfering but always there when we needed them.

The participants were men and women who have been working in the field of health and specifically addressing issues of women's health. Since the format of the workshop was a series of presentations, all the participants were themselves the resource persons. There were seven participants from Pakistan, eight from Bangladesh, 20 from India and one each from Sri Lanka and Nepal.

The workshop was very intense, stretching late into evening. On the first day, we had a special evening session with Dr.Zafarullah to discuss the upcoming People's Health Congress. Friends from Jagori and our community group joined us one evening to perform their play and this was followed by music and songs from all participants. The participants managed to find time to go into the city for shopping at 'Delhi Haat' and to catch the late show of contemporary Hindi films. There was also lots of music and dancing in the evenings which provided the spaces for us all to get to know each other better.

Welcome Speech

Kamla Bhasin
FAO-NGO South Asia Programme

Feminists have taken the lead to break barriers between countries and understanding has survived through difficult times in war and peace. SANGAT was born in April 1998 with dreams of peace, justice and equality in South Asia. Feminists started making connections in a holistic and ecological way and realised that there could be no development without peace. Health was integrally linked to agriculture and trafficking was to be understood in relation to rural livelihoods. The real agenda was to make friendships across borders.

"Development" has not reached the majority of people, but infact to many it has spelt the death of culture, livelihood, self-respect and ideology. Something positive must emerge from this darkness and we must look towards alternate people friendly initiatives in development done by NGO's to set examples for us. The instance of an organization in Cuba winning the Right to Livelihood award for good organic agriculture is heartening.

The fight is to have people control their own resources especially now as everything is being patented. The main challenge is thus to have people control what is theirs and stop the government from giving it away to national and international capitalists.

One should be averse to "there is no alternative" (TINA) syndrome which is the biggest danger to South Asia in terms of free trade, globalization, SAP. We need to believe in "there is an alternative" and the majority of the world is with us. The need of the hour is to move away from the profit-oriented paradigm, militarization, tragic nuclearization of South Asia and unacceptable wars like Kargil.

This workshop is an opportunity for people from South Asia to come together to share some of their concerns and experiences in their work on health. We hope that it will lead to shared learning and initiatives in the region on health issues, since many of our concerns are similar.

Health Policy in India : An Overview

Dr. Rama Baru
Jawaharlal Nehru University, India

The evolution of health policy in any country can be studied in two ways :

* As a series of landmarks marked by committee reports and plan documents or
* As a process which reflects the changes in the overall socio-economic development of any nation.

The former approach is important to get a sense of policy direction; however it does not give any insight into the reasons for the choice or shift in policy. By merely analyzing health policy without placing it within the policy on social security will be a partial analysis. Similarly one also needs to examine the ways in which social security is conceived of and the patterns of provisioning that arise out of it. For evolving strategic changes we need to explore the links between health, social security and the economic policies over time.

The manner in which social security services are planned for a population depends on how its role is conceptualized. There are broadly three ideological positions from which social security can be viewed :

* As a right
* As an investment
* As a consumption

When social security is viewed as a right then the access to full employment becomes fundamental and it is upon this that all other social programmes are built. The integrated view of economic and social policies is seen in many of the socialist countries. In most capitalist countries, social security schemes are seen as necessary for protecting certain sections of the population that are considered to be vulnerable viz. the unemployed, the disabled and the elderly. When a society views social security as a 'consumption', then it is largely the responsibility of individuals to take care of their needs. Here the state plays a minimal role for providing protection to the vulnerable sections of the population.

China and India started their health programs at the same time and today China has a health care system on par with developed countries as they created social security systems which addressed food security and livelihoods. In China, communicable diseases are no longer the main causes of death and illnesses. Maternal mortality has also gone down. Many European countries have come up with excellent social security systems which have focussed both on the individual and a strong state component. The American model is primarily consumption based and the individual has a more important role than the state.

In India at the time of independence, the Bhore Committee recognised the need for locating health policy in relation to social security and economic development. This integrated view of social security was

seen in the first two plans when the state invested in anti poverty programs and food security through the Public Distribution System.

The second five-year plan recognized the need for economic development and full employment to all its citizens. India has had a number of social security programs since independence, but the financial outlays have been inadequate. The social security schemes include PDS, social assistance, poverty alleviation programs and provisioning of health services through the Central government. There have been several state governments that have initiated social security programs such as the midday meal in Tamil Nadu and the Rs 2 per kg rice in Andhra Pradesh, the Employment Guarantee Scheme in Maharashtra, head loaders pension scheme in Kerala. Most of these have been financed through general taxation.

There are two striking points to note about social security schemes – firstly there has been little synergy between the overall economic policy and social security schemes and secondly the social security policy has been fragmented and under-financed.

Health policy has focussed largely on health services and family welfare. Though the focus in the early years was on building an extensive primary health care network, over the years the priorities shifted to building secondary and tertiary care. The investments in health have been registering a decline through the successive plan periods. There has also been little discussion on the role of private interests in the health sector although both medical and pharmaceutical interests have been accommodated.

In 1982 there was a shift in the health policy and it was the first time that a government document stated that it could not be the sole provider of health services. The involvement of the private sector and NGO's was sought. Concessions were given to the private sector. This was followed in the 1990s by the structural adjustment programs period which was a period of further disinvestment in health and social security. The World Bank has become a central actor and it has provided soft loans with conditions. In Latin America, the World Bank prescription was to close state intervention and the private sector was given free hand and this resulted in a total failure. It is therefore essential for the state to continue as the main provider of social security and health care since NGO's and the private sector cannot replace the state.

We need a public health system to regulate relations between the primary, secondary and tertiary sectors. Change should also come in the health bureaucracy. Women's health issues have been largely restricted to deal with family planning and population control. The focus has been on maternal and child health, with a strong element of fertility control. There are also many new challenges for the health system such as the resurgence of communicable diseases like malaria and tuberculosis. We need a health care system that is responsive to the needs of people, especially the poor, who find it difficult to access good private health care.

Discussion

* **Outlay for health policy from budget** - The problem of lack of funds for health services needs to be looked at. Since the tax base has been reduced, money for investing in the public health becomes less. Further, loans from World Bank come attached with conditions like buying modern medical equipment produced by the first world. This leads to a drain in resources. The issue of whether user fees can be used to generate revenue and make the health system more sustainable was discussed. However, user fees do not generate the kind of revenue required in the health sector.

* **Public doctors doing private practice** - Some state governments have banned government doctors from private practice, but the powerful doctors lobby has protested and managed to revoke the order. This practice is so deep rooted that a strong government policy is required to tackle this. Small and medium sized nursing homes need government doctors who divert their patients to them.

* **Maternal, child and reproductive health policy have become linked to population policy** - MCH services were not actually meant for fertility control, but were for poor people who had very high maternal and child mortality.

* **Integrating multiple healing systems into the health policy** - Despite the existence of different healing traditions in the region being actively used, these have been sidelined in the national policies. The role of women as health care providers has also not been recognized since they have mainly been associated with alternate healing systems.

Health Policy in Bangladesh : An Overview

Nasreen Huq
Nari Pokkho, Bangladesh

The life expectancy of women in Bangladesh is 57 years. Maternal mortality is very high [450-600 per 100,000 live births]. Deaths due to unnatural causes [burns, poisoning, snake bite, accident, homicide and suicide] have an even higher rate than maternal mortality. Nutritional status of women is also quite low. Many women have chronic energy deficiency and 50% of mothers with children under 5 have low haemoglobin. Iodine deficiency affects 50% of population and women are more severely affected. The most common health complaints of women are aches and pains, gastric ulcer, weakness and reproductive tract problems.

The government outreach services at the village level are :

* **Domiciliary services**- Includes Family Welfare Assistants [FWA] and Health Assistants [HA]. Main services provided by FWA are family planning- pills/ condoms, recruitment for clinical contraceptives. Main service by HA is immunization and mobilization for health campaigns.

* **Satellite clinics**- Outreach centres providing family planning services and antenatal care and limited curative care-linked with immunization. Female para-medic, family welfare visitor provides service. Health Assistant provides immunization. Family planning clients are brought by FWA's.

Proposed community based clinics will provide static services and replace domiciliary services. Services at the community clinic will be provided by the Health Assistant and Family Welfare Assistant.

Thana level services

* Thana health complex-31 bed hospital. 8 doctors, 5 nurses, lab technician etc. In-patient services, small surgery, limited pathology. Under the health administration, 15 beds for women and children.

* Family services which control the work of the FWV's and FWA's, satellite clinics, clinical contraception.

District level services

* 50-100 bed district hospital. Post for gynecological consultant; facilities for major surgery. Full obstetric services.

* Maternal and child welfare center Antenatal care, delivery care including EOC, clinical contraception

Tertiary services

* Medical college hospitals and specialized hospital ward for women.

Abortion is illegal except to save the life of a woman. Menstrual Regulation (MR) is a means of ensuring that a woman at risk of pregnancy is not actually

pregnant. In 1979 Government of Bangladesh stated that MR services should be made available at all government health facilities at district and thana level.

The National AIDS Policy was adopted in 1995 and it recognizes human rights of all, including persons infected with HIV. It endorses confidentiality of personal and medical information. It also recognizes vulnerability of women in protecting themselves from HIV due to their subordinate status and the difficulties in negotiating safe sex, burden of care and concerns due to placental transmission of HIV. It also addresses issues of condom use, HIV testing, blood transfusion services, protection of commercial sex workers.

National Policy on Women was adopted in 1997. Actions for health include strategies to:

* Increase women's access through the life cycle to appropriate, affordable and quality health care, information and related services.

* Strengthen preventive programs that promote women's health.

* Develop adequate measures within the health system to identify and respond to cases of violence against women.

* National action plan based on National policy for women's advancement

* Undertake gender sensitive initiatives that address sexually transmitted diseases HIV/AIDS, sexual and reproductive health issues.

* Promote research and disseminate information on women's health.

* Increase resources and monitor follow-up for women's health

* Develop strategies to address the gross nutritional deficiencies in women and girls including micro-nutrient deficiencies.

The government of Bangladesh and the World Bank consortium of donors initiated the health and population sector programs. It had previously supported this as five-year population and health project. The main focus has been family planning and the aim was to broaden the focus to include other aspects of health. When the strategy was being planned the aim was to have participation by NGOs and women's groups. Special emphasis was given to stakeholders to provide support for re-unification of health and family planning. Essential services package provided jointly by health and family planning workers at the community clinic level was endorsed. Provision for local health watch committees and stakeholder participation in reviewing health services was built into the programme. There was a stipulation for annual performance review. In actuality there was no participation from women's groups or NGO's.

The reunification of the two ministries – Health and Family Planning did not happen as planned, as there was no real commitment from the 'rank and file' of the services for reunification. The focus and budget allocation remained in favour

of family planning and not women's health.

Health policy concerns for women

Essential services package and outreach services [Community clinic, satellite or domiciliary services]- does it address women's complaints other than family planning. What services are provided for contraceptive side effects? What avenues are put in place to provide full information on contraceptives to women?

Important area of work for women health activists in Bangladesh

* Monitoring grassroots implementation of health programs described in policy.

* Monitoring budget allocations

* Taking the initiative from opportunities based on ICPD (International Conference for Population and Development), Beijing, CEDAW to dialogue with government for specific women's health concerns

NGO innovations

* Gonoshasthya Kendra- female paramedics, door to door service for PHC, antenatal care and reduction of maternal mortality, infant mortality, taking ORS out of ICDDR and thus to the community.

* Bangladesh Women's Health Coalition - reproductive health services for women including MR (Menstrual regulation) with other health services.

* BRAC (Bangladesh Rural Advancement Committee) - developing the model integrating outreach services linking satellite clinics with immunization, taking pilots to scale.

Discussion

* **Integration of health and family welfare services-** While this attempt at integration is interesting in Bangladesh, in India the two services remain seperate. The integration of health and family services is definitely donor driven because of the costs involved. Now with the ICPD the reduction of cost has become a legitimate affair.

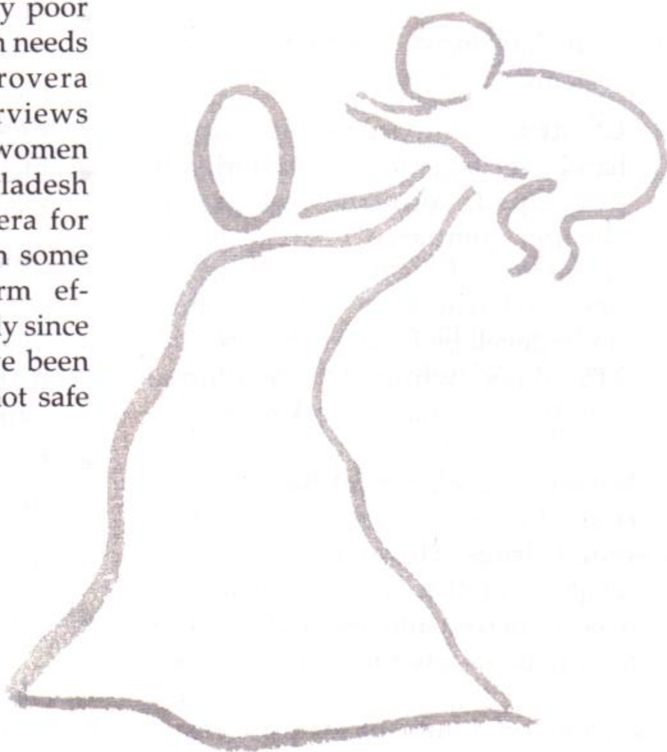
* **Need to critically look at vertical programmes and the rationale for them-** India has large number of vertical programmes for HIV, Leprosy, TB etc. More such programmes are being introduced in Bangladesh, which already has 128 such programs. World Bank report states that the personnel involved in such programmes have resulted in increased salaries. There exist now specialised hospitals for eye, leprosy but no women's hospitals. However, these programmes also duplicate infrastructure and personnel that already exists and look at specific illnesses too narrowly.

* **Lack of other systems of healing in Bangladesh** - Allopathy is dominant. Homeopathy training and certification are not very clear.

* **Role of traditional midwives** - They are accessed by 98% of the women and are the mainstay of obstetric ser-

vices, but the government does not pay them.

* **Population policy** - The 1976 population policy is outdated. The new policy will be separate from the health policy. It will include performance targets. Male sterilisation till now has been provision of lip service instead of behavioural change. Women in Bangladesh prefer pills, followed closely by Depo-Provera, which is quite common. There has been resistance to this by NGOs but it continues to be commonly used. The reasons why it is popular and commonly used is because of the advantages like its universality, return of fertility, global acceptance and WHO approval. But it also reduces lactation and induces depression in the users. The women using it in Bangladesh belong to the very poor segment of society. Research needs to be done on the Depo-Provera records available and interviews need to be conducted with women users. Since women in Bangladesh have been using Depo-Provera for around 20 years, we can gain some valuable data on the long term effects of Depo-Provera especially since women's health activists have been claiming for years that it is not safe for women to use.



Drug policy : Situation in Third World Countries

Dr. Zafarullah Chowdhury
Gonoshasthaya Kendra, Bangladesh

Some interesting statistics:

* 40% of the Indian people cannot have two square meals and the case is worse in Bangladesh.
* 7.4% Indians are unable to buy all essential drugs despite the fact that Indian drugs are the cheapest in the world.
* 60% Bangladeshi children are malnourished.
* 25% Bangladesh citizens are unable to visit physicians.
* 48% of currently prescribed drugs in USA came to market after 1990.
* USA has most expensive health systems.
* US drug companies have upper hand over federal drug authority. In developed countries drugs are cheaper compared to third world countries. To buy 13 drugs an unskilled worker in a developing/ underdeveloped country has to work 215 days while in developed countries, one has to work for 8 days.

In Britain the government has authority to compel drug companies to produce essential drugs. However, the case of developing countries is different, as they have been coerced into selling themselves to multinational pharmaceutical houses.

The common argument for price rise is huge investment on R&D. Most of the drug development research is done in developed countries and marketing is done in third world countries. [Under research expenditures like clinical development, market development etc.] Indian companies manufacture most of the drugs produced in developing countries. Many developed countries claim to spend billions of rupees on developing drugs. India has got scientists, capabilities in the area of drug research but has opened its market to multinational drug companies.

Politics of medical and health research

* The research documents related to drug companies are very difficult to locate and expenditures are not made available to the public.
* Pharma-economics is not a part of medical curriculum
* Medical information is not easily available in third world countries.
* Third World country subscribers pay higher subscription rate for scientific journals.
* Lack of knowledge is taken advantage of both by Third World drug companies and developed countries drug companies.
* Costliest drugs are the most misused

Developed countries complain that most of the drugs are counterfeited by Third World drug companies especially those

drugs whose production cost is cheap and cost price is high. But the fact is that more counterfeit drugs are produced in USA than in India.

Main issues for third world countries:

* Price of drug should be affordable.
* Book of accounts of drug companies should be transparent.
* Rational prescription of drugs by medical profession is essential.
* Technology transfer in vaccine development to developing countries so that it is affordable.

The Bangladesh drug policy of 1982 was a copy of India's policy. After that Bangladesh banned 1700 drugs some of which are still available in India. This approach raised vital questions in the British parliament, which felt that Bangladesh had played a pioneering role in this field. France is now banning drugs, which were banned by Britain in 1984.

Drug price is still falling in Bangladesh. There is no production of raw materials therefore they are dependent on imports. National companies control 60% of market and quality of drugs has improved. None of the foreign companies left despite threatening to do so. But even now the majority of people are outside health care. Some unethical drugs are officially available in Bangladesh and doctors prescribe some banned drugs.

Discussion

* **Drug Research** - Drug companies do much research on drugs and it is difficult to totally believe all the results. The research conducted by drug companies is often fictitious and major journals are also funded by them. The findings of this research are swallowed by Third World nations. Journals should declare their sources of funds. Transparency of drug companies and research into new drugs is required. Granted that companies must make profits but it could be mandated that 2% of the income before tax should be kept aside for research so that it could go to the university. Further, NGOs should act as monitoring bodies of drug research.
* **Drug Prices** - Pakistan has the second or third highest drug prices in the world. Most people feel that the costly drug is the best which unfortunately is not true for drugs. Drug prices need to be regulated.
* **Introduction of contraceptives** - In Bangladesh initially contraceptives were not included in the drug policy and were imported. The practice was that the drug must be used in a developed country to be registered in Bangladesh without proper trials.

Health Policy in Nepal

Dr. Aruna Uprety,
Health Researcher, Nepal

Peoples' right to health is being adversely impacted upon by globalization and structural adjustment policies. The liberalization of national economies favours those who own capital. Government responsibility for social welfare is decreasing. Reduction of government health budgets has affected cost and availability of services. This has resulted in :

* Privatization of public health services has led to more private hospitals and expensive drugs which are less accessible to the common people. Even in medical colleges, doctors indulge in private practice.
* Water and electricity has become more expensive which then raises the costs of health services.
* Deregulation (Removal of price control) - In private hospitals one very simple operation can cost 10 to 14 thousand rupees 3-4 times more than a salary of government officer. Oral rehydration therapy has become 300% more expensive. It was one rupee, now it is three rupees and the ORS sold by private companies are 10 rupees. Increasing user fees have been increased for health services along with decreased responsibility of the doctor. For example, medical staff in public facilities invest more time in private practice to the detriment of quality of public health services.
* Cut down in health budget - Less budget for hospitals has had an impact on services and personnel.

Primary health care has suffered due to these factors. Many local health posts are without paramedical staff. Drugs available are only sufficient for 3-4 months. Though the family planning services are still provided by the governments in rural areas, in many urban areas commercial organizations are taking over the provision of services. The government is still providing immunization but slowly it is going in private hands. Though the data shown by the government is very high, it is rather doubtful.

Education has increasingly got privatised. Privatization of medical colleges, nurse courses and ANM courses has made it affordable only for rich people. Due to privatization, health has become a commodity rather than a right.

Migration of male population for various reasons has led to more women-headed families, which has led to a double burden for women. Also the increase in trafficking has led to further oppression of women.

The Safe Motherhood program has a vision, which states that only emergency obstretic care can substantially reduce maternal mortality. DFID, a British donor agency which supports this

programme brought out a document where it stated that only emergency care can save a woman's life. Education and status in the family do not have a significant relation with the outcome of pregnancy. It also stated that antenatal care does not make much difference to the maternal mortality rate. The critique from women's groups has been that though emergency care is important, it is essential to have a life cycle approach to women's health.

Women are discriminated against in their childhood and adolescence, in terms of nutrition, education, empowerment and all these have to be taken into consideration. Secondly, the emergency approach also assumes that all pregnant women are at risk of obstetric complications.

Women's Health Policy 1997-2002

* Visible improvement in the status of public health will be brought by strengthening existing health infrastructure in the services relatedwith preventive, curative, rehabilitative and family planning services. However, at present the health infrastructure is very poor and few people have access to health facilities.
* Family planning versus population growth – the stated focus of the health policy is to shift towards family planning in keeping with the recommendations of the ICPD. At present, the family planning program provides target oriented services. These services are not available in time and insufficient counselling is provided. Contraceptive technologies that are available have many side effects.

Discussion

* **Women's Health Policy-** The government's lack of interest in women's health policy is reflected in the fact that there is no consultation with doctors and women's activists when policies are being formulated.
* **Maternal mortality** - There are two major misunderstandings about how maternal mortality can be reduced. One is that improvement in women's socio-economic development will lead to its reduction. The second misconception is that antenatal care is not linked with maternal mortality. While most obstetric complications can neither be predicted nor prevented, screening for risk factors can identify groups of women at risk. Though obstetric emergencies cannot be prevented, they can be treated. In reality both aspects have to be looked into – women's socio-economic status and emergency medical facilities.
* **Hospital facilities** - According to Nepalese Government only 8% of the population can access hospital facilities. The leading reason for hospital admissions amongst women is post abortion complications (54%). The second most important cause of hospital complications was postpartum haemorrhage (30%) which implies that there are problems both inside and outside the health facility.

Overview of Health Situation in Sri Lanka

Dr. Jaylakshmi
Centre for Human Development, Sri Lanka

In Sri Lanka, women have a very high status primarily due to the Buddhist doctrine, which stresses on the equality of both sexes. The health sector in Sri Lanka is wide reaching and accessible to everyone. Ayurveda and Western medicine are both practised and universities exist for both. The Health Ministry is divided into separate departments for Western medicine and Indigenous medicine.

A primary health centre exists for every 2-3 villages and a doctor is available at these centres. Each health care worker covers 800-1000 families. The Family Health Bureau under the Ministry of Health in Colombo gives free advice and free test for anaemia. There are three types of hospitals - national, teaching and rural hospitals. The plan is to integrate doctors from different streams.

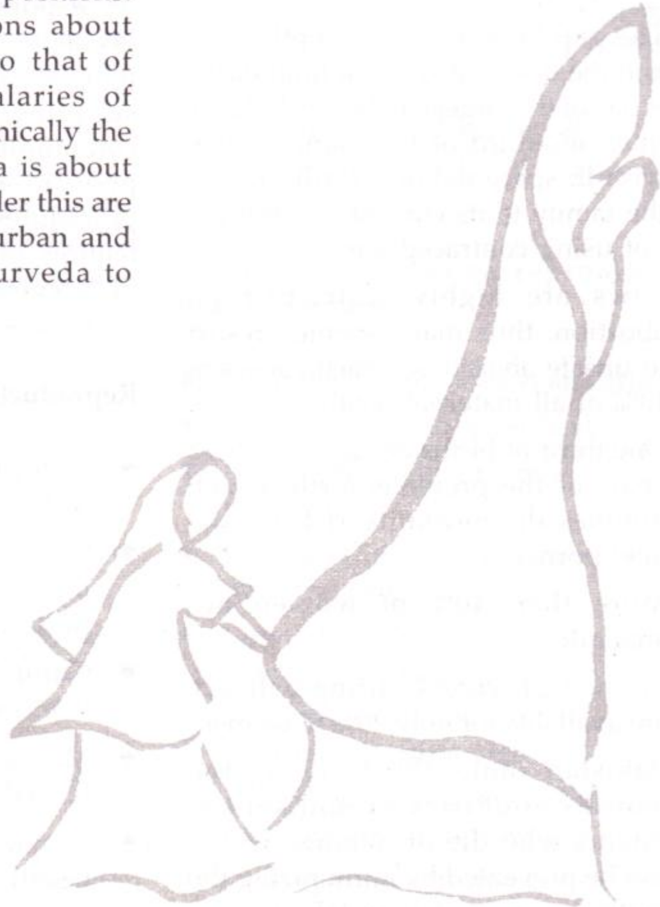
Every pregnant woman gets a card and the health worker visits her every month. This falls under the mother and child care program. Every woman is required to attend the health clinic. The worker is given midwifery training for two years along with basic knowledge of medicine. The most popular family planning methods used are sterilisation, pills and Depo-Provera. A majority of deliveries take place in hospitals. Medical Termination of pregnancy is illegal and only if the mother's health is in danger, it can be done with the recommendation of two doctors.

The maternal mortality rate has been zero for the past five years. Infant mortality rate has reduced from 139 in 1945 to 21.3 in 1996. Vaccination system is extremely efficient and the BCG vaccine is given to the new-born child within twenty-four hours of birth. Without this vaccination children are not admitted to school. The health status of the population is very good and health services are accessible to a large majority of the population.

Discussion

* **Traditional widwivery** - It is interesting to note that in Sri Lanka with the good system of medical and health care, the tradition of midwives is no longer existent, unlike the other countries in the region where a majority of deliveries take place with the help of midwives. In the earlier traditional system antenatal care also used to take into consideration psychological issues. The village doctor did not charge money for services delivered. However, even now, pregnant women are well looked after in the villages and have a high status. Working women are given three months leave after delivery. In the labour room there are windows so that the baby, which is seen to be coming from a dark cave should not have its eyes affected by the harsh light. It was shared that this sounded very familiar to the practices in Kerala.

* **Sri Lanka presents a different scenario** - The health situation of women and the availability of health services in Sri Lanka is quite different from the other South Asian countries. This is may be due to the higher social and economic status of women in the society and also the country's higher GNP. The problems faced in the other South Asian countries such as high child and maternal morbidilty and mortality are not faced by Sri Lanka.
* **The status of allopathic and Ayurvedic systems** - Doctors from both systems are in high positions. and rules and regulations about Ayurveda are similar to that of allopathic medicine. Salaries of doctors are also same. Ironically the first chapter of Ayurveda is about surgery but operations under this are not allowed. People in urban and remote areas prefer Ayurveda to other systems.



Women's Health Policies in Pakistan A situational and future perspective

Faraah Parvez Saleh
Citizen's Commission for Human Development,Pakistan.

Pakistan lags behind most developing nations in women's health and gender equity:

* About 24% of Pakistani married women use contraception [usage is 40-80% in most of Asia], although this marks a substantial increase from the 9% in 1985.
* The gap between contraceptive use and the desire to space or limit births is one of the largest in the world.More than one-third of Pakistani women wish to space the next birth or limit the family to its current size but are not using contraception.
* Laws are highly restrictive on abortion, thus many women resort to unsafe abortions, which causes 5-13% of all maternal deaths.
* One third of births occur within two years of the previous birth, which doubles the mortality risk for the new-born.
* More than 40% of women are anaemic.
* Trained providers during delivery are available for only 20% of women.
* Pakistan ranks third among the world's countries in numbers of infants who die of tetanus, which can be prevented by immunizing the mother as part of prenatal care.
* Information and services to prevent and control reproductive infections [including transmission of HIV] and to combat gender-based violence are virtually unavailable.
* Households spend considerably less on women than on men in the event of illness.

The quality of care is depressed by a lack of responsiveness to women's special health needs - shortage of staff (especially female paramedical workers), lack of supplies and drugs, inadequate community outreach and counselling, poor adherence to standard medical procedures, and weak supervision. These failures are reflected in under-utilisation of services as well as poor health indicators.

Reproductive Health Package in Punjab

* Comprehensive family planning services for females and males.
* Safe motherhood comprising of maternal health care and pre and post abortion care.
* Child health care to children less than five years.
* Management of reproductive health related problems of adolescents.
* Management of other reproductive health related problems of women.
* Prevention and management of RTIs/STDs and HIV/AIDS.

* Management of infertility.
* Detection of breast and cervical cancers.
* Enhancement of male involvement.

Safe Motherhood Programme

* To ensure the early detection and management of prenatal and post natal period with a focus on EOC.
* To improve antenatal coverage, enhance TT vaccination, detect and treat anemia.
* To ensure provision of 100% EOC at all DHQ hospitals and 75% of Tehsil hospitals by 2010.
* To reduce MMR by 50% of the existing level by 2010.
* To reduce maternal morbidity by 60% of the existing level by 2010.
* To establish database for maternal morbidity and mortality.
* To develop institutional capacity for training health personnel.

Infant Child Health Care

* To reduce IMR to 80 per 1000 live births by the year 2010.
* To establish database for infant morbidity and to adopt strategies to address the problem.

Prevention and Management of RTI/ STD

* To reduce prevalence and incidence of RTIs/STDs.
* To create awareness in the community and service providers.
* To develop institutional capacity for prevention and management of RTIs related issues within public and private sectors.
* To integrate RTI services with health and FP services.

Management of Reproductive Health Issues of Men

* To enhance male involvement in reducing the family size, identification of STDs, screening and treatment.
* To develop facilities for management of male sexual dysfunction, infertility problems.
* To create awareness about the rights of women and responsible parenthood.

Gaps and failures in reproductive health care are

* High risk pregnancies at an early age
* Limited access to good health care
* Iron deficiency, anaemia and poor nutrition
* Unavailability of emergency and obstetric care
* Low utility rate of contraception amongst married women
* Unavailability of contraceptives, especially in rural areas
* Lack of antenatal care and childbirth by trained health providers
* Lack of sufficient number of female paramedical and medical staff
* Spread of HIV and drugs amongst women and children

* Spread of malnutrition among women and children
* Deficiency of proteins
* Deficiency of iron amongst pregnant women
* Deficiency of iodine amongst women and children
* Deficiency of vitamin A
* Lack of household food security
* Lack of health services and health environment
* Lack of potable water and poor environmental sanitation

Recommendations for covering health gaps

* Decentralization
* Community participation
* Health and education management information systems to be strengthened.
* Co-ordination of development efforts needed between the government and donors.
* Involvement of private sector in provision of Service Delivery.
* Women-friendly district health systems.
* Building of institutional and human resources capacities.
* Midwifery training.
* Strengthening of skills of NGOs in social sector delivery.
* Communities involvement in assessing their own needs/ identifying priorities for action.

Discussion

* **Health and Family Welfare Programmes** - The reproductive health package is the national policy. The plan is to integrate the Ministry of Health and Ministry of Population and Family Welfare. It is donor driven and World Bank technology provides the support unit. The predominant family planning methods in use are copper-T and condom under the family planning program. Depo-Provera has been used for the past 15 years and sterilization is still available. 80% of population have awareness of family planning methods but service delivery is poor. People start using contraceptives but stop midway because of side effects. Doctors do not do any counselling and women are the targets of the family planning program.
* **Abortion services** - Women can get Medical Termination of Pregnancy for psychosocial reasons according to law. This needs to be certified by two doctors. But due to the overbearing societal norm woman do not access this facility much.
* **Public and Private sector involvement in health service delivery** - An experiment is on to give over 10 hospitals to the private sector to run them efficiently. The Chief Executive will co-ordinate and has the power to hire, fire from the Secretariat. Decentralization of health department should be done by the local government but it has not materialized till now.

Implementing Reproductive and Child Health (RCH) policies in Tamil Nadu

Dr. Leela Visaria
Institute of Economic Growth, India.

A precursor to the new Reproductive and Child Health (RCH) policy has been the removal of method specific family planning targets. Since targets were mainly used as a monitoring tool, monitoring of family planning in TN (Tamil Nadu) was shifted to the district level on an experimental basis. An earlier initiative in 1991-92, to remove the non-health personnel in the district of North Arcot had shown that family planning performance had not declined due to it.

The overall climate in Tamil Nadu had been conducive to bringing about such a shift in policy. There was rapid decline in fertility taking place in spite of relatively high infant and child mortality rates due to changing aspirations of people and expectations about and from children, growing awareness of the problems of continuous land fragmentation and lack of employment in the government sector.

Certain policies pursued by the TN Government in the past had also been conducive to strengthening health care delivery at the primary level, such as the reservation policy for education. Due to this a cadre of doctors has been created who have roots in small towns and are willing to work in primary health centres in those areas. Given the background of the doctors and unavailability of resources to specialise they take up private practice as general practitioner or a government job that ensures a steady income.

According to the data provided by the TN government, nearly 40.5 percent of medical officers in the PHCs are women. This has helped rural women to access health and discuss their health and contraceptive needs. Further, the government has made employment as Medical Officers (MO)in the primary health centres quite attractive on several counts by allowing doctors to have their own private practice and reserving 50 percent of the post-graduate seats for government sector doctors. The medical officers can pursue postgraduate studies under the quota only if they have completed a minimum three-year rural service. The TN government has also reserved 15 percent of the seats at the MBBS level for rural candidates with the expectation that these candidates would be more willing to work in the rural areas.

To strengthen the logistics management system for health care the Government of TN established a Tamil Nadu Medical Services Corporation Ltd in January 1995. Its main role is to purchase, store and distribute high quality drugs, medicines, sutures and surgical equipment to various Government Medical Institutions in the State. It also renders services to the other hospitals like supplying equipment to the hospitals and maintaining its own CT scan centers in the premises of few government

hospitals. The TNMSC ensures price and quality control and also sufficient stock of medicines.

The government has taken proactive measures to involve the corporate sector in its objective of improving the health status of its people. Industrial houses are being encouraged to fully or partially adopt and maintain the Primary Health Centre (PHC) and government hospitals in the state. Fifteen industrialists had expressed their willingness to maintain 60 PHCs in 1997-98.

The government is also actively involving the donor community in its quest for health for all. Recent projects with donor agencies include the DANIDA health care project, grant-in-aid from the Japanese government for The Institute of Child Health and Hospital for Children, Chennai and World Bank grant for the implementation of RCH (Reproductive and child health) project.

The TN government has introduced a reward and an incentive system that operates at both the individual level as well as the community level, and which is applicable both for the providers as well as the client. For example, the ANM who ensures that there is no infant death during a year in her area, is rewarded with one sovereign gold coin. At the district level, the Medical Officer of a PHC registering the highest percent of reduction in IMR in the PHC area will get a rolling shield. Similarly, the collector of a District achieving maximum reduction in IMR(Infant Mortality Rate) would also be given a rolling shield. Other incentives include paying an ANM(Auxillary Nurse Midwife) each time she conducts a delivery at home in the rural areas (Rs. 50) or refers a complicated case to the higher level of care (Rs. 25). To help cover the entire sub-centre area, the VHN/ANM are given advance for purchasing mopeds or two wheelers. Pregnant mothers who are unable to earn their daily wages during later months of pregnancy are compensated for wage loss with Rs.500.

To improve the availability of services, the TN government has introduced provision of 24-hour services in the primary health centres in 124 PHCs and will be extended to 126 more. To strengthen these PHCs, the government has sanctioned funds for 250 posts of additional MO's and ANMs each, improvement of lab facilities, provision of ambulance, labour rooms in all the PHCs and hiring additional VHNs on a contractual basis.

However, while these are some of the positive initiatives taken by the Government of Tamil Nadu, there are still some limitations in the existing policy and challenges that need to be addressed. Importantly contraceptive choice still remains limited, with excessive focus on female sterilisation and information on modern methods not being provided to women. Women undergoing sterilization are given a monetary incentive of Rs.130 and the accompanying VHN earns a motivation fee of Rs.100 per patient. Further, the focus in contraceptive delivery is on woman and male responsibility needs to be given more attention.

High infant mortality rates, particularly in rural areas where in some places it exceeds the national rate of 80, is a

concern that needs to be dealt with by the state government. Importantly, female IMR is exceptionally high. Female infanticide in TN accounts for 8 percent services for abortion, Reproductive Tract Infections (RTIs) and the reproductive health needs of adolescents.

Discussion

* **Sterilization** - There was a discussion on whether women would still opt for sterilization if incentives were withdrawn. In Rajasthan for example the incentives had been removed and the same money was being used for providing drugs and transportation for patients. While there is no state law on the matter of when sterilization should be conducted, it is mostly done soon after childbirth because of the convenience, time and money saving factor. The question about whether women were willing to have sterilization after two daughters when a two children norm was being promoted needs to be looked into. Sterilization camps continue to be held in the states. Health Watch Network has started looking at medical standards in these camps in Gujarat to ensure that basic equipment, water, drugs, toilet are available. Since there are not enough qualified doctors at the PHCs alone – the doctors from private hospitals are sometimes asked to conduct the camps.
* **Contraceptive choices** -Among the issues raised about increasing contraceptive choice was whether the existing methods besides sterilization was not promoted because of provider or user attitudes, since in most cases women themselves stick to one particular contraceptive. In Tamil Nadu meetings are held with women to discuss the contraceptives available and if they can be obtained from the PHC.
* **Male involvement in reproductive health** - There is need to increase male involvement and responsibility in contraceptive use and reproductive health care initiatives. In TN nurses are having open meetings for both men and women so that both can know about contraceptive methods, RTIs, child bearing and rearing. Involvement of men requires social engineering and is difficult to address without addressing wider social issues. More male contraceptive methods should be made available. Male sterilization is going to be reintroduced in the state after doctors are retrained because the state has lost an entire generation of doctors experienced in conducting vasectomies.
* **Role of traditional birth attendants** - With changing circumstances, such as increased western medicine and the state's assurance of institutional deliveries, the role of TBA needs to be reconsidered. The GOI has trained TBA's 3.6 times over but they don't have a significant role to play in Tamil Nadu where 70% of deliveries by the year 1998 took place in institutions. Lot of NGOs' are looking into the traditional role of TBA's and providing them with delivery packages.

Managing Primary Health Care Centres by VGKK

Dr. Sudarshan
Vivekanand Girijana Kalyana Kendra (VGKK), India.

The Indian scenario since independence:

* Food grain production has more than doubled between 1951 and 1991.
* Famines and starvation have been virtually eliminated.
* Per capital income has more than doubled between 1951 and 1995.
* Life expectancy has nearly doubled from 32.1 years in 1951 to 60.8 years in 1992.
* Infant mortality has been halved from 146 in 1951 to 74 deaths per 1,000 live births in 1995.
* The number of primary health care centres and sub-centres has risen from 725 in 1951 to over 154,000 (21,000 PHCs & 1,33,000 sub-centres) in 1996.
* The literacy rate has risen from 18 percent 1951 to 52 percent in 1991.

However it is sad that the people are still impoverished in the country:

* 53 percent of children under four years of age, approximately 60 million, remain undernourished.
* Close to 36 percent of India's population, nearly 329 million, live below the poverty line
* About 2.2 million infants die every year from preventable causes.
* Only about 5 percent of the rural population have access to sanitation facilities.
* Nearly 36 percent of school children dropout before completing primary school.
* In rural areas, about 4 percent of children, 6-14 years belong to the labour force.
* 50% of the PHCs do not have functional microscope to diagnose Tuberculosis, Leprosy and Malaria.

VGKK has started a new experiment whereby the government has handed over the running of two PHC's to them. This was a cabinet decision; one was a new PHC and the other was already existing, albeit with poor infrastructure. VGKK had to appoint staff for both the PHCs. Since the experiment has been largely successful with VGKK, the government is considering handing over some more responsibilities to VGKK and other NGOs.

In this particular experiment with the PHCs, the government still finances 75% of the project which made the understanding between both parties easier. The benefits of this venture have been - cost effectiveness, innovation, zero MMR in one PHC, one MMR in the other PHC, IMR is 28 per 1000 in one and 32 in another. Family planning has also been fairly successful at both the clinics.

Tuberculosis and malaria have been neglected in the past health initiatives

and are now being dealt with through vertical program which is not a healthy sign. Health as a vertical programme will not succeed and what is needed is an integrated approach which will bring together health, education and income generation. VGKK is introducing leprosy, tuberculosis, epilepsy, cataract and diabetes diagnosis and treatment programs through a community based approach.

There is an effort to involve the people for whom the services are provided in the planning and delivery itself. The Tribal Awareness project is trying to look into the access of PHCs by tribals. Identification of traditional herbs and integration of traditional medical people with paramedics and medical officers is being done to ensure community participation. Most deliveries are being done in the traditional squatting position as gravity helps pelvic muscles and is more acceptable to the people. In the tribal population of 20,000 there has only been one C-section in the last 19 years. Often ANMs do not stay in the area where they work because they do not belong there, however, under this particular project ANMs are selected from their own area. User fee of Rs. 1 as a token for the OPD has also been introduced with the idea that the treatment should be valued and not given free and also to respect the dignity of the patient

Health has to be a movement of the people. New techniques, such as PRA and micro planning, are important to empower people at the village level. The government of India has supported the efforts of VGKK to form village health committees, which will influence the gram sabha and eventually the gram panchayat.

Presently there is a plan afoot to prepare a community needs assessment manual with the help of health workers. The ANM's work includes reading and making the annual plan, doing demographic studies for understanding population profile and community needs of the people.

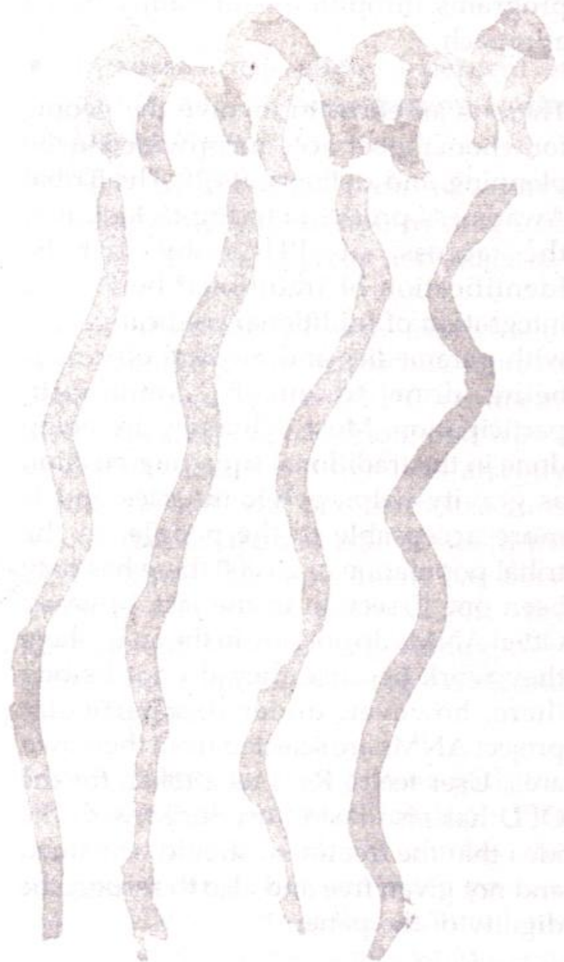
At the macro level, the World Bank has tried to push the DOTS programme for tuberculosis in 10 cities of the country spending 700 crores. However, the same resources could have been used to feed the entire country. This program is ironical because India has Asia's best institutions for this disease and at the same time the World Bank has less information, but unfortunately some of our people have succumbed to this plan. We must evolve our own programs that are not vertical and macro but micro and integrated with the different and local needs of the people.

Discussion

* **NGO involvement in health services delivery** -A Cabinet decision was formulated to give over running of the PHC to NGOs and they have to take total responsibility. However, presently since 75% funds for the project still come from the government the involvement is by both parties. 25% generation of finances is dependent upon financial contributions and spending from the trust.
* **User fee** - The policy does not let VGKK collect user fee, and only a

token fee of Rs. 1 is taken. Donations are taken for development of infrastructure. In Pakistan, some small health centres for mother and childcare, collect Rs.200/- per family per month and they have 400 members. This is to make process sustainable. However, this method could have the disadvantage of being exclusive and discriminatory and may exclude poor people who cannot afford the fees.

* **VGKK work** - In the surrounding area of VGKK, there are no private practitioners in rural areas except one or two and the PHCs have taken over the major responsibility of providing health care. ANMs at the VGKK PHCs have been doing tremendous work including registration of pregnant women after 12 weeks, haemoglobin and sugar tests and giving tetanus injections. They visit pregnant mothers once a month, provide postnatal care, immunization and encourage community participation. They also provide curative care. Diabetes has emerged as a problem in the rural areas and the VGKK clinics are looking at the incidence and prevalence to see if it is an emerging problem. This has been taken up as a pilot project and included in the agenda of the PHCs. Tuberculosis status has shown 4% sputum positive. The DOTS programme has not been followed by VGKK because the PHC is not equipped to do so. The demand is not to push vertical programs unless PHC infrastructure is in place.



RUWSEC'S work with Public Health Centres

Deepa Venkatchalam
RUWSEC, India

RUWSEC (Rural Women's Social and Education Center) a community-based organisation in Tamil Nadu has sought to lobby and pressure for changes in the existing health services system from its very inception in 1981. Initial efforts were ad hoc, where women's groups from the community would pressure the local health functionaries to make regular visits, hold regular ante natal clinics, or demand that the functionaries treat poor rural women with minimum respect. But these efforts did not make much long-term impact.

In 1994, RUWSEC undertook an experimental study on the quality of health services, covering a range of reproductive health services provided at the PHCs in rural areas. Three NGOs from Tamil Nadu participated in this study. In the same year three workshops were conducted to identify major reproductive health concerns of women and recommendations on how to respond to them, including services offered by PHCs, sub-centres and district hospitals.

In 1995-96, a participatory study was conducted in Tirukazhikundram, involving the local community to monitor and assess the health facilities that served them. Following this, RUWSEC held review meetings with PHC staff. Meetings were also held with the local health officials, VHNs etc. to share the details of the study and to create an opportunity for sharing of information, future plans etc.

RUWSEC was initially reluctant to work with the government given the government's track record. Finally, a research intervention project - "Implementing Cairo: an NGO-Public sector collaboration for the promotion of quality RH services" was initiated.

The objectives of the study were:

* To gain insights into the potential for NGO-public sector collaboration on a wider scale for the promotion of RH services; to this end, to identify the strengths and limitations of the collaborative process, and mechanisms to deal with bottlenecks.
* To improve the quality of RH services at the PHC and the sub-centre level in a select area.

This project aimed to:

* Identify, in consultation with the health sector functionaries at the state and district level and with a cross section of users of services, activities to improve the quality of MCH/FP and other gynaecological services available to women in the PHCs and sub-centres.
* Facilitate and/or carry out activities identified, in collaboration with the PHC and sub-centre staff and with the local community in a select area.
* Document the entire process, including carrying out baseline and impact assessment studies.

* Disseminate the findings from this project to policy makers and planners through a national seminar.

Collaboration between NGOs and the public sector has been widely identified as an important strategy towards implementing commitments made at the ICPD in Cairo, and the Government of India has endorsed this. The technical expertise of the public health sector combined with NGO insights into the health needs of poor women and barriers to their accessing health services could go a long way towards making services gender sensitive and client oriented.

This project includes training of local women leaders from the village panchayats (councils) to monitor quality of services in the local health centres and to be advocates for women's reproductive rights and health. Training began in May 1998 in topics like leadership, health, gender, panchayat etc. From January 2000 these local women leaders are involved directly with PHCs. Workshops for health personnel on client oriented and gender sensitive health care began in June 1998, but progress has been very slow because of bureaucratic delays. Six months lapsed before official permission was granted to work with the local PHCs. Subsequent monthly trainings required months of waiting for permission.

At the same time, visits to the PHCs showed that the staff was very interested in the project. Two PHCs were identified for the project, based on the following criteria:

* Reasonably good infrastructure
* Medical officer willing to collaborate.

In February- March 1999 a baseline study of users perspectives on quality of services at the PHC's was carried out. Most clients stated proximity and free service as reasons for coming to the particular centre. In April a meeting was held with the PHC staff and the panchayat / local women leaders participating. Skits and discussions were carried out on the existing health situation and services and on the abilities of PHC staff and the community to intervene for improving it. The objective of meeting was that the PHC staff and Panchayat members would meet each other as the first step in this program which required the PHC, the local government and RUWSEC to work in co-ordination.

In June and July, based on the findings of the baseline study, observations of the health centres and suggestions of staff, two activities were initiated - counselling and laboratory services for gynaecological problems like gonorrhoea, white discharge.

The counselling has got very good feedback. In addition to individual counselling there have also been group meetings on topics such as information on our bodies, cleanliness for girls during menstruation, contraception, sexuality, antenatal care etc. Books and material are available at the RUWSEC health centre. As the counsellors were women, some of the men were hesitant to discuss their problems with them, therefore male members also began counselling. The counselling has also been useful in involving men in taking responsibility for women's reproductive health. Men are counselled about contraception and the importance of ante- natal care.

The future plan of action includes:

* Training of PHC staff to conduct women oriented deliveries
* Improvement of infrastructure
* Local community participation

  Monitoring the work of doctors by training the panchayat women for reporting

Discussion

* **Local community involvement** - Most of the staff involved in the project are villagers themselves and this should in the future help the project be self-sustaining. Panchayat women leaders have been involved in the project, as they too are part of the community.
* **Private practice by PHC doctors**- the accountability of doctors of the PHC who do private practice is an issue faced in the project. The PHC doctors often leave the PHC early to be fresh for their private practice. However, the people do not really complain because it is a remote area and if he does not come at all there will be no one to look after their needs.
* **Counselling** - The RUWSEC staff does counselling. The counsellors are specially trained women who belong to the same area as the clients. They use material on health to disseminate information – such as posters, booklets, pamphlets etc. Even when people come for treatment of common cold, flu etc., the counsellor discusses other subjects like contraception, immunization etc. with them along with what they have come for. The idea is to share with women a variety of health issues that may affect them.
* **Private public sector roles in service delivery** - It was suggested that the aim should be to educate the ANM to play the role of the counsellor instead of replacing her. This issue was also brought up in the context of other functionaries. It is important to not replace government staff and take over the work of the government, especially in the context of reducing government expenditure in areas of health, education and other social service sectors.
* **Influencing health policy** - It is essential to evaluate the quality of care and analyse how the work is being carried out so as give input to the government in policy formulation. There is a need to influence the government in bringing about changes in the health system and ensure that drugs and other facilities reach remote areas. It is very essential to modify the health system by getting into it instead of fighting it from the outside.

New Contraceptive Technologies

N. B. Sarojini
Sama, India

A number of new fertility regulating technologies have been introduced with the aim of checking population growth.

The "good" lobby is pro technology under certain conditions. It insists that new technologies are good because:

* They are convenient to use
* Family planning (avoiding conception) is more important than the method itself.
* Women should have a choice that provides them with reproductive freedom. Technologies such as injectables provide an alternative for mothers to avoid repeated and unwanted pregnancies.
* Barrier methods are a headache for rural women
* Notion that researchers and doctors know best.

However, the **"bad"** lobby argues that new technologies need to be seen in the present context of the status of women in India, the status of people's health and livelihood in the country and the negative outcomes of new contraceptive technologies.

Some facts about the position of women:

* There are now 929 females for every 1000 males. In India out of all deaths among women:
  - Obstetric deaths constitute - 2.5%
  - Deaths caused among women by infections in nature like TB - 65.5%
  - Due to injuries and accidents - 7%
  - Due to old age - 26%

The need to block harmful anti-women contraceptives is because of the following reasons:

* Unethical trials without proper screening and follow up, lack of informed consent.
* No information on side effects and poor health care facilities.
* No studies on return of fertility.
* No compensation for women who suffer from side effects.

Achievements of the campaign in India against the introduction of hazardous new contraceptive technologies:

* The issue of safe contraception became a national issue.
* Depo-Provera and Net-en were not included in the family planning programme.
* Norplant trials reduced to 10 centres.
* Inclusion of 78 side effects in the Indian package insert of Depo-Provera
* IDRC, Canada stopped research funding on anti-fertility vaccine.
* Gained support from activists/ groups both national and international.
* Attention of media on the issue.
* Drugs Controller of India forced to

accept the over-the-counter sale of Depo-Provera and Net-en is taking place

* Supreme Court judgement banned quinacrine.
* Women's groups initiated diaphragm trials.
* Training on fertility awareness.
* Discussion on sexuality, gender roles.
* Discussion on male involvement

Ironical state of health care:

The annual budget in 1994-95 for family planning was Rs.1442.03 crores, which was more than the health budget of Rs.993.83 crores. Norplant costs Rs.2000 per user that is equal to the medicine budget of a health sub-centre per year. Depo-Provera costs Rs. 2000 per user, for ten such contraceptive users the government can provide a source of potable water or a primary school.

Chronology of the introduction of different contraceptive technologies in India:

1950→ The Indian family planning programme was initiated with methods like rhythm, diaphragm, jellies.

1960→The IUD was introduced along with sterilisation. Cash incentives were provided for doctors, motivators for meeting targets. Promotion of the barrier method was stopped.

1970→ The stress was shifted to sterilisation.

1971→the MTP act was introduced.

1980-90 → Hormonal contraceptives like the pills, Depo-Provera, Net-en, hormonal IUDs and Norplant. Anti fertility vaccine trials are conducted.

1993-94→ Trials of quinacrine were initiated by the government and banned because of high failure rate.

1997→ some private practitioners and NGOs began trials for quinacrine and sterilization.

The aim of the campaign:

* To create mass awareness and understanding about these issues.
* To create a pressure group against arbitrary and anti human policies of the government
* The campaign was aimed at. - Policy makers, Donor agencies, Drug companies, Technocrats, Technician, Non party organizations.

Some of the strategies used were demonstrations, protests, dialogue and advocacy, legal recourse, media and tribunals.

Lobby against New Reproductive Technologies wanted to incorporate following features:

* Safety
* Ethical trials
* Informed consent
* Social accountability
* Women's general and reproductive health
* Allocation of funds
* See women as a "person" and not only a reproductive body
* Address other process of empowerment for making decisions.
* Devise methods with socio-economic context in mind

* Address gender and power relations.

The actors involved in the campaign:

* Autonomous women's groups
* NGO's
* Political organizations
* Research and Academic groups
* Legal education groups
* Medical professionals

As women we want :

* Contraceptive methods which do not in anyway harm the physiological functions of our bodies
* Contraceptives based on the understanding that reproduction is a joint responsibility of both men and women.
* Contraceptives that are based on an understanding of our bodies.

We feel:

* Technology should be understood within social, political and cultural context
* We believe in human dignity, equality in man-woman relationships, empowerment and social justice.

Discussion

The discussion was initiated by detailing a case of a young woman, Navrati who has five children but has too much of work to make both ends meet. She is very tired at the end of the day and does not eat properly. With frequent pregnancies her problem is compounded. Her husband does not use any contraceptive method. She goes to the hospital where she is advised to use a new contraceptive in the form of an injection that will be convenient and effective, maintain privacy and no one will know about it.

The participants were divided into three groups to discuss convenience choice and safety of contraceptive methods.

* Group one wanted to redefine convenience from the perspective of both the user and provider. Availability of information for the user including research and safety, has to be contextualized. The user's social and cultural context has to be looked at keeping in mind their health and nutrition status. It is important to involve the woman and share her feelings. It is also important to get rid of the hierarchy both at the level of providers and family.
* Group two stated that the women had no choice and hence there is no question of a discussion about choice. One needs to be informed to make a choice. Thereby it is important to empower her, give information to her husband and this should fall under the duties of health care providers to disseminate knowledge.
* Group three stated that the safest bet would be the condom to look at power relations within the family, talk about sexuality and other modes of sexuality since the condom privileges heterosexual intercourse.

TB Burden: Gender Difference

Dr. Purabi Dutta
BRAC, Bangladesh

Global situation

* In 1998 there were 2200 million TB patients of which 900 million were women (41%)
* The ratio between notified female and male cases in 1998 was 7:1
* The maximum sufferers are the women of reproductive age (15-44)
* The rate of prevalence is similar until the period of adolescence.
* 10% of the total global deaths represented by women of 15-44 years of age due to TB.

Bangladesh Situation

* 300,000 new cases, 600,000 existing cases and 60,000 deaths in 1997.
* The ratio of notified cases between female and male is 0.4:1 [25%lower than men]
* Of the total women TB patients in 1998, 76% were among the women of 15-44 years.

TB: Phases of gender bias

A series of steps maybe identified to quantify gender bias:

* Onset of symptoms
* Seeking health care
* TB suspected
* Sputum smear examination
* Start of treatment
* Treatment outcome
* Rehabilitation in the society/ labour force.

Gender and TB: Biological factors

* Beginning in adolescence the prevalence of infection is higher in men than women but the progression of infection and the incidence of clinical disease are higher in women in the age group of 15-44.
  This maybe due to physiological changes associated with reproduction, such as:
- Rapid hormonal change
- Post-partum descent of the diaphragm and the expansion of the lungs
- Nutritional strain of lactation
- Stress associated with insufficient sleep
- Unhygienic living conditions during the first month post-partum [religious/cultural]

Gender and TB: Access to modern medical care for women is limited by a combination of factors

* Inferior social status
* Poor education
* Poverty
* Dependency
* Discrimination
* Distance to health services
* Conflicting health beliefs and illness behaviour

* Stigma
* Lack of decision making power
* Gender of health workers

Health seeking behaviour of women

Reporting symptoms and using health services:

* Developed countries: Women > Men
* Developing countries: Women < Men
* Mothers with pre-school children< other women
* Employed women< housewives
* Married women< single, widowed or divorced
* Women with more demanding roles may have less time to seek health care

Gender differentials in stigma and TB

Men worry about:

* Loss of wages
* Financial difficulties
* Reduced capacity for work
* Poor job performance
* Consequences of long absence from work

Women worry about:

* Rejection by husband
* Harassment by in-laws
* Reduced chances of marriage
* Dismissal from work [often women are hired as domestic help whereas men are often self-employed]

Gender and TB: Effect on household

* Women's illness has profound effects on the social and economic well-being of households
* Women's workload increases when other family members are ill.
* Women replace the labour of those who are sick and may have to neglect domestic and childcare duties.
* Stigma may affect other household members especially unmarried women.
* There is a strong correlation between maternal death and child death till age ten [especially for daughters].

TB and HIV/ AIDS

* Someone with HIV is 30 times more at risk of developing TB
* Women are at particularly high risk for both HIV and TB - other than socio-economic and cultural factors, there maybe a biological basis for this [The direction of sexual spread of HIV favours male to female transmission]

Gender and TB: BRAC's strategies/ interventions:

Gender related capacity building

* Gender quality action learning; gender resource centre; Gender advisory committee
* Training on gender and sustainable development .
* BRAC culture and value: gender relations

Gender related interventions

* Training on TB and gender
* Gender and health: male involvement
* BCC materials on TB and gender

* Gender and DOTS: modified strategies [confidentiality; privacy]
* Active case finding by household visits
* Women health volunteer [*Swasthya Sevika*]: The pivot of the program

Global TB burden is on 4 countries, namely India, China, Bangladesh and Indonesia. India tops with 28.4%; it is vital to identify gender differentials every step of the way. It is also important to look at reporting patterns - as per one study done men take 27 days to report and women 49 days. A woman often reports only when she finds it impossible to do her household chores and her illness begins affecting the family and work.

A stigma related study done by BRAC revealed through focus group discussions that the strong prejudice towards TB patients results in open fear and avoidance. Social sanctions are more severe for women. Their husbands often rejected them and unmarried women would probably ruin chances of marriage because people believe that the disease is hereditary.

Discussion

* **Gender bias in DOTS** - In the DOTS program the focus has not been on active case finding. In BRAC's experience active case finding is essential till awareness about the disease is generated so that there is increased self-reporting. There is a gender dimension to this as women have less access to services and their cases do not emerge without active case finding. It is an essential to have women's groups form an educational forum. We also need to look at issues of access and usage of drugs for women.
* **Financial sustenance of BRAC programme** - BRAC is like a parallel government with no problem of sustainability. Only problem is drugs. The policy used is to take a 200 Taka from each patient as a bond, which they will lose if they don't complete treatment. If the person is very poor community participates in collection and when the individual is cured the money is given back with a ceremony. But the patient is encouraged to give some money back to the *Swasthya Sevika* who doesn't earn anything except 25 taka for each positive detection.
* **Drug Resistance** - The issue of drug resistance has been raised in the context of TB. Drug resistant cases exist but they are very low in Bangladesh (5% according to BRAC findings). The drugs and treatment schedules for drug resisitent cases need to be clearly defined.
* **Vertical health programmes** - There has been a felt need to abolish vertical programs. Since there are 128 communicable diseases, such programmes will only increase expenses. Efforts should instead be made to integrate the these initiatives and the money can instead be used for other health expenditures.

The Baluchistan Safe Motherhood Initiative

Dr. Farid Midhet
The Asia Foundation, Pakistan

The Baluchistan Safe Motherhood Initiative (BSMI) is an operations research study to develop and test community based interventions to reduce maternal mortality and morbidity in rural Khuzdar district of Baluchistan. Khuzdar is one of the largest districts of Baluchistan which is the most backward and under developed province by any standards but specially in terms of women's status.

During 1991-1993 a large scale survey was conducted by the Agha Khan University of Karachi to estimate the levels and causes of maternal mortality in Baluchistan and the NWFP-Maternal and Infant Mortality Survey (MIMS).

The MIM Survey 1991-93

* Over 55,000 households visited in 16 rural districts of Baluchistan and the Northwest provinces of Pakistan.
* During last five years, 63,683 live births and 251 maternal deaths were reported in these households.

Objectives: In 16 districts of Baluchistan and the North West Frontier Province

* Determining the levels and medical causes of Maternal Mortality (MM).
* Identify the important individual and contextual determinants of MM.
* Determine the impact of district health services and access to emergency obstretic care on MM.

Results from MIMS 1991:

* The overall MMR was 365 per 100,000 live births. One third of maternal deaths were attributed to post partum hemorrhage, 11% to ante-partum hemorrhage and about 13% of puerperal sepsis.
* Women having their first birth, those with a past history of foetal loss and those aged 40 years and older are at a higher risk of MM. Women having electricity in their houses and those living in houses with three to more rooms are at a lower risk.

The BSMI project conducted baseline studies to estimate the patterns of maternal and related morbidity among women in Khuzdar.

Features Observed:

* Health services infrastructure is poorly developed, particularly in terms of adequate obstetric care.
* Over 90% deliveries occur at home, conducted by untrained birth attendants or family members.
* Health services utilization is poor, particularly by women of reproductive ages.

Three delays that can lead to higher maternal mortality:

* Delay in decision-making to seek medical care

* Delay in transportation
* Delay at hospital

Survival Pathways

* Introduce family planning
* Prenatal care and safe delivery
* Early recognition of and action for managing obstetric emergencies.

Specific Objectives of the Initiative

* To cause a significant decrease in the prenatal mortality rate in the intervention site.
* To increase the proportion of births attended by a trained provider.
* To increase the proportion of pregnant women receiving adequate prenatal care (three or more visits by a trained provider, the first visit being in the first or second trimester).

Baseline Research :

* Qualitative research
* Situation analysis
* Health services research
* Household survey
* KAP interviews with women and men
* Female reproductive ages morbidity study
* *Dais* interviews.

Preparatory Phase :

* Orientation of *Dais*
* Orientations of HCPs.
* Developing and Pre-testing IEC.
* Community mobilization
* Linkages with government.

Outcome Indicators :

* Prenatal mortality rate
* Proportion of unmacerated still births out of all births.
* Proportion of pregnant women who experienced a serious complication.
* Proportion of pregnant women who had a C-section or received blood transfusion.
* Number of pregnancy related deaths during past one year (ICD-10)

Intervention Strategies:

* IEC to women and their families
* Training of primary providers (Traditional Birth Attendants and Lady Health Workers)
* Upgrading the primary health care facility and training of staff.
* Setting up reliable transport and communications system.
* Upgrading the district hospital and training of staff.

Interventions

* IEC to women and men
* LSS training to *Dais*.
* Transporters training
* Telecommunication system

All but the last intervention are in place. In addition the government health facitlities including the district hospital are being upgraded through staff training and improving the equipment and supplies. We believe that these interventions will bring down maternal mortality atleast by 50%.

Discussion

* **Access to services** - All delays can be equally critical. The first delay is failure to recognize symptom and not know where to take the woman. It is not easy to attribute death to one particular cause. There is a plan to have walkie-talkies for transmission of information for the program. Walkie-talkies will prove helpful in time of need and the entire cost is 32,000 dollars for the 100 registered TBA's. The ambulance will be kept ready and the walkie-talkie will be able to cover a radius of 30 kms. With the walkie-talkie service ambulance takes an average time of 1 hour and without the walkie-talkie it will take 3 hours.
* **Gender of the doctor** - Among poor and lower class women there is no major discrimination of whether it is a male or female doctor. There is no question of women being choosy as it is a matter of life and death. Besides she wouldn't visit a Doctor at all if it weren't a pressing issue.
* **Dai practice** - After deliveries, the *Dais* stay with the woman for 5-6 days. They cut the umbilical cord, clean the room etc. The program is trying to give the *Dais* a professional image which will result in the increase their status and more respect for their services.
* **Indicators of economic status** -There was a discussion about using specific indicators like availability of electricity and refrigerator. This was done not because it has any relation to maternal mortality but because it is an indicator of income. It is difficult to ascertain income directly because in this area all income is not in cash and is often in kind. It has co-relation with women's education. Also durable items like TV and refrigerator indicate proximity to the national grid, nearest town and availability of facilities.
* **Linkage between violence and maternal mortality** - The subject needs to be looked into. It was not done in this study but another agency found that the correlation existed. In Bangladesh domestic violence goes up because of pregnancy.

Mental Health Policy and Gender

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Law is an instrument for implementing policy, however whilst there is in-built flexibility within a policy document, there is a relative inflexibility within law. One general point is with regard to the constant demand for accountability and monitoring enforcement which has been voiced at the workshop. The performance of each of these functions required the establishment of some kind of an enforcement structure It is necessary to explore strategies whereby people internalise a norm.

This presentation traced the law-policy dynamics in the realm of mental health and the necessity for gendering it. The Indian mental health policy serves as a footnote to the health policy and has been actuated by similar bio-medical motivations, and has primarily focused on the sites where mental health care shall be provided. These motivations are evidenced by the sites in which mental health care is provided i.e. mental hospitals, general hospitals with psychiatric units, private psychiatric nursing homes and the so called community mental health care programme. The community mental health programme is no more than dispensing psycho-therapeutic drugs to people within the community instead of requiring them to come to the hospitals to obtain the same. The National Mental Health programme of 1982 just factored in mental health into the health policy.

Mental health in Indian society, as in others, carries with it stigma and the law has to a great extent contributed to this perception. Mental health is seen as disruptive of law and order thus laws are devised as interventions. The role of law in the field of mental health and the impact of existing mental health law on women with mental illness was outlined.

Law interacts with mental illness in three kinds of ways: one in order to adjudge whether a person possesses the legal capacity to undertake any transaction be it entering into a contract, taking a child into adoption or selling property. The legal conception of capacity has a mental and a physical element. In so far as mental illness could undermine this mental capacity there is a legal engagement with mental illness in wide ranging areas adjudging the validity of the transactions.

The maintenance of order is another major function of law. Persons with mental illness are believed to pose a danger to this order. The need to control the dangerous dimensions of mental illness provides the second reason for legal engagement with mental illness. Insofar as a person with mental illness lacks the capacity to undertake a legally valid transaction and is vulnerable to exploitation, the establishment of caretaker arrangements is the third function of law.

Commenting on the impact of various laws on women with mental illness it was

pointed out how an examination of law relating to institutionalization showed that it was easy for women to get in but difficult to come out. The discharge procedure is discriminatory of women because, despite the constitutional dictates, the managers of mental hospitals refuse to release women without an escort even when they are medically fit. Since a number of women make it to a mental hospital because of family abandonment, this requirement becomes impossible to fulfill. Mental hospitals function as closed institutions and it is not open to the ordinary norms of public visiting. In these closed institutions many travails of sexual exploitation never see the light of the day. Even with the inadequacies of mental health institutions it is important to realise that if there no institutions it will be women who will be the major carers of persons with mental illness.

Moving to Family Law it was discussed that divorce and nullity on ground of mental illness was introduced into Hindu Law in order to provide relief to women who were saddled with insane husbands. But the utilization of law was primarily against women and not by them.

The exercise of gendering mental health policy would promote a more complex and complete understanding of the field which would not lean either only towards society or the affected individual as women figure on both sides of divide.

Discussion

* **Individual versus societal needs** The balance between individual and collective needs can also be better understood from a gendered perspective. This dichotomy also needs to be looked at within uniquely Indian perspective. Here discussion focussed on how the individual needs were often subsumed under societal needs and norms. Women often play the role of carers but are not given care when they need it. On the other side we need to to give value to the role of care giving and its place within a society that values the collective, often over the individual. We thus need to find a balance where both the individual and the collective are given important.
* **Linking sexual violence to mental health** - Need to look at whether sexual harassment and rape have been addressed within the mental health law. For example there was the case of sterilization of women in the mental health home without their consent. Women who are mentally unwell and especially those within institutions are in a vulnerable position to be sexually exploited. Laws that are supposed to empower women sometimes become a double edged sword. For eg. Section 498A is treated as a non compoundable offence and women are not allowed to withdraw their complaint. This sometimes renders them more powerless.
* **What needs to be done** -It is essential to bridge the gap between mental health and law and important to establish the rights of the person. We should begin with the premise that all of us have an unsound mind and it is important to have a revolving door between institution and society.

Health Needs of Pre-Adolescent Girls

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Vacha, India

Background :

A UNICEF document, 'Glimpses of Girlhood in India', reveals that one-fourth of the 12 million girls born in India do not survive to see their fifteenth birthday, and a third of these deaths occur before their first birthday. The document also says that approximately a quarter of India's population of over 900 million comprised girls up to the age of 19 years. But despite being biologically stronger than boys, almost 300,000 more girls than boys die annually.

It is important to look into causes of these deaths and the relative risk of death of girls. The report said that despite the improvement in the economy and provision of basic services in India, the sex ratio has been deteriorating. The 1991 census recorded a numerical excess of 31.3 million males in India. Assuming parity in the 0-14 age group, there were an estimated 7.8 million fewer girls than boys in 1991 and in the 0-19 group the number of "missing" girls was 13.3 million. It is further observed that the relative risk for females increased for the following age group of 5 to 14 and was 15% higher in 1981. The risk for females of this age group increased to 22% and 25% in 1986 and 1993 respectively. The numbers generally do not talk about quality of life but here the numbers are so striking.

Efforts by UN and SAARC have brought about a change in perspective to the girl child's need to be supported and helped. Indian government's efforts to control sex determination tests and to put a ban on selective abortions are some concrete efforts in this direction.

There is the need for increasing women's knowledge about themselves and the need for sex education. Pre-adolescent and adolescent girls remain invisible and there is no systematic study done on this group.

This project opted to study pre-adolescent girls because this age group is not catered to as they are considered too young; and yet what is demanded of them is the work of a grown-up. In our study we found:

* A nine-year old longing for her lost childhood.
* An eleven-year girl likes to listen to music but cannot because being a girl she is forced to take the responsibility of the household chores.
* Almost all bear a heavy burden of some kind of housework.
* Almost sixty percent of these schoolgirls had to take up money earning jobs.

One important issue is child labour, which affects their personality. Child labor does not only mean work done outside the home or for money. There is both earning and non-earning child

labour. If we count school hours and school going, these girls spend between 15 to 18 hours in some kind of labour. There are girls who get up in the wee hours of the morning sorting shrimps, making garlands and other such jobs. There is a myth that child labour can get reduced if primary education is compulsory. It is important to understand that even if girls go to school, they still spend many hours labouring and we need to work out some meaningful solutions rather than blaming parents for not allowing these girls to go to school. The other problem with this group is malnutrition. This is also due to the way the girls themselves and others view them and their needs as secondary in relation to other family members, especially the men and boys. They eat last along with their mother and are busy working whereas the brother studies and does not help. Child labor and unhealthy working conditions often lead to physical problems. Sexual harassment, violence, child abuse, battering, beating as well as sexual violation inside and outside the home are other traumatic experiences faced by adolescent and pre adolescent girls.

The study found that one of the reasons most of these girls dropped out of school was that there was no conveniently located schools that they could attend to pursue further education. One popular misconception about them is that they or their parents do not want to send them to school. The other thing that we found is that it is not their work that is depriving this girl from coming to school. What is serious is directly linked with the total hours they spend in school, work, and in addition caring for and maintaining the family unit. All this is at the cost of making their childhood needs of playtime invisible, depriving them of growth and development and saddling them with adult roles, duties and responsibilities. Its long run effect on their development is tellingly brought out by a remark one of them made, that she wished she could 'go back to her childhood' - this from a girl of ten!

How do we take into account the special needs of these girls in Indian society? They should grow as responsible adults and independent thinkers. Education is one of the ways to equip them to be rational, thinking beings capable of facing and dealing with traditions and pressures of society with an open mind and understanding. The process of urbanisation in growing cosmopolitan city like Bombay has to ensure that amenities provided to these girls have to be of good standard and also should take responsibility to provide schooling facilities beyond seventh standard.

The health needs of this age group have particularly been neglected and have to be looked into with a perspective that goes beyond only looking at them as potential reproducers and focussing on controlling fertility. Health services have to be located in the context of the socio-economic realities of the lives of these girls.

Discussion

Adolescent sexuality- There were questions about sexuality among girls in this age group. Girls are generally shy at this age and often find it difficult to

talk about sexuality. They are exposed to the feeling of shame attached to phsiological change such as the development of breasts.

There was some discussion about lesbianism among girls of this age and that they have a tremendous capacity for physical interaction. Teachers and parents disapprove and are not comfortable, leading to further feelings of shame.

Violence and sexual abuse - Violence is a part of the daily lives of many of these girls, often within the family. But incest is a difficult issue to talk about. Alcoholism is also prevalent in many households.

Self image - This is a very vulnerable age and an important time for the formation of their self image. There are some studies that are looking into this issue.

Addictions - Many girls of this age group are also vulnerable to addictions such as gutkha, tobacco or even alcohol and this also needs to be addressed in interventions with this age group.

Health Care Concerns of Women Workers in Mumbai
Case Study of the Informal Sector

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Introduction :

In the slum area of study there is no dearth of health care facilities. The study found that more than the 430 households had used 40 doctors and hospitals interviewed. This indicates a wide range of providers but does not necessarily ensure access to health care. The problems in the health care system as well as the dynamics operating in the household make it difficult for women to use health care facilities effectively. The nature of health problems suffered by women and the use of health care is inextricably linked to their domestic and work roles.

Health care facilities

Women have utilised a wide range of health facilities apart from the use of self-medication. Women also considered taking time off work as some kind of an alternative to seeking health. In general women expressed a preference for using private health care rather than public hospitals and dispensaries [most studies found that 70% of the non-hospitalized cases are treated in the private sector. The reason for this is that health care sunavailable in the government sector.

Because of the poor state of services in public hospitals, people are using the private sector and thus health services have come to be viewed as commodities that have to be bought. The responsibility of the state for providing health services is not being addressed and this has laid down the foundation for complete withdrawal of the state from the social sector. By this logic it seems likely that no resistance will be encountered when the meagre services are withdrawn.

Commodification and withdrawal of the public sector

The commodification of health is in eveidence in this system as well. The effect of this can be devastating for the poor and especially for women. There is recognition in any health facility that it is not the severity of the problem which guides the decision about seeking health care, but the availability of money. The system is especially cruel and ejects people who cannot pay for the services. It also reveals the insidious way in which peoples right to free health is being violated. Women, in addition, face resistance when they go in for health concerns when they have more than two children.

The most commonly used private facility is the local general practitioner. The women prefer to use the private health facility. Going all the way to a public health facility is seen as a waste of time as they have to spend on travel and they don't even receive 'good' care and have to pay for the medicines. For a working

woman, utilizing the public health facility means that she has to lose the days wages. Even at the cost of ethical/scientific practice, the private sector allows women to tailor the treatment according to their needs [rather compulsions].

The market has an effect on the distribution of health care at the household level. There is a tendency to economise on health care for the economically non-productive members of the household. The study shows that the use of health care by elderly women is higher than that by the younger women. The constant cycle of ill health and debt can be debilitating for some households and compels them to cut down on household expenditure.

Labour and health care

The use of health care is essentially for alleviating symptoms and not for a lasting cure. Women themselves recognize that the root cause of their problems is in their life situation that they are powerless to change. The expectation from health care use is merely to restore their energy enough to enable them to return to work. This, in general, is the limited objective of health care in a capitalist society.

The shift to informal sector employment has further reduced the space that women had to look after their health. As they are not entitled to paid leave or employee benefits in times of illness, they bear the financial cost of health care. In the event of not being able to bear that cost, they pay in the form of developing chronic health problems.

Decision making in the household

Having described the context in which health care is used it becomes easier for us to analyze the process by which decisions regarding health care are taken in the household. Women are constrained by many factors like conditions of work, scarcity of resources and lack of support from the health care system in their choices of health care use. Within this restricted space, women negotiate with their families to seek health care.

The least empowered are the young, unmarried girls whose physical mobility itself is highly restricted. As the girls grow older and accept more responsibility for the household, they themselves do little for their own health, as they are busy looking after others. The role that the husbands play is not only that of granting permission but they are also the means by which women can access healthcare. It is implied that women cannot take responsibility for their own actions. Thus the absence of the husband itself makes using health care difficult for women.

Women do not have the privilege of taking time off work for treatment or for recovery and their paid and unpaid work has to be accommodated within the treatment regimen. This is also borne out in the study where it was found that average period of rest per illness episode was 0.29 days. The treatment may be avoided because the woman does not have time to rest.

The absence of help in the household is a very important deterrent for women seeking health care. Social conditioning prompts women to make sacrifices at the

cost of their health for the sake of the family. With the withdrawal of free public services, the need to gather resources poses a strong obstacle to women's access to resources. Women who act as the invisible workers in the new economy also invisibly pay the cost of health. As the prime responsibility for financing health care is borne by the household, they subordinate their needs to that of other members. At the same time, they seek health care not as an end in itself [for their well being], but only as a means to preserve their capacity as workers.

It is also important to note that the effect of neglect is not visible in a dramatic rise in mortality or morbidity. However an examination of the condition of women's lives and the strategies that they use to cope with illness and childbearing makes it evident that economic uncertainty and the subordinate position of women in the household affects women's access to even the most basic healthcare.

Discussion

* **Food scarcity** - The question of amount of money spent on food was not asked in the survey but scarcity of food was reported. 10-11% people stated that occasionally they had to go without work for week or two and the resultant debt made them unable to buy essential items such as food.
* **Maternity leave and provisions for employees** - The issue of maternity leave was brought up. It was suggested that it is necessary to look at societal provisions instead of only employers. Women's work is invisible and hence it is essential to recognize their work. It was pointed out that even in welfare states paid maternity leave does not exist and in an anti natalist state like India it is difficult to imagine the state supporting women to have children. It is thus necessary to set up fund in which various sections of society contribute, not only the state, so that it is easier to monitor and to have participation of more people. It is important to give value to women's labour. A participant from Bangladesh shared that garment workers there are mostly women. Though employers have the provision for maternity leave, women were wary of taking leave as they would often be replaced during their absence. Thus they would neither get the benefits and they would lose their job.
* Maternal benefit cannot be seen in isolation from childcare facility. It is difficult for a woman to come to work leaving a three-month-old baby behind. The woman does piece-rate work at home thus her labour continues to be used. No allowances are given to her, as she cannot take recourse to formal regulations between employers and employees.
* **Violence against women** - Sexual harassment at work is an important issue and needs to be addressed when we look at issues of women and health. Also domestic violence in the home needs to be explored and effect it has on women's labor.

Matrika Findings about Indigenous Reproductive Health Knowledge and Skills

Janet Chawla
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Introduction

This paper focusses on the worldview and indigenous knowledge that traditional midwives (*Dais)* possess and seeks to validate their knowledge and work. Although words such as traditional and indigenous are often used in the context of *Dai* knowledge, Matrika, which has been working on the traditional knowledge of *Dais* for the past few years, considers the following appropriate words to describe women's reproductive health knowledge: affordable, sustainable, accessible, popular, effective, culturally appropriate. In India there are approximately one million women who work as traditional midwives and attend to 60% of births. They are often the only affordable and accessible practitioners available to poor urban and rural women.

Indigenous diagnostic systems are inseparable from comfort and support giving methods as well as therapeutics and body concepts. *Dais* understandings of the female body are more congruent with Ayurveda, yoga, tantra and other indigenous body concepts than they are with western-derived obstetrics and anatomy-physiology.

The *Dais* ethno-medical system is extensive in its elaboration of postpartum diagnostics and therapeutics. Herbs, rituals, massage, comfort and support are modalities used to facilitate labour, and all of these-with the possible exception of ritual-are readily understandable as being effective. Diagnostics from the beginning of pregnancy (which can be detected by palpating from the fourth week) to postpartum is based on a skilled practitioner's ability to feel, with her hands, the palpable and traceable manifestations of life force in the mother's body. This life energy (sometimes referred to as *'jee'* as in *'jeevan'* or life) seems to provide an important woman centered model of the body and health care based on normative life processes rather than pathology.

Indigenous Diagnostics

Hawa gola

Hawa-gola is an important concept used by *Dais*. *Hawa*-loosely translated as wind, but more specifically within Ayurveda it means movement or motion. *Gola*-again loosely translated as ball or something round perceived to exit the body in 'bad blood and clots'. It is difficult to understand fully what the meanings of *hawa-gola* are-but they are considered threats to the woman's well being postpartum. *Hawa-gola* are some kind of matter, force, or energy which must come out of the body (through the vagina or birth canal), and by all means not go up into the upper part of the body. The space, which was previously, occupied by the

baby is now empty and must be dealt with or it will become a site for the pathology of *'hawa-gola'*. Heating-fomentation and hot foods are therapeutic interventions to deal with gola. Massage to expel the 'bad blood' is also a postpartum therapy to manipulate the space and control it.

Indigenous Therapeutics

Massage is one of the most powerful practices - the hands (and feet) of *Dais* are used during labor and postpartum. Massage, when used appropriately, is an effective therapeutic tool-but used by an inexperienced or unskilled *Dai*, can be harmful and dangerous.

In all four areas *Dais* cut the umbilical cord after the placenta has been delivered. One of the reasons they do this is that if the baby is not responsive, they stimulate the placenta by heating it. Even after the cord stops visibly pulsating they claim that *'jee'* or life force passes into the infant. One Rajasthani *Dai* stated that in hospitals they have drugs and machines to help resuscitate a baby-but that they have no such options, so use this time tested method. They also state that the placenta is more easily delivered if it is still attached to the baby. Both *Dais* and obstetrics advocate the mother's physical movement immediately postpartum.

Indigenous body concepts

Open/closed body

'Opening' of the body is widely used terminology to describe the process of labor; 'closing' of the body refers to postpartum. At the time of birth *'sharir khula hai'*-the body is open. [*Sharir* is also the womb or cervix] At this time of openness the mother is considered extremely vulnerable and raw, open to the other powers. Particularly feared are the *nazar* or evil eye; *bhut-pret* or ghostly spirits; demonic feminine powers, the distorted power of *Bemata* [who grows the baby and is related to *hawa-gola*]. Closing' of the body must occur after the 'bad blood' is expelled. As mentioned above this is facilitated by hot fomentation, heating food, drinks and herbs, massage, binding of the waist, encouraging the mother to cross her legs which also prevent *hawa-gola* or *'hawa'* entering the body.

Issues emerging

* Commonalties in indigenous skills, knowledge and practice throughout the four areas exist- and this evidence points to the probability that there is an ethno-medical system-not random and individual based empirical customs.

* Matrika perceives a need to create a bio-medical language to explain mechanisms by which *Dais* methods maybe effective. It is important to not only train TBA's but also re-orient the scientific community, medical personnel, health policy planners and administrators, NGOs and women's health practitioners towards the efficacy of some of the *Dais'* skills and the bases of their knowledge.

* The negative impact of pharmaceutical marketing and misuse in poor and rural areas cannot be overstated. We might speak not only of the medicalisation of rural India but the

pharmaceuticalization. The irrational and harmful use of *sui-goli* [injection and tablets] is a big problem especially where government medical facilities and practitioners don not exist and untrained people purchase and utilise pharmaceuticals. The danger of re-used syringes in the spread of HIV infection is also a matter of concern.

* The protective and nurturing motivation of tradition-oriented families and communities must be recognized. Some public health and feminist critiques of indigenous practices [such as food prohibitions during pregnancy and post-partum] imply the assumption that practices are motivated by anti-women sentiments. With the glaring exception of the bias towards the male child, this is not usually the case.
* The issue of compensation for *Dais'* work is a pressing one. *Dais* serve the very poor who have no other option of assistance at birth. Barter and ritual recompense is dying out. Almost all *Dais'* are impoverished monetarily and yet they continue to serve in their communities often without pay

Discussion

* **Differences in Dai and allopathic practices** - It was pointed out that during delivery in a clinic or hospital the focus is on the doctor. On the contrary with the *Dais* and traditional methods of delivery, the focus is on the baby and the *Dai* is seen as merely "catching the baby" which is coming out. Modern medicine does not treat pregnancy as normal and natural. Episiotomy is done as a routine by doctors. It is tantamount to female genital mutilation.
* **Misuse of allopathic medicine** - Malpractice in obstetrics is commonly observed and injections of syntocin are a given without much thought. It can be seen as a ritual use of scientific medicine. The injection is used as a symbol of power; there is a need to break out of the myth that institutional deliveries are best. The older *Dais'* state that people nowadays are in a hurry which makes them resort to injections and other such practices. The focus quick devliveries and services, reflects what is happening in societies and *Dais'* end up taking the flak because of lack of power and articulation.
* **Role of Matrika** - The speaker stated that their group did not train *Dais*. Many women's groups and health groups are now involved in training of *Dais* but Matrika feels that it is important to listen to the *Dais* and respect them as decision makers in their own right.
* **Son preference and the role of *Dais*** -*Dais'* popularity reduces with consecutive birth of girls and is also paid less. In Punjab *Dais'* knowledge of lunar rhythms is a effective way to predict conceiving a male.
* **Pollution of childbirth**-This is more because of caste factors and the *Dai* is usually from a lower caste.
* The work and role of *Dais* was brought up in several presentations. It was suggested that all the issues could be brought out together and policy issues could be formulated.

HIV/AIDS - Gender and Policy Issues

Kavita Mathur
Naz Foundation, India

An integral part of slowing the spread of HIV is education and training. HIV / AIDS are complex issues that affect our lives whatever the age, gender, class, caste, religion, sexuality and sexual orientation. HIV is not just a health or medical issue-it is a development issue. The actual number of people living with HIV is on the rise though the Government of India does not have a comprehensive policy inclusive of all players to either tackle the spread of infection or support, care, and provide treatment for those already living with HIV / AIDS.

There are many myths around HIV which hinder successful information dissemination. In India prevention programs for those at risk are often woefully inadequate or non-existent. For example there has never been a media campaign in the area of sex between men. It is believed that the infection can be transmitted only through sexual contact with women, not through sexual contact with other men.

Due to Section 377 (which labels criminal the act of sex between two men), the government has been reluctant to support HIV / AIDS prevention, care and support programs that focus on men who have sex with men. Further, condoms especially for anal sex are not readily available. This discrimination leads many policy makers to ignore gay and bisexual men when funds are allocated for HIV / AIDS programs.

In their work Naz found that approximately 80% of men who have sex with men are married and have children.

Sex and sexuality are not openly discussed in Indian society. 75% to 80% of people with HIV were infected through the sexual route. This presents us with a huge problem-as no one is discussing sex infection rates will continue to rise.

India is largely a patriarchial society and women are the main care givers within the family. They continue to provide care to their husband and children while they themselves take no treatment or care.

In India, eight out of ten HIV positive women were infected by their husbands. The power imbalance between men and women is extreme. Hence women are unable to bring up the issue of condom use with their husband. The position of women in society does not allow them to request for the use of condoms as it is seen as a contraceptive and a barrier to the husband's sexual pleasure. The other key issue with condoms is that they have been linked only to family planning, not as protection against HIV and STDS. Women are also at increased risk of HIV infection since STD symptoms show up late in women and they are often embarrassed to seek treatment.

In India many organisations have prevention and awareness programs focussing on HIV and STDs. A few of the successful interventions include

* Increased condom use with commercial sex workers in Calcutta and Sangli
* Sensitization of hospitals in Maharashtra and Tamil Nadu so that they will accept and treat people living with HIV/AIDS
* A model counselling center at Safdarjung hospital, New Delhi
* A HIV/STD clinic offering treatment advice and counselling for people living with HIV/AIDS
* A care home for people living with HIV/AIDS in New Delhi
* A holistic support program for people living with HIV/AIDS in Chennai

Some of the strategies that have not been as successful generally, include the early interventions and awareness campaigns focussed at "high risk" groups. This had a dual effect of marginalizing these groups and making others think that they are not at risk of infection.

In spite of the National Aids Control Organizations (NACO) training programs in various government hospitals to sensitise medical fraternity, people living with HIV/AIDS still face discrimination and are denied treatment.

It is important to keep in mind certain points when we seek to influence policy related to HIV/AIDS.

* Women are blamed for the spread of the virus in many ways, for instance female sex workers.
* Discrimination is wide spread against people living with HIV/AIDS.
* Confidentiality is extremely important when working with people living with HIV/AIDS
* Partner compliance is difficult
* Any intervention, regardless of its focus on women or men, needs to include both parties
* Where will all the ill people seek treatment? Even if hospitals readily accepted HIV positive people there is already a shortage of hospital beds in most government hospitals.
* There is tendency to blame or think that it is "only those sort of people" that are at risk of infection.

Recommendations for forming policy include:

* As the majority of HIV positive women clients are pregnant or have children already, all antenatal clinics should have counselling facilities for their patients. Also, to reduce the vertical transmission of HIV, AZT should be provided to all HIV positive pregnant women.
* More research into how to make services women friendly need to be undertaken.
* While setting up care and support programs, various options for HIV related treatment need to be taken into consideration.
* Incorporate an HIV/AIDS component in the ongoing work. For instance if an NGO has a clinic for reproductive health clinic they can very easily include information and advice on HIV/AIDS.
* Fighting HIV must be undertaken at all levels in society, including central

government, local government, employers, educational facilities, grass roots organizations, and media.

* Good quality condoms and lubricants should be supplied to reduce the risk of STDs and HIV.

Discussion

* **HIV is not just a medical problem** - It has to be understood as a social issue. Sometimes the person remains asymptotic and passes infection unknowingly. The person's life is stigmatized within the family and community and there is a constant problem of finances as treatment is very expensive.
* **HIV a privileged disease** - Some of the participants stated that far too much emphasis has been put on HIV and it gets privileged over other diseases which are also serious public health concerns such as TB, malaria etc. This was also emphasized in the context of donor agencies and funds being given for research and work on HIV. Funds then determine which issues and diseases get priority.
* **Partner confidentiality** - This issue has been brought up in several forums. It has been suggested that partners have the right to know if their partner is infected; while others stress that confidentiality of the person who has the virus has to be respected. Similar moral issues come up in the context of an HIV positive woman choosing to have a child.
* **Naz outreach** - Naz has various outreach programs where they go to public parks to meet up with homosexuals, kotis etc. who visit looking for partners. Naz also provides with free medication and rehabilitation.

Abortion laws in Nepal

Dr. Aruna Uprety
Health Researcher, Nepal

The presentation began with a description of a case involving a 14-year girl who was sentenced to jail for 20 years for aborting her foetus. However, word of this got around to human rights activists who started a large-scale campaign with headlines in several international newspapers. Due to the pressure, the government was forced to release her after 20 months behind bars.

Nepal is one of the few countries in the world where abortion is illegal. Unsafe, illegal abortion is a major cause of maternal deaths (approximately 4000 each year). It also comes under the definition of "homicide" so that women are sent to jail in case they are found guilty. The abortion issue has never been perceived as health issue for the people who are in the government and those who make policy. Even feminists and activists have not raised it as a women's health issue. It was only after the ICPD and the Beijing conference that this issue began to gain momentum among women's activists in Nepal.

World-wide, the percentage of maternal deaths due to unsafe abortions is 13% but in Nepal this figure is almost 50%. Nepal is among those 4% of countries where abortion is illegal even if pregnancy is a threat to the mother's health or life. That is why hospitals do not perform abortions even as a medical procedure and women are forced to look for other methods.

Many village women are aware of some kind of traditional medicine for abortion in the first 2-3 months of pregnancy. They also seek help of old women and village doctors who might be male or female. Often, pregnancies are terminated in the villages in a brutal manner. A stick with mud or cow dung and even sometimes poison grass is inserted inside the vagina to induce the contraction of the uterus, causing the foetus to be expelled. Sometimes the abdomen of the pregnant woman is massaged with the hand or feet so that the foetus is expelled.

The laws against abortion are especially harsh towards women. Not only are they imprisoned, but the sentence may include confiscation of woman's entire property. This is a provision that makes woman particularly vulnerable to false charges from greedy relatives. As a result of this, an estimated two-thirds of the women in Nepalese jails are convicted of *garbhapat* [abortion].

Abortion and infanticide are crimes against the state, dealt with under the homicide chapter of Muluki Ain, the civil code of Nepal. The punishment is wide ranging from 2- 3 years to confiscation of property.

Ironically, not a single man has been punished for abortion in Nepalese legal history. Society has forgotten the fact that men are equally responsible for women's pregnancy. Male sexuality has never been challenged or even questioned by

society, religion or culture and that very "non-challenge" is reflected in law and practice.

The human cost of illegal abortions

In Nepal maternal death is one of the highest in the world 1500/100000: half of these are caused by illegal back-street abortions. Between 10 and 50% of all women who undergo unsafe abortions need medical care for complications. These and more problems can limit women's productivity inside and outside the home, constrain their ability to care for children and adversely affect their sexual and reproductive lives.

This creates a tremendous impact on the health system. The treatment of such complications often requires several days of hospitalization, staff time, antibiotics etc. The provision of this care depletes funds and medical supplies needed for other types of treatment. As much as 50% of hospital budget in some developing countries is used to treat complications of unsafe abortion.

Movement to legalize abortion in Nepal

Feminists and activists in Nepal are working towards legalizing abortion from the perspective of health and justice for women who are forcibly jailed. A Bill has been drafted and put through parliament recommending legalization of abortions carried out by registered physicians in the first 12 weeks of pregnancy and thereafter in special cases like rape, incest, life threatening situations and where the foetus is diagnosed as being severely handicapped. Medical doctors will be obliged to perform the operation, services will be more accessible to women, and proper information will be made available.

This proposal is based on three realities: First, it responds to the limits of public tolerance and public opinion in Nepal. Second, it responds to the increased awareness of women's rights and the growing concern about victimization of women who go in for abortion. Third, it accepts modern evidence that legal abortion is significantly safer.

Despite the suggested reforms, much work still needs to be done. The proposed Bill does not look at abortion as a 'reproductive rights' issue and does not consider male responsibility. Another Bill was introduced which addressed a number of issues relating to property inheritance, rape and a proposed amendment to the abortion law. But the parliament was dissolved in 1996 before legislative action could be taken.

After legalisation

We cannot hope that the legalization of abortion in Nepal will automatically guarantee access to safe abortion for all segments of the population. There are too many constraints, including the lack of human resources such as doctors and nurses in many parts of the country, lack of confidence of women and financial obstacles. This is only the first step in making abortion a real and safe option.

After legalization, the government will have to ensure that abortion is available to all women who need it. In order to

reduce the current heavy toll of abortion-related maternal death and morbidity, governments, international agencies, women's groups and NGO's must take the following steps. They must ensure universal access to family planning, increase availability of safe abortion services to the extent allowed by law, improve the quality and accessibility of post abortion care, educate communities about reproductive health and unsafe abortion and work for changes in policies to safeguard women's reproductive health. High priority should be given to the prevention of unwanted pregnancy through comprehensive client-oriented reproductive health services, non-judgmental attitudes and confidential counselling. Also, quality family planning information and services should be universally accessible to all women, including emergency contraception where feasible and appropriate.

Discussion

* **Illegal abortions** - One of the reasons cited for MTP not being legalized is that the younger generation will become promiscuous and indulge in free sex. Abortions happen in secret as medical practitioners are not prosecuted and the need is high. This is taken as murder charge and imprisonment could be anywhere from 3 to 20 years. The man or the doctors are never punished. It is essential to bring in the medical community into this discussion of abortion and legalization.
* **Abortion as women's right** -We need to look at abortion as a right and within the context of women's right to their body. Abortion should be placed within the context of safe motherhood – if it is a woman's right to have a baby, then it should also be her right to not have a baby.
* **Abortion as contraception** - However, on the other end one finds that in India abortion is often used as a contraceptive and for sex selection. In Nepal MTP is done by ANM equivalent. MR (Menstrual regulation) is usedfor abortion but it cannot be done officially and has to be done in secrecy.

Symposium on Women and Health Policy

November 12, 1999

UNDP Hall, New Delhi

The symposium was organised to share the proceedings and recommendations from the workshop with representatives of government and international development and donor agencies.

The symposium began with sharing the recommendations that were drawn up by the participants of the workshop (See Appendix - I).

This was followed by presentations by representatives of donor and international agencies and government. The summaries of these presentations are given below:

Geetanjali Mishra
Ford Foundation

The Ford Foundations' Reproductive Health Program aims to stimulate both the non-government and public health delivery systems to better address reproductive health needs. The programme currently supports social science research; innovative community level projects that can serve as replicable models to the public sector; HIV/AIDS prevention activities; and a wide range of media, documentation, networking, and training initiatives to advocate reproductive health and women's empowerment.

The foundation funds three types of women focused programs -

* Reproductive Health
* HIV/AIDS and Sexuality – HIV is an entry point for addressing issues of sexuality. It is important to break the silence around sexuality. Women and adolescents are priority groups.
* Violence against women – It is necessary to engage with public and private institutions in addressing this issue. Violence is also a health issue and not just a legal issue since the health sector is very often the first contact for women affected by domestic violence. Research work on domestic violence shows that community based health facility gets reports of cases. There is a project with BMC and CEHAT in Mumbai to have crises centres in public hospitals.

Gerard Howe
DFID

Regional meetings like this are very informative as they bring together bilateral offices to communicate and stand on a common platform. DFID has a target to reduce Maternal Mortality, Infant Mortality Rate and provide access of health services to all by 2015. DFID has a gender equitable strategy also known as the twin track approach. The requirement is to mainstream gender while addressing power dynamics to look at interventions. DFID has collaborated on producing a gender atlas to look at various aspects of gender

discrimination using the medium of maps. Work is also being done with Lal Bahadur Shastri Academy in Mussorie to train IAS officers to give inputs on gender and sensitise them to this issue. Health work supports GOI on different programs such as TB, HIV, SMP etc. The major emphasis is on RCH and there is a need to work with women's groups and organizations. DFID wants to work with civil society, unions to lift out people from poverty and it is committed to this work. They are also interested in multilateral programs like World Bank's RCH program.

Currently WB, DFID and Government of India are conducting a study on decentralization of health services in India. One of the concerns that most NGOs have is about the secrecy of WB documents which are not shared despite peoples' right to information but this is not a problem unique to big agencies. There should be a democratic process of sharing information.

Dinesh Aggarwal
UNFPA

UNFPA is focussing its work on 40 districts in the 6 states of Madhya Pradesh, Rajasthan, Gujarat, Maharashtra, Kerala and Orissa. It has an extensive program with active participation by NGO's, PRI's and the government. There is a need for a broader public health perspective and to look into reproductive and non-reproductive mortality and morbidity. The focus of the government programs has been on maternal mortality and not on incidence and patterns of morbidity. UNFPA is focussing on quality of care. Occupational hazards among women in the unorganized sector are being studied. A study was conducted in five states to look at pollution and effect on respiration, lungs, bodily function, still birth and premature babies etc. Hard data is required to study risk to women. There has been training of medical doctors in Himachal Pradesh and Haryana for gender sensitization so that they can be more sensitive to the needs of the client.

Reproductive health is a phrase not many people are comfortable with and this needs to be changed with consultative processes. Reproductive health approach is very broad; it is a set of mechanisms to ensure a set of rights.

Ashi Kathuria
USAID

USAID works with ICDS on maternal health aspects. Most programs club women and children together. There is need to talk about women's empowerment and violence against women. USAID funded two National Family Health Surveys where the preliminary reports revealed indicators of women's health and violence against them. The need is to share data and disseminate it on a wider regional and national level with NGO's.

States of Bihar, Andhra Pradesh, Sikkim, Rajasthan, Gujarat, Orissa indicate high levels [70-80%] of anaemia in women and children. Girls tend to lose more blood after menarche, which gets aggravated by pregnancy making anemia a life long problem. Iron and Folic Acid tablets were distributed to 20% women. The antenatal

care received by women is as follows: -

30% in Bihar
88% in Andhra Pradesh
39% in Rajasthan

Access to health services is a big problem; MCH program is difficult to reach by mothers even during their pregnancy and hence has not been very effective. A better Management Information System is the only solution. Women hardly ever come forward with their queries of STDs and RTIs showing that health-seeking behavior among them is very poor.

Programs have to be broadened to include new audiences such as adolescent boys, along with adolescent girls.

UNICEF

In South Asia discrimination against girls and women is widespread. Bias against girls is evident when boys receive better care, nutrition and access to health services, education and job skills-advantages that carry over into adult life. Discrimination also leads to violence against girls and women and often to death.

Discrimination is further evident in the region's high maternal mortality rates, which average 610 deaths of women for 100,000 live births. The Safe Motherhood Initiative, has been a major area of work in South Asia for the UNICEF among the programs related to women's health. The Safe Motherhood Initiative, supported by UNICEF, WHO and other organizations, aims to ensure that girls and women receive essential care and adequate nutrition and have occess to timely emergency interventions when birth complications arise. In India, Safe Motherhood now represents the largest component of UNICEF support for women's health.

One of the greatest strengths and challenges that international agencies such as UNICEF face is working with the government, especially in a country like India, which has a strong national policy. Over the years, UNICEF has been able to work succesfully with both the government and local non-government organizations.

Dr. Ali Razaque
Government of Punjab, Pakistan

Pakistan has inadequate health services for women at all levels in the public sector. The neglect of the obstetric and gynaecological departments in most tertiary hospitals.

The government of Punjab is initiating a Women's Health Project that will focus on the improvement in quality and coverage of services for women and children. The objectives of this project are

* To increase access to reproductive health interventions
* To develop women friendly district health systems delivering comprehensive health care at community, primary and first levels in eight districts
* To build institutional and human resource capacity to support MCH/

FP with special emphasis on women's health.

The expectation is that the project would help improve the health of women and children resulting in lowering the morbidity and mortality rates. Improvement in the health of women would increase productivity and welfare of the people living in the area.

In Pakistan there are several independent bodies working for the cause of women's health such as Pakistan National Forum for Women's Health, National Council for Maternal Health. In addition there are a number of NGOs like Family Planning Association of Pakistan, Women's Action Forum, War Against Rape, Rozan, Shirkat Gah which are actively involved in different aspects relating to women's health.

Ms. Ayesha Begum
Ministry of Health and Family Welfare
Government of Bangladesh

Health is an important phenomenon which is intricately related to a given socio-economic and cultural context.

The major problems in relation to women's health in Bangladesh are:

* Poor sex ratio (94 females for 100 males).
* High female infant mortality rates, especially upto the age of one year, which ranges from 105 to 125 per 1000 live births.
* High maternal mortality due to abortion, eclampsia, postpartum and tetanus

Besides these, poor nutritional status, vulnerability to sexually transmitted diseases such as HIV and AIDS are important health issues to be dealt with by the government.

One of the major areas of work by the government has been on reducing fertility rates. This is being done with the support of donor agencies. Steps have been taken to increase contraceptive choices and make the service more sensitive to women's needs

Mr. Guha
UNIFEM

Mr. Guha was requested to speak on the health policy in India as there was no representative from the Government of India. He stressed the need to explore health in a holistic manner and have an overview of women's health and gender issues and to look at the thrust of the health policy. It has been noticed that women's life expectancy has increased slightly. But a commonly perceived problem is that state wise data is skewed to give a correct picture. For example there is a major gender gap at different age levels in terms of mortality beyond 1 year, and excess mortality of girls is reflected in decreasing sex ratio.

GOI has played a pro-active role, through the 5-year plans. The 1st and 2nd plan showed a welfare approach to women. Major change from 3rd plan has been to look at women from the view of population experiment and act as instrument of control. 6th plan took on a different flavour with emphasis on employment and the anti-poverty question. The next two plans focussed on re-

search and development. The MTP Act was passed in 1971 and the amniocentesis act was passed which was seen as pro-women. But there is still need for more Doctors, Primary Health Centres and sub-centers. India comes second to China in the number of PHCs but the system is not helpful to women. The 9th plan wanted to see empowerment of women as an objective and mentions strategy for ensuring this : -

* Transfer control of social infrastructure to women's groups which is a very progressive and positive approach if implemented.
* Every minister of state and government will have to a) Do evaluation of past plan and how it has affected women, b) project new plans " doing mode" for women.
* Space would be given to women to ask questions and generate data but not many follow-ups have been done in this regard.

The following were among the issues that were discussed:-

* There is a need to co-ordinate efforts to look at multiple healing systems and to encourage regional participation in this area.
* Occupational mobility of women has not been included in the recommendations and there must be some cognizance of the issue as it was discussed during the workshop and identified as another invisible group.
* The hierarchy of diseases needs to be recognised and how certain diseases are pushed behind the overwhelming shadow of HIV. For example India and Bangladesh together have one third of the world's TB population. This serves as a reminder for us to recognize other pressing issues, which deserve attention.
* We should not only to look at the so-called " high risk groups" but view peoples' life in an integrated manner. One cannot speak in isolation of women's health and well being without connecting it with other issues because it will be spoken of in a piece-meal manner. HIV should be viewed in a holistic and broader scenario.
* The problem is that it is difficult to get a monitoring system in place which will be usable in a wide area. It might be a good idea to set up a community based MIS and to include paramedics, doctors, educationists and women. Community monitoring should have the involvement of minorities and other groups.
* All the participants felt very strongly about integration of several issues. Maternal mortality is high but more women die of TB and domestic violence. The major issue is women's health seeking behavior and how to make the health care system friendlier.
* *Dais* are very important in delivery of health in the subcontinent and this needs to be recognised.

Concluding Session

Akhila Sivadas (Centre for Advocacy Research, Delhi) facilitated the session on advocacy and future strategies. She stressed the importance of advocacy as a strategy through which clear objectives can be achieved to change peoples' opinions. The distinguishing characteristic of advocacy is that it begins with a clearly defined goal. Advocacy exists at many levels. It has to be addressed at different levels to be effective. The final goal is to bring in policy changes that will impact different groups.

We should network and advocate on issues which have emerged in the course of the workshop and follow up with some kind of activity.

Major issues to work which have been identified from this workshop are : -

* To build a South Asian data base of contraceptive usage focusing on injectables such as Depo–Provera. This could be used to campaign for safe and effective contraceptive delivery
* To have a strong campaign for decriminalising abortion in Nepal and making it accessible for women.
* To create a database on issues and innovative case studies about PHC's. These case studies and experiments could be used for advocacy.

To supplement all these efforts one has to start accessing government records as we have a right to avail information. What can be done to impact the system and creation of data, which will be useful, built on the knowledge of all participating countries.

The workshop participants were divided into three groups to plan for work to be done on the three areas

PHC Database

* Look into the management of the health system from within- including MIS and recording of data.
* Management from outside which will include participation of external agents and how they influence the health system.
* Documentation based on women's problems, needs and expectations.

Depo Provera Database

* To look at Depo Provera usage in the five countries.
* In Bangladesh to look at the records, which could be accessed from Gonoshasthya Kendra which has been providing Depo for the past twenty years.
* To look separately at user and provider perspectives.

Abortion campaign in Nepal

* To collect data on existing abortion services.

* To document women's experiences of accessing abortion services.
* To network in the region.
* To lobby with the government, using international conventions such as CEDAW.

RECOMMENDATIONS FROM WORKSHOP ON WOMEN AND HEALTH POLICY IN SOUTH ASIA

Women's Access to Health Services

- Promote healthcare seeking behaviour among women
- Create a pro-active environment for women to access healthcare in PHCs/ BHUs and other community based healthcare services, especially in terms of availability of female staff.
- Strengthen community based healthcare services
- Empowerment of community based health workers by providing technical and effective and skilled for community participation
- Integrate Primary Health Care and Family Welfare Services at community levels as well as higher levels.
- Health personnel should be women friendly and gender sensitive
- Comprehensive healthcare for women at PHC/BHUs, specifically for tuberculosis, malaria, reproductive health services, mental health, control of cataract blindness. There should also be community-based rehabilitation for people with disabilties.
- Services for safe motherhood including antenatal care, safe delivery, postnatal care should be ensured through PHCs/BHUs with appropriate referral as required
- Referral system from the community to the PHCs/BHUs to Secondary and Tertiary Services
- Better monitoring systems for efficient health care services
- Accountability to community by forming Village Health Committees and PHC level Committees
- The right to information to citizens (particularly women) for greater transparency and effective utilisation of health care services.
- Consumers Forum and Laws to protect citizens rights to Health Care
- Multiple healing systems should be recognised and promoted

Abortion

Unsafe and illegal abortions are a major threat to women's health in the region. The particular case in point is Nepal, where about 50% of all maternal deaths are attributed to unsafe abortions. Not only that, but due to peculiar social and legal circumstances

a large number of women are prosecuted each year on charges of having illegal aborions. The issue was looked into from health and rights perspectives of women. Therefore abortion should be:

- decriminalized
- safe
- affordable
- accessible

Traditional Midwives

Traditional and indigenous knowledge systems should be recognized. Today in South Asian countries 50-80% child births are attended by traditional midwives. Therefore their role as health care providers to women must be recognized. An effective referral system must be developed to increase safety . This should comprise of Traditional Midwives, Primary Health Facilities and Secondary Care Hospitals. There is a need to conduct research to better understand cultural, traditional systems which the traditional midwives are part of.

Pre-adolescent and Adolescent Girls

- To have space for adolescent girls to be able to discuss problems and have access to counseling.
- Compulsory sex education in schools in which information on rights of children according to UN Convention on Child Rights should also be provided
- Training to be financially independent.

Drug Policy

- Rational, essential, non-hazardous drugs should be made available to and affordable for people.
- All drugs should have list of side effects, contra-indications and contents clearly for both the health care providers and users.
- Before allowing drugs into the country they should be properly tested for safety and efficacy
- Steps should be taken to check the manufacturing and distribution of spurious drugs
- Adoption of Drug Policy in one country in the region is undermined by the availability of unnecessary and spurious drugs in other countries. It is important to consider a regional perspective on drug policies.

- Important life saving drugs should be manufactured in the country/region to make them accessible and affordable.
- Mechanism should be set up for effective monitoring of drug policy implementation
- In a context of present globalization taking place, the cost of life saving drugs has increased several folds - this should be taken care of.

Contraceptive Technology

- Availability of safe and non-hazardous contraceptives for men and women be ensured
- Initiatives to encourage male contraceptive technologies.
- Make proper information and counseling services available to women on contraception and its possible effects including long term ones.
- Need for informed consent to be given importance and priority
- Reduce expenditure on foreign contraceptives and allocate resources to conduct research on and provide safe, indigenous, herbal contraceptive.
- Recognize right of women to not use and/or stop using contraception
- Adequate health infrastructure for screening and continuity of care for contraceptive users, particularly for long-term effects.
- Contraception should be provided according to what women want and need.

STDs, RTIs and HIV/AIDS

- STDs, RTIs and HIV/AIDS are significant health problems. Education about safe sex should be provided through the education system.

WORKSHOP ON WOMEN AND HEALTH AND POLICY SOUTH ASIA: STRATEGIES FOR CHANGE

November 9th to 13th 1999.
Sanskriti Kendra, Anandgram, New Delhi

Day One (Tuesday 9th November)

Welcome Speech and Introduction to SANGAT
Kamla Bhasin, FAO-NGO South Asian Programme

Introduction to the Workshop
Kalpana Viswanath, Jagori

Health Policy in India - An Overview
Dr. Rama Baru, School of Community Medicine, JNU-India

Health Policy in Bangladesh - An Overview
Nasreen Huq - Nari Pokkho -Bangladesh

Drug Policy Situation in Third World Countries
Dr. Zafarullah Chowdhury - Gonoshahsthya Kendra - Bangladesh

Health Policy in Nepal
Dr. Aruna Uprety- Nepal

Day Two (Wednesday 10th November)

Overview of Health Situation in Srilanka
Dr. Jayalakshmi - Centre for Human Development - Sri Lanka

Women's Health Policies in Pakistan
Faraah Parvez Saleh - CCHD - Pakistan

Implementing Reproductive and Child Health (RCH) Policies in Tamil Nadu
Dr. Leela Visaria - Institute of Economic Growth - India

Managing Primary Health Care Centres by VGKK
Dr. Sudarshan - VGKK - India

RUWSEC's Work with Public Health Centres
Deepa Venkatachalam - RUWSEC - India

New Contraceptive Technologies
N.B. Sarojini

Need for a gendered approach in treating Tuberculosis
Dr. Purabhi Dutta - BRAC - Bangladesh

Day Three (Thursday 11th November)

The Baluchistan Safe Motherhood Initiative (BSMI)
Dr. Farid Midhet - The Asia Foundation - Pakistan

Mental Health Policy and Gender
Dr. Amita Dhanda - NALSAR - India

Health Needs of Pre-Adolescent girls
Swatija Manorama - Vacha - India

Health Care Concerns of Women Workers
Neha Madhiwalla - CEHAT - India

Matrika Findings about Indigenous Reproductive Health Knowledge and Skills
Janet Chawla - Matrika - India

HIV/AIDS - Gender and Policy Issues
Kavita Mathur - Naz Foundation - India

Abortion related complications in Nepal
Dr. Aruna Uprety - Nepal

Day Four (Friday 12th November)

Symposium - UNDP HALL

Welcome Speech
Abha Bhaiya - Jagori

Presentation of Workshop Proceedings
Kalpana Viswanath - Jagori

Recommendations
Shipra Bose - Bangladesh

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