INTRODUCTION

The health of mothers has been a subject of national interest in India since independence. Mention has been made time and again in different documents of how crucially important the health of mothers is for the health of children and of the future generations. Specially targeted programmes have been implemented within the larger family planning programme looking after maternal health. But over the last fifteen years or so there has been a growing unease (all over the world) over the exclusive concern for women only as mothers or potential mothers (cases for contraception). This single-minded attention to only one aspect of a woman's life and health also reflects the overall value that society places on women.

Women's health is a very complex issue- it is influenced by a host of social and economic issues. In the male-dominated/patriarchal social setup that we live in, women's own perception of their bodies and health is very low, and is controlled and mediated by numerous mores and practices. In such a situation women often do not even bring forward different complaints – especially if these have anything to do with their reproductive tract. Women's reproductive morbidity has been referred to as a silent emergency, taking into consideration how widespread and serious the problem is. Current evidence indicates that it is not just the burden of reproductive morbidities that women, have to silently bear, but many of the so-called public health diseases too show increasing preponderance in women, not because of their sex but because of gender.

This Resource Pack covers the different issue and concerns around women's health in two booklets. The first of these, the present booklet, covers some of the basic determinants of women's health with a focus on maternal health, while the second booklet deals with other non-maternal issues like abortion, infertility, reproductive tract infections and cancers in the social context. This booklet is arranged somewhat differently from others inasmuch the first section deals with concepts and issues around women's health while the second section deals with safe motherhood. As in other booklets brief profiles of organisations working on the issue as well as different resource materials that are available are included in sections three and four.

SECTION ONE

Understanding Maternal Health in the Context of Women's Health

What is Women's Health?

The term `women's health' is a complex one and encompasses the entire gamut of social, cultural and medical aspects of a woman's life, which affect her health – either positively or more often negatively. It has now been clearly established that the socio-cultural determinants of health are equally important as the bio-medical determinants. This is more so in the case of women whose lives are controlled by numerous social norms and practices. For understanding how these impact women's health we need to look no further than the different customs and taboos associated with menstruation, pregnancy and childbirth. Examples of how different socio-economic factors affect women's health will be discussed at greater length later.

The term women's health has also to be understood with reference to some other popular terms like maternal health and reproductive health. **Maternal health** is the oldest of these concepts and clearly relates to health of those women who are involved in bearing children. It excludes from its ambit the health of a whole range of women who cannot, do not want to, or are simply not involved in the process of becoming mothers. Therefore it excludes a large group of women – all their lives (women who are infertile or do not choose to bear children), and all other women for most of their lives (as adolescents, adults not in the process of bearing children, or older women). Hence it can be argued that following an exclusive maternal health approach limits the health system to viewing, or giving importance to women only as child producers. This also reflects the intrinsic value such a system places on women. Looking only or mostly at women as potential cases for contraception is an extension of this limiting approach.

The term **reproductive health** is a recent arrival in the mainstream health related jargon in India. Though this term is equally applicable to men and women, its use is often more closely associated with women. The International Conference on Population and Development has defined reproductive health as *a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes*. When applied to women, the canvas of Reproductive Health is much wider as it includes women who are suffering from gynaecological morbidities like reproductive tract infections, cancers, infertility and so on. It also addresses the health problems of adolescents. Maternal health is part and parcel of Reproductive Health. The framework of Reproductive Health includes the socio-economic determinants that have been mentioned earler. The only limitation of this concept is that it is restricted to the health concerns around reproduction. Unfortunately, despite all the hullabaloo over the new Reproductive and Child Health (RCH) programme, for many people in the Establishment, Reproductive Health is just a new name for maternal health and family planning.

Women's health not only includes Reproductive Health and maternal health, but also includes other matters that are generally seen as public health concerns. Thus any health problem/situation which affects women due to their gender are included within women's health. There is increasing evidence to show that women are more susceptible to a number of health conditions because of differential gender relations which include poverty, workload, violence, lack of decision-making and so on. Thus if women suffer from tuberculosis due to certain circumstances which have to do with their being women, then it is still a women's health issue. Similarly with malnutrition. In some countries, women's activists have got together and advocated for separate women's health policies. Three countries where such policies have been framed are Brazil, Australia and Colombia. South Africa is in the process of doing so.

Women's Health policy in Australia

Australia is the first country to have a Women's Health Policy. The concern for a separate policy for women's health was articulated by women and the Government announced its commitment in 1985. Between 1985 and 1989 when the policy was formally announced, extensive consultations took place throughout the country.

Goal **-** To improve the health and well-being of all women in Australia espcially those most at risk and to encourage the health system to be more responsive to women's needs.

Principles **-** The policy recognises that health is determined by a broad range of social-environmental, economic and biological factors. It also acknowledges that differences in health status and health outcomes are linked to gender, age, socio-economic status, ethnicity, disability, location and environment.

Women's health and the socio-cultural context

A woman's socio-cultural situation and her health are very closely inter-related. Earlier there was a tendency to view health purely in bio-medical terms, but there is an increasing awareness that a woman's health is a product of the complex social, economic and cultural (perhaps even political) circumstances in which she lives. While these factors affect the health of all individuals, they affect women's health more. Some of the different socio-cultural factors affecting women's health are as follows – financial status, education, religion, cultural mores, patriarchy, mobility and so on. Interestingly, socio-cultural conditions are not just contributing factors but also consequences of women's health situation. A small example will illustrate this situation. On the one hand son preference is one of the important reasons behind a woman undergoing repeated pregnancies and sex-selective abortions. On the other hand the inability to bear sons, leads to a consequence where women have to face social alienation and even desertion. And this is just one example.

Gender and Women's Health

Gender and Sex

Gender – Gender refers to the socially constructed roles ascribed to males and females. These roles, which are learned, change over time and vary widely with and between cultures.

Sex – It is the biological distinction between males and females. It is determined with reference to genetic and anatomical characteristics.

In India (as in many other countries) women's low social, political, legal and economic status contribute to the health problems of girls and women. Unequal gender relations are one of the strongest determinants of women's health. Right from the womb there are a number of gender - based discriminations which affect women's health. Selective female infanticide and female foeticide is prevalent in our country. It is common knowledge that girl children are given less care and nutrition and are less educated. The work load of women is greater from childhood itself - work they hardly get credit for. Then there are numerous restrictions – during menstruation, during pregnancy, and during lactation. In addition, women are rarely allowed to influence decisions in the family and community. They often have no rights under traditional laws and have no control over money or other resources. All these factors contribute to women's poor health in numerous ways -by preventing them from getting timely or adequate medical care, limiting the amount of money that can be spent on their food or other necessities, and of course subjecting their bodies to far greater wear and tear. There is a basic inequality between men and women in which-

- more women than men suffer from poverty,
- more women than men are denied the education and skills to support themselves,
- more women than men lack access to important health information and services,
- more women than men lack control over their basic health care decisions.

As mentioned earlier, these inequalities affect their state of health. Usually, except for women's reproductive abilities, the health needs and concerns of men and women are considered equivalent if not the same. But women are not only biologically different from men, they are socially, politically, and economically different. Women's roles, the way they are treated, is different

from men, both at home and within society. There are many health consequences of such inequality. Fortunately the ICPD has included gender as one of the important determinants of Reproductive Health, but time alone will tell whether this important principle of the Cairo agenda is translated into practice in our country's programmes.

Women's health and the health care delivery system

The quality of health care women usually receive is unsatisfactory at almost all levels. Most health care service providers from nurses to doctors are trained in the bio-medical causation of disease and are inexperienced about

Gender Dimensions of Maternal issues

Anaemia in Pregnancy

Level	Gender dimensions
At the level of causation	Dietary customs and restrictions leading to inadequate food intake Unequal workload distribution leading to heavy workload Repeated abortions and pregnancy etc…
At the level of consequences	
• Response of the individual	Self blame Works hard despite weakness fearing scolding Delays treatment seeking etc…
• Response of the family	No sharing of workload Accused of malingering Delayed treatment etc…
• Response of the provider	Blames for not seeking care early, not taking proper diet, not following instructions, not taking I/FA tablets etc…

This is true for other maternal health related conditions as well like - Ante-natal care, childbirth, ante-natal problems and so on.

the different socio-cultural factors that affect women's health. This often leads to a gross insensitivity to women's health needs, and this is reflected in their treatment of their clients' needs in terms of quality of service and nature of advice. This is true even for service providers who are women. The problem partly lies with limited availability of resources but the limited professional skills of health service personnel also plays a major role.

There is an urgent need to take certain measures to change the situation. Foremost among them is to provide upgraded training to health professionals (at all levels, but especially at the level of ANMs, nurses and PHC doctors) so that they can improve and update medical skills. Secondly service providers need to be reoriented in a way that helps them to develop their social understanding of women's problems and skills in better

communication. This would sharpen their ability to identify women's needs and understand their problems, and also enable them to deliver services in a more gender sensitive woman-friendly manner.

Women's Perception Of Their Bodies

As human beings, our perceptions are mediated by how society, the people around us, view certain things. Likewise women's perceptions of their bodies is not really *their* own perception only but a conforming version of what society perceives in general. Society sets standards which are considered normal and anything differing from that standard is not considered `normal' giving rise to a sense of inadequacy in many women. Different social institutions and factors play a vital role in setting standards and in defining what is normal. Among these the role of the media (print and audio-visual), market (advertisements, beauty pageants), peer group and the marriage market are some of the most influential. Women's self worth is also shaped by the numerous inequalities they experience within the family and society right from early infancy, if not from the womb. All this leads to a general feeling of low self-worth.

Elements of women-centred health services

Any health policy or programme that aims to deliver gender sensitive health services for women should have the following elements. It should -

- be gender sensitive at all levels
- respect diversity of women's health needs,
- respect women's cultures and local health traditions,
- be based on epidemiological and women's expressed health needs,
- keep socio-political reality of women in mind, and finally
- have intersectoral coordination of all policies and programmes affecting women's health.

The case is even worse as far as their reproductive organs are concerned. In this context women's bodies and its bodily processes are considered shameful and defiling in most Indian cultures. Consequently, women shrink in and are segregated to their little spaces during menstruation, pregnancy and childbirth. For example, shame and pollution are obvious in most menstrual practices and taboos. Pollution comes to the

forefront even during advanced stages of pregnancy, and after childbirth. In many societies the new-born infant and mother are often considered impure and polluting until they have taken a purifying bath some days later.

Since women's bodies are devalued in society, very little information is given to a girl about her body and bodily processes. She grows up hardly knowing anything about the form and substance she is devalued for, but the sense of devaluation is very strong. Soon she also starts disapproving of her own body. This sense of alienation from her body affects her health-seeking behaviour also. She does not give much importance to her ailing state, and hence seeks no remedy to overcome her illnesses. This is particularly seen in her phenomenal silence about gynaecological morbidities.

Menarche, Menstruation and Menopause

The biological difference between men and women lies primarily in their reproductive organs and the way these organs function. The obvious physical characteristics/ differences of the male and female are divided into primary and secondary sexual characteristics – primary being those which are evident from birth (genitals) and secondary being those which become evident after puberty (body hair, breasts, timbre of the voice, shape of the hips etc.) Menstruation and child-bearing are two fundamental process differences between the two sexes. Menarche and menopause define the limits of the maternal life of a women while menstruation is considered an indicator of fertility or maternal potential. In bio-medical terms menstruation is the periodic shedding of the uterine lining approximately every 25-30 days for 3-7 days. Menarche is the time when this process first starts. The usual range being between 10-16 years. Menopause is the time menstruation finally stops. This usually takes place anywhere between of 40-45 years, even 50 in some women.

Cultural practices surrounding menstruation

A study on socio-cultural aspects of menstruation reveals the following -

- One fourth of the women were married before menarche
- In some cases marriage was even cosummated before menarche
- Menstruation is seen as the expulsion of dirty blood from the body
- Menstrual blood could harm the body if it did not come out
- Menstrual blood is considered heat of the body
- Sexual intercourse is avoided during menstruation
- Very few women have knowledge about mensturation prior to its onset
- Women are considered untouchable during mensturation
- Women are not supposed to go into the kitchen during menstruation , but due to the nature of families many women do
- Many women do not bathe during mensturation
- Certain kinds of food, especially hot and sour should be avoided but most women do not follow these restrictions
- Religious practices were avoided during menstruation- visiting holy places, touching religious text etc.

(From:Garg Suneela, Sharma Nandini, Sahay Ragini (2001) *Socio-Cultural Aspects of Menstruation in an urban slum in Delhi, India* in Reproductive Health Matters, Vol 9 No 17, May pp 53 - 62)

Menarche, menstruation, and menopause are not just biological events but social events as well. Among these three, the social consequences of menstruation are perhaps the most all pervading. Firstly, there is ignorance and incomplete knowledge about the biological basis of menstruation among women in general and young girls in particular. Then there are the numerous misconceptions. And this is true not only of a conservative nation like India but also of a more open, free and progressive society like America as shown by Koff and Rierdan (1995). They found that school-going young girls who view themselves as "prepared" for menarche have incomplete knowledge about the process of menstruation and harbour a variety of misconceptions.

Also, their knowledge of the location and function of reproductive structure was faulty - most did not understand how reproductive structures are interrelated.

The situation is India is worse. The socio-cultural norms and practices associated with menstruation in India have made it an unwelcome and often disgusting experience for women. Despite the fact that onset of puberty (and menarche) is celebrated in some parts of country, a menstruating woman is often considered polluting, impure and unholy. Women are often not allowed to participate in religious or social functions and restrictions are placed in terms of living space, mobility, diet and so on. The authors have found in their experiences that in some places of Uttaranchal an unmarried girl's menstruation is not acknowledged even by her mother (if it is, then the girls pollution has to be acknowledged) and society colludes in maintaining this secret. Interestingly, in this very society, the menstrual cycle of each married woman is closely monitored by community elders. It is also common practice in many villages to celebrate when the daughter-in-law has her first period, most probably as a symbolic menarche celebration.

Studies (Chaturvedi and Chaturvedi 1991; Sveinsdottir 1993;) have also shown that socio-cultural and biological problems or comforts faced by a menstruating woman define her attitude towards menstruation. Women who report considerable menstrual problems consider menstruation to be

Menstrual hygiene
A public health challenge of epic proportions

While advertisements of sanitary napkins have invaded the drawing room of most Indian families with a television set, many women who see these advertisements have to do without one. The most common practice for soaking menstrual blood is to use a piece of cloth - a rag in many cases. Very little attention is given to cleanliness of this piece of cloth. If this cloth has to be reused - it is dried in a very surreptitous manner. The casualty is menstrual hygiene, which could be one of the contributory factors behind the widespread problem of excessive while discharge among women in India. Sanitary napkins are way too expensive for the poor though some experiments in producing cheap napkins have started in different parts of the country.

"debilitating" and have an "unhealthy" attitude whereas those who have premenstrual well-being consider menstruation to be a natural event and have a "healthy" attitude.

Menstrual Problems

Pain or general discomfort (cramps, backache and breast tenderness) felt by some women around the time of menstruation is known as dysmenorrhea. Some premenstrual symptoms (bloated feeling, weight gain, headache, irritability, mood changes etc.) may or may not associated with dysmenorrhea. There is no single cause for dysmenorrhea, but water retention, hormonal imbalance and other chemical reasons are suggested as possible factors. Social perceptions also mediate the amount of pain and discomfort that is felt during this time. But menstrual pains can also be due to medical problems such as an infection, tumor or endometriosis. The term premenstrual syndrome or PMS is used to refer to those causes in which the woman has a particularly severe combination of physical and psychological symptoms (as mentioned above) premenstrually. Interestingly, for a long time PMS was not accepted as a true health problem by the medical profession and was considered an imaginary situation or an over-reaction. It is important to realise that women who have repeated and severe discomfort and change in behavior before menstruation should be advised to seek specialised medical attention.

The issue of menopause is covered in Booklet Six - The Promise of Better Health.

SECTION TWO

Maternal Health and Safe Motherhood

The Importance of Safe Motherhood

According to WHO figures there is a great difference between the maternal mortality rate (MMR) of developed and developing countries. Maternal mortality being defined as the death of a woman while pregnant or within 42 days of the end of her pregnancy from any cause related to or made worse by the pregnancy, regardless of the duration of pregnancy. In developed countries 1 out of 1,800 women die from the complications of pregnancy and childbirth whereas in developing countries the risk is a far higher: 1 out of 48. A regional variation of women's lifetime risk of dying from pregnancy and childbirth is given below-

Region	Risk of Maternal death
Africa	1 in 16
Asia	1 in 65
Latin America and Caribbean	1 in 130
Europe	1 in 1400
North America	1 in 3700

In India the lifetime risk of a woman dying from pregnancy or childbirth is about 1 in 37, and any risk more than 1 in 100 is considered high risk. The MMR in India is about 500 (per 100,000 live births) and this is probably a low figure because of the inadequate reporting system in our country. In absolute terms this means that over 125,000 Indian women die due to maternity related causes every year. When going through these figures it is important to realise that this is the situation fifty years after the country accepted that maternal health would be a priority area of concern.

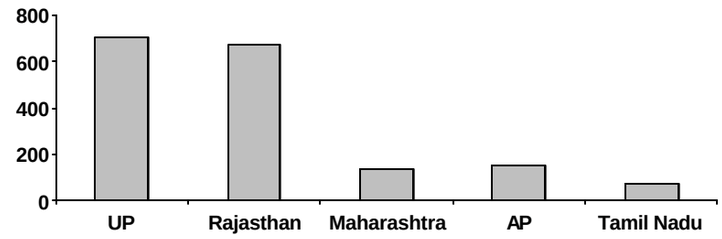


Chart 1: Maternal Mortality Ratio- selected states
Source: SRS-1997

Reasons behind unsafe motherhood

The high risk of maternal mortality and morbidity are surely consequences of the poor socio-economic situation in a country as is clearly illustrated in the figures given earlier. The availability or lack of trained personnel and

equipped birthing facilities are also an important determinant of maternal safety. Women who are young, poorly nourished, anaemic, multiparous and with low interval between childbirths suffering from low social status, lacking appropriate knowledge about health, have far greater chances of complicated pregnancy and delivery. It is difficult to predict complications in many cases. But what makes the different between life and death for the mother is the timing and appropriateness of decision-making, which often depends on the economic situation, the availability of appropriate emergency services, the community's faith in them, and the intrinsic `value' of the woman concerned.

Safe motherhood: the right to life?

"Why should mothers continue to die every minute when the world knows how their lives can be saved? The neglected tragedy of maternal mortality is not simply a health problem; it's a human rights issue"

Professor Mahmoud Fathalla

In India, the incidences of early marriage and childbirth are so high that they pose a serious threat to the life of the mother and the child in question. This teenage pregnancy is not only socially sanctioned but in many communities seen as ideal. We have a law regarding the minimum age at marriage, but this legal restriction has made little difference because of the lack of political will to enforce it. Health care service delivery is extremely poor despite years of pursuing a maternal health agenda. Ante-natal care is restricted to anti-tetanus injections and an overwhelming majority of childbirths take place under the supervision of untrained attendants. Even so-called trained attendants often leave all their training behind when actually conducting the delivery. Referral facilities are often ill-equipped and the current promises of FRUs (First Referral Units) and EmOCs (Emergency Obstetric Centres are the only hope millions of Indian women can look forward to.

Ensuring Safe Motherhood

Safe motherhood means ensuring that all women have access to the information and services they need to go safely through pregnancy and childbirth. As outlined in the ICPD (PoA), maternal health services should include

- education on safe motherhood
- prenatal care and counselling with focus on high risk pregnancies
- promotion of maternal nutrition
- adequate delivery assistance in all cases
- provisions for obstetric emergencies including referral services for pregnancy, childbirth and abortion complications
- post natal care

Common causes of Maternal death

The main causes of maternal mortality may be divided into 3 categories - social, medical and availability of health care facilities. Among the **social causes** are

- early marriage and pregnancy,
- repeated childbirth
- preference for sons
- anaemia
- lack of information about danger signs and symptoms
- delay in referral

Among the **medical causes** are

- obstructed labour
- haemorrhage, (ante-natal, during labour and post-natal)
- toxemia and
- infection or sepsis

And among **availability of health care facilities** are

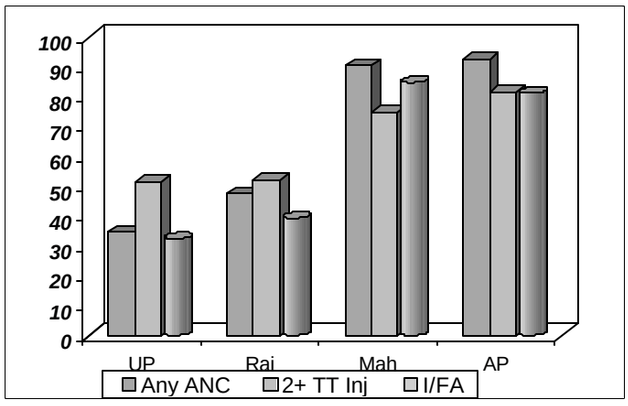
- lack of essential supplies and trained health personnel at the centers
- non-sympathetic attitude of health personnel
- deficient medical treatment of complications and
- inadequate action taken by medical personnel.

(Adapted from: Safe Motherhood in India,; The Need for Comprehensive Policy and Programmes 1994).

Antenatal Care

Infant and maternal mortality rates (IMR and MMR) of a country reflect the socio-economic development, accessibility to health care and nutritional status of that country. Hence IMR and MMR - which still remain pretty high in India - not only represent a loss of precious lives, but also discredit India's

Chart 2: Antenatal care indicators in selected states Source NFHS 2 1998-99



health and welfare programmes. Such a high rate of IMR in India persists for want of political will, professional commitment and people's action. Though with the implementation of different programmes related to maternal and child health there has been some reduction in IMR and MMR, but it is far from adequate. Proper antenatal care (ANC) is perhaps one of the first things that can assist in this direction.

Ante-natal care refers to health education and regular medical check-ups given to a pregnant woman in order make the outcome of the pregnancy safer, reduce cases of maternal morbidity and mortality through early detection and treatment. ANC is also necessary to screen high risk pregnancy (HRP) and high risk labour signs. A history must be recorded of any past and

Table 1: Health Problems during pregnancy

Problem during pregnancy	Urban	Rural	Total
Night blindness	6.4	13.7	12.1
Blurred vision	17.0	23.2	21.8
Convulsions for from fever	11.0	15.2	14.3
Swellling of legs, body or face	28.2	25.8	26.3
Excessive fatigue	43.6	43.3	43.4
Anaemia	27.1	26.3	26.5
Vaginal Bleeding	3.1	3.6	3.5

Note: Table indicates only the two most recent births during the three years preceding the survey

From - NFHS 2- 1998-99

present pregnancy-related problems, the abdomen must be examined, height, weight and blood pressure must be monitored, tests for protein in urine must be done. Most of these tests are very simple and can be done with minimal training. Nutritional and other relevant counselling and provision of tetatus toxoid injections are also mandatory parts of antenatal care. The task of high-risk screening can be done by the most peripheral health worker.

In many parts of the country, the socio-cultural milieu does not consider

Table 2 : Reasons for not receiving ante-natal check-up

Source: NFHS 2 1998-99

Reason	% of births
Not necessary	59.5
Not customary	4.3
Costs too much	14.7
Too far/ no transport	3.7
Poor quality of service	0.8
No time to go	1.8
Family did not allow	8.5
Lack of knowledge	4.1
No health worker visited	1.5
Other	1.2

regular check-ups during pregnancy as a desirable practice. Any kind of check-up or preparation to deal with emergency is seen as an ill-omen, something that will bring on the mishap. But even for those in favour of getting the service, the moribund state of the health system ensures that simple but essential ante-natal care, is not available to millions of women in the country.

Supplementary Programmes of the Government

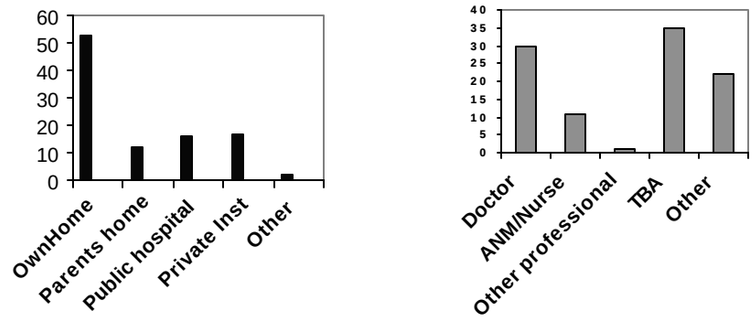
To achieve the goal of Safe Motherhood the government has implemented many schemes and benefits which aim at the health of mother and child. These benefits are part of the Mother and Child Health package of the Department of Family Welfare. In the recent past the package has been renamed from the CSSM (Child Survival and Safe Motherhood Programme) to the RCH (Reproductive and Child Health Programme). In actual terms the services are mostly limited to providing every pregnant woman two tetanus toxoid injections and 100 tablets of iron-folic acid tablets. In many places there are no regular check-ups for high risk screening. Besides this, the government also has Maternity Benefit Act 1961 under which three months maternity leave is given to all pregnant women working in organized/ unorganized sector who have worked for a period of at least 80 days with the present employer. Another scheme called the National Maternity Benefit Scheme provides women above 19 years and living below the poverty line, financial aid of Rs 300 for her first two children .

Care during Childbirth

Childbirth is a normal physiological process and in most cases it happens without any mishap. It is only in some situations where problems occur, and it is necessary to have all possible facilities available to take care of these problems. Physiologically, labour consists of three stages - in the first stage there are contractions of the uterine muscles, leading to labour pains. In the second stage the baby is pushed through the now fully opened cervix through the vagina and into the outside world. And in the third stage there is separation of the placenta from the uterine wall and its passing out of the body as the “afterbirth”.

This bio-medical description of labour differs significantly from the socio-cultural reality. Practices related to childbirth differ from region to region - some beneficial and some harmful. For example, conducting delivery in unclean surroundings (for child birth is considered impure and defiling), cutting the cord with unsterilised sickle or knife and applying dung or turmeric on the umbilical cord are unsafe. On the other hand there are practices which are women-centred and healthy: for example, squatting position during labour, massaging the back of the woman, giving her something hot to drink and so on.

Chart 3 : Place of Delivery and Assistance during Delivery
Source: NFHS 2 1998-99



There are differing points of view on whether labour is best conducted in an institution under technologically managed conditions or under more natural surroundings. In the present context of the inadequate quantity and the very poor quality of available obstetric services available it seems unrealistic to push for universalisation of institutional deliveries. But one thing is certain: if we have ensure safety it is essential to have expert obstetrical support close at hand, in case there are any problems. Unfortunately there are a number of labour-related complications which cannot be predicted. For real-life situations in rural India the best option is to have a trained person conducting the delivery, with a clear emergency plan chalked out before hand. The FRUs and the EmOCs that the Government has promised, when functional, will prove the best bet for managing emergencies.

Natural and other forms of Childbirth

In this modern technological age there is an increasing demand for universalisation of institutionalised delivery so that many of the complications can be can be adequately handled. On the other hand there is small but vocal view point championed by feminists in favour of deliveries at home. Their argument is that if due care is taken before and during childbirth, then conducting deliveries at home is perhaps best for the mother and the child. According to this point of view institutionalized deliveries not only deprive women of a comforting and supportive atmosphere(of people, surroundings etc.) but also the lithotomy position (in which many institutional deliveries take place where the womens legs are hiked up and put in stirrups) is not woman friendly, and only keeps the doctor's convenience in mind.

The focus of most prepared childbirth methods has been two-fold : drugless techniques that minimize pain, and education regarding the birth process. The first such method introduced by G. Dick-Read in 1933 advocated the use of relaxation and deep breathing, believing pain to be a product of fear and tension. Then F. Lamaze talked about different

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types of exercise. Then there was R. Bradley, the founder of "husband-coached childbirth" who advocated slower, deeper breathing exercises for this purpose. Michel Odent emphasized privacy and darkness to facilitate the natural process and advocated the use of water pools in labour.

In all these methods the emphasis of giving control of the birth process to the mother. Thus birth becomes more than just a hospital procedure. The essence of these methods or "natural childbirth" is respect for the wisdom of the birthing process, trusting nature to work in the most efficient way for each particular mother and child. When a woman is taught to move beyond pain and fear, she can then work in harmony with her labour, reducing or eliminating the use of interventions. She can be mobile throughout the labour, can choose positions that allow gravity to assist the birth process, and she can be fully conscious to appreciate the coming of the baby. These methods do not have many followers in India, but many of our traditional birthing practices also use some of these principles.

Post Partum Care

The six-week period after the birth of the baby during which the mother's body gradually returns to non-pregnant state, and she adjusts to the presence of the baby in her life and in the life of her family is known as post partum period and care provided during all this is called post partum care (PPC). After delivery a woman has to make both physical and emotional adjustments and she needs support and understanding. Some of the medical disorder during this are peurperal sepsis or infection of the uterus and surrounding tissues, urinary infection, acute prolapse of the cervix and puerperal psychiatric illness. It is important to diagnose and treat these conditions as early as possible as some of these may lead to more serious/life threatening complications.

Soon after delivery many women feel slightly depressed, scared or low and experience mood swings. Irritability, difficulty in sleeping, crying, uncertainty and loneliness are some of the other problems women sometimes go through. The main reasons cited for these feelings are hormonal changes and the adjustment to a new schedule. Women usually overcome these feelings with rest, comfort and support in caring for the baby but if these persist then professional counseling should be sought. Post partum care includes the mother's recovery to normal physiology, establishing healthy breastfeeding and contraception and not just the treatment of complications like haemorrhage and sepsis.

As with pregnancy and labour , different regions of our country have a host of cultural/traditional practices for the post partum period. Many of these affect the health and wellbeing of the mother and the child adversely, while others are beneficial. Much of the attention in the postpartum care is focussed on the well being of the child. Care of the mother is a relatively neglected area. And this true both for traditional practices as well as for the health services.

Elements of Post partum care

The elements of post partum care are

- medical management of post partum complication / morbidities,
- promotion of optimum practices of breastfeeding,
- timely and appropriate choice of contraceptives,
- promotion of adequate rest ,diet and hygiene of the mother,
- promotion of timely immunization.

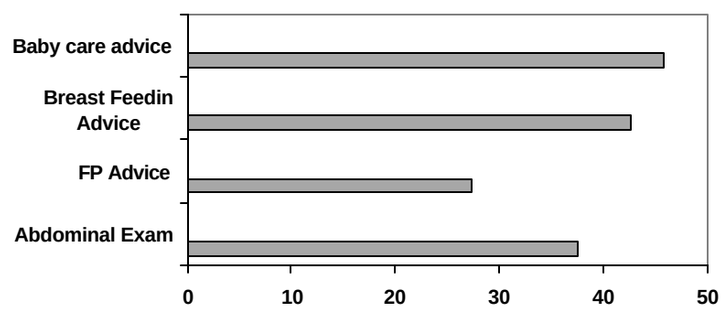
India has been implementing a Post Partum Programme since 1966 as a part of a global experiment. The main objective of this programme was to motivate women within the reproductive age group of 15-44 years, and also their husbands to adopt the small family norm. This was to be achieved through "education and motivation during antenatal, natal and post partum and after medical termination of pregnancy (MTP)." The programme set out to provide an integrated package of maternal and child health and family welfare services, including information, education and communication activities through a hospital based post partum centres.

Table : Postpartum Care in India

Proportion of women receiving postpartum care within two months of birth- 16.5%

(Source : NFHS 2 1998-99)

Nature of care provided



SECTION THREE

Implementing a Maternal Health Programme

Maternal and Child Health Programmes are among the commonest interventions in the sector of Health by NGOs in India. Earlier the trend was to run charitable clinics and hospitals but over the years MCH programmes have become more prominent. As it has been already mentioned the condition of the state-run health services are so poor in many parts of the country that poor women in the rural communities seldom get access to the various schemes and programmes meant for them . The economically well off not only get better services from the state functionaries but they also access private services elsewhere. It has already been mentioned that the Maternal Mortality figures in India are pretty high. Thus even in the age of Reproductive and Child Health (the new Government programme) the need for an effective Maternal Health programme cannot be over-emphasised.

Despite the over-medicalisation of pregnancy and childbirth in urban areas, a large proportion of pregnancies and childbirths can take place with the minimum of trained supervision. Fortunately it is possible to run an effective maternal care programme with paramedics and nurses but with an effective referral support system. It must be mentioned here that the effectiveness of such a programme does not lie in technical expertise, but often on the degree to which the programme is able to identify with the communities and vice-versa.

Understanding The Community

On the technical front the programme may be reduced to a set of simple discrete activities like –

- identification of pregnant women;
- providing at least three check-ups for high risk screening;
- providing tetanaus toxoid injections, iron and folic acid tablets; and
- giving the relevant health education about rest, diet, travelling, medicine intake, intercourse and so on.

But if the programme is taken up in a mechanical manner not taking into consideration the actual reality within which the pregnant woman lives, it might not succeed, just like the government programme. In some places it might be culturally inappropriate for daughters in laws to rest during the day. In others it might be that some food items are proscribed which we would like her to include in her diet and so on. In such a situation it is essential to first understand what the normative beliefs and practices are in the realm of mother care before embarking on any health education programme. The community cannot be just directed to adopt some new practices without first resolving the conflicts with their earlier traditions.

The first step is to realise that getting the community to adopt new behaviour is complex and there are no ready made answers. One has to explore the existing social and cultural norms, beliefs and practices around the issues of pregnancy, childbirth and care after birth. The community itself needs to be thoroughly convinced on the need to change behaviour and practices, before it will willingly do so. Participatory Rural Appraisal is a useful method to jointly analyse the problem with the communities for future planning and interventions.

Strengthening Community Capacities- Training TBAs

It is being increasingly realised that with the kind of health services that we have at present , strengthening the local capacities is one of the most effective ways of ensuring sustainability of the intervention. Besides it also encourages self-reliance a virtue that has been systematically undermined by the state-driven development initiatives. Traditional Birth Atttendants (TBAs) are often considered the cornerstone of any effort towards sustainability and self-reliance in the sphere of maternal care.

In large parts of India the facilities for institutional deliveries just do not exist and thus home based deliveries will continue to remain the norm for large number of Indian women. Training TBAs in conducting safe deliveries assumes great importance in this context. But it must be remembered that in

many places it is often the mother-in-law or any older woman who assists during the childbirth. In many places dais belong to a specific caste (often lower castes) and their role in childbirth is very limited. One should understand the existing situation in the community before adopting a universal pattern of TBA training. While arranging TBA training it must be kept in mind whether we want to train them afresh or build on their existing skills. Much has been mentioned of the five cleans, but unfortuantely TBA training programmes all over have often resulted in TBAs losing some of their vital skills especially with respect to their woman-centered-ness while acquiring some extremely bad hospital practices. For example instead of waiting for labour to take its normal time they insist on giving pain inducing injections or prefer lithotomy position over sitting or squatting position.

Preparing For Referral

A large proportion of life threatening events happen during labour. At this point in time preventive action is often of no use and and the only way out is to seek expert medical help. Three things are
crucial at this juncture once the danger has been recognised-

- to decide to seek expert help (often this depends on the men in the family, their attitude towards women and financial resources),
- have available means of transportation and
- visit a facility which is competent to handle the complication.

The FRUs and EmOCs mentioned earlier are meant for this purpose. But at the community /family level there must be adequate preparation before hand so delays may be avoided, decisions taken and the right place reached.

Dealing With Traditional Practices

Up until some time ago traditional practices were uniformly considered harmful and all efforts at health education were directed at replacing them with modern scientific knowledge and practices. There is another school of

thought where every thing traditional was revered. One has to be careful not to fall into either of the traps. There are a number of practices which are very useful and others which are equally harmful. Before either condemning or recommending, the particular practice must be clearly understood. Harmless or innocuous traditional practices are better left alone because changing an established pattern of behaviour can take a lot of energy.

Health Education And Communication Strategies

Some points which could be kept in mind while formulating a health education and communication strat-egy are given below:

- It should respect local knowledge,
- It should keep local socio-cultural factors in mind,
- It should raise questions on existing gender, caste discriminatory practices,
- It should encourage people to raise questions on unhealthy practices relating to maternal health prevalent in the community. But that should be done only after giving scientific information on the issue,
- It should be such which is sensitive to otherwise marginalised sections of the society viz. women, dalits, minorities, illiterates etc. Promotional materials should have more visuals, should have signs to which these people relate to easily and should have names which are not necessarily referring to one particular community,
- It should be interactive, should not be one sided
- It should encourage people to think of solutions
- It should provide necessary health information and information about rights and services

Some Innovative Projects In The NGO Sector

There are a large number of voluntary organisations working in the field of safe motherhood. Here we provide an introduction to a few such interventions. This is no way a representative list of the different kinds of approaches and strategies that organisations such as these have adopted.

1. CINI , West Bengal.

Child in Need Institute(CINI) was started in 1974, and Maternal and Child Health is one of its main areas of work. Mahila mandals, or women's groups are given the responsibility of running the MCH programme at the village level. Services include growth monitoring, immunisation, ante-natal and post natal care, health education and low cost curative care. They also have a programme to support poor pregnant women.

Further details about their work may be obtained from :

CINI,
Village Daulatpur, P.O. Pailan via Joka,
Dist – 24 paraganas(s), West Bengal – 743512.
Email- cini@cal.vsnl.net.in

2. SEWA-Rural, Gujarat

Sewa-Rural is a unique organisation because the Gujarat government handed over the PHC to the organisation ten years ago. SEWA- Rural thus has to follow many government guidelines, and is a place to experience how the government system can function at its best. There is also a large hospital run by the organisation which provides essential referral services.

For further details contact:

Dr Lata Desai, Managing Trustee,
SEWA-Rural,
Jhagadia, Dist Bharuch,
Gujarat- 393110

3. VGKK, B.R.Hills, Karnataka

Vivekanada Girjana Kalyan Kendra is an organisation working exclusively with the Soliga tribals in Mysore district. The organisation has been experimenting to integrate tribal herbal systems of medicine with modern medicine in its MCH programmes. They are also involved in training tribal girls as ANMs. The MCH programme is part of a larger community health work. The organisation is also involved in running two Primary Health Centres of the Government.

For more details contact:

Dr H Sudarshan,
Director, VGKK,
B.R.Hills, Yelandur Taluka,
District Mysore, Karnataka-571441
email- vgkk@vsnl.com

4. Sewa Mandir, Rajasthan.

Sewa Mandir, was set up thirty years ago and works primarily in the tribal areas of Udaipur district. Its MCH is based on a cadre of primarily male village level workers. Besides TBA training Sewa Mandir is also involved in providing referral support through ayurveda. They have also initiated a form of health insurance sheme where families have to pay a membership fee for accessing services.

For further information please contact:

Director,
Sewa Mandir,
Fatehpura,
Udaipur, Rajasthan 313001.

SECTION FOUR

Resource Section

Further Reading

Some of the books that we found useful in preparing this booklet were :

Akhter,H.H. and T.F. Khan 1997. *Selected Reproductive Health Elements and Interventions*. Dhaka: BIRPERHT.

Arkutu,A.A. 1995. *Healthy Women,Healthy Mothers*. NY : Family care International.

Boston Women's Health Book Collective, 1998**.** *Our Bodies Ourselves*. NY : Touchstone Rockefeller Centre.

The Carrera,M.A. 1992. *The Wordsworth Dictionary of Sexual Terms*. Herfordshire : Cumberland House.

Chaturvedi,K.S. and P.S. Chandra 1991. "Socio-cultural Aspects of Menstrual Attitudes and Premenstrual Experiences in India". *Social Science Medicine* 32 (3):349-351.

Chawla,J. 1994. *Child Bearing and Culture***.** N.Delhi : Indian Social Institute.

CHETNA 1994. *Thematic Meeting on Reproductive Health : The need for Comprehensive Policy and Programme*. Ahmedabad : CHETNA.

Family Care International *Sexual and Reproductive Health Briefing Card.*

Hyman,J.W. and E.R.Rome 1995. *Sacrificing Ourselves for Love.* California : The Crossing Press.

Jeffery,P. et.al. 1985. *Contaminating States and Women's Status*. N.Delhi : Indian Social Institute.

Joshi,A. et.al. *Socio-cultural Implications of Menstruation and Menstrual Problems on Rural Women's Lives and treatment Seeking Behaviour.* Baroda : Operation Research Group.

Koff,E.and J.Rierdan 1995. "Early Adolescent Girls' Understanding of Menstruation" *Women and Health*.22(4): 1-21.

Ministry of H & FW(Bangladesh) *Safe Motherhood***.**

Nobel Forum 1994. *Safe Motherhood in India* (Symposium Report).

Population Council 1997. *A Reproductive Health Approach to Post Partum Care* (Workshop Report). Population Council : S.E.A. Registered Office.

Sathyamala, C. et.al. 1986 *Taking Sides***.** Madras : ANITRA

Shephard,B.D. and C.A. Shephard 1990. *The Complete Guideto Woman's Health***.** NY : Penguin.

Weisenheimer,R. 1994. *Dr. Ruth's Encyclopaedia of Sex.*

Werner, D. 1994 *Where There is no Doctor*. Palo Alto: Hesperian Foundation.

Werner, D. and B. Bower 1987 *Helping Health Workers Learn*. Palo Alto: Hesperian Foundation.

Burns A A, et al *Where Women Have no Doctor*. Palo Alto: Hesperian Foundation.

Some recent research articles on Maternal Health are :

Bhatia, Jagdish. 1993. *Levels and causes of maternal mortality in Southern India,* Studies in Family Planning, 24, no. 5 (September-October).

Bhatia, J. C. 1988. *A Study of Maternal Mortality in Anantpur District, Andhra Pradesh, India.* Bangalore: Indian Institute of Management.

Bhatia, J. C., and John Cleland. 1999. *Health seeking behaviour of women and costs incurred: An analysis of prospective data,* In Saroj Pachauri and Sangeeta Subramanian (Eds.) Implementing s Reproductive Health Agenda in India: The Beginning, The Population Council, New Delhi.

Bhatia, J. C. and John Cleland. 1994. *Obstetric morbidity in South India: Results from a community survey,* Social Science and Medicine, 43, pp. 1507-1516.

Chhabra, Rami and S. C. Nuna. 1993. *Abortion in India: an Overview*. New Delhi: The Ford Foundation.

Ganatra BR, Hirve SS, Walawalkar S, Garda L, Rao VN (1998a): *Induced abortions in a rural community in western Maharashtra: Prevalence and patterns.* Ford Foundation Working Paper Series.

Ganatra, B. R., K. J. Coyaji, and V. N. Rao. 1998. *Too far, too little, too late: A community based Case Control Study of maternal mortality in rural West Maharashtra.* Bulletin of the WHO 76, 6, pp 591-598.

Ganatra, B. R., and S. S. Hirve. 1995. *Unsafe motherhood: the determinants of maternal mortality.* Journal of the Indian Medical Association, 93, 2, pp. 34-35.

Gupte Manisha, Bandewar Sunita, Pisal Hemlata 1999: *Women's Perspectives on the Quality of Health Care: Evidence from Rural Maharashtra.* In MA Koenig and ME Khan (ed) Quality of Care within the Indian Family welfare Programme, New York, Population Council. Forthcoming.

Garg Suneeta, Sharma Nandini, Sahay Ragini 2001 *Socio-Cultural Aspects if Menstruation in an urban slum in Delhi, India* in Reproductive Health Matters, Vol 9 No 17, May pp53 - 62

Gupte Manisha, Bandewar Sunita, Pisal Hemlata (1997): *Abortion Needs of Women: A case study of Rural Maharashtra*. Reproductive Health Matters. Vol 9, May 1997 pp 77-86.

International Institute of Population Sciences (IIPS). 1995. *National Family Health Survey (MCH and Family Planning),* India 1992-93. Bombay: IIPS.

Jejeebhoy, Shireen. 1999, *Women's autonomy in rural India: its dimensions, determinants and the influence of context,* In Harriet Presser and Gita Sen, (Eds.) Female Empowerment and Demographic Processes: Moving Beyond Cairo. Clarenden Press, Oxford .

Mari Bhat, P. N., K. Navaneetham and S. Irudaya Rajan. 1995. *Maternal mortality in India: estimates from a regression model,* Studies in Family Planning, vol. 26, no. 4, pp. 217-232 (July/ August).

McCarthy, James and Deborah Maine. 1992. *A framework for analysing the determinants of maternal mortality.* Studies in Family Planning, 23, 1 (January-February).

Nag, Moni. 1994. Beliefs and practices about food during pregnancy: implications for maternal nutrition. Economic and Political Weekly, XXIX,37

Pachauri, Saroj. 1995. *Defining a Reproductive Health Package for India: A Proposed Framework*. South and East Asia Regional Working Paper 4. New Delhi: Population Council.

World Health Organisation. 1991. *Maternal Mortality: A Global Factbook*. Geneva, World Health Organisation.

Resource Organisations

There are a large number of organisations providing technical support on the issue of maternal health within the country. We are listing the names and addresses of some of these organisations here.

1. VHAI

As far as maternal health is concerned VHAI is important for the material that it publishes. VHAI is one of the best sources for slides on maternal and child health. Its newsletter Hamari Chithi Napke Naam , (and its various translations) is very useful for the village level helth worker. The different state level VHAs are more useful as training resource organisations in the different states.

Voluntary Health Association of India,
Tong Swasthya Bhawan,
40-Institutional Area, (behind Kutab Hotel)
New Delhi –220026
email-vhai@vsnl.com
Tel : 011- 6518071-72, 6515018, 6965871

2. CHETNA

CHETNA is perhaps the most important NGO resource organisation on the issue of women's health in the country. They have large number of publications and material which is freely available by post on payment. For organisations in Rajasthan and Gujarat CHETNA provides resource support in the area of training in Maternal and Child Health. CHETNA has two units devoted exclusively to providing resource support in Women's Health and Children's Health.

CHETNA
Lilavatiben Lalbhai's Bungalow
Civil Camp Road, Shahibaug,
Ahmedabad
380004, Gujarat
Tel : (079) 286 8856, 286 6695
email: chetna@icenet.net

3. Various State Voluntary Health Associations

The state VHAs are important resource organisations for material and training support in the regional context and in the appropriate regional language. Addresses of the different state VHAs are available from VHAI.

4. KRITI Resource Centre
Kriti Resource Centre is primarily involved in providing training and technical support to Government projects and NGOs and produces manuals and materials in Hindi. It works primarily in the Hindi speaking states of India.
KRITI Resource Centre
C-2015 Indira Nagar,
Lucknow -226016
Tel-(0522)-341319,387010
Email- kritirc@satyam,net.in

5. Survival of Women and Children Foundation (SWACH)
SWACH is involved in adapting WHO material related to MCH for the Indian situation. They have available a number of pictorial and other material for TBAs. They are also involved in providing technical support to NGOs under Government sponsored projects.
SWACH,
Near Sanatan Dharam Mandir,
Sector 16, Panchkula, Haryana 134109

6. Ministry of Health and Family Welfare
The MOHFW is involved in preparing and distributing a large variety of pictorial and other material every year. The best way to access this material at the local level is from the office of Chief Medical Officer of the district.
Programme Officer (Audio Visual)
Ministry of Health and Family Welfare
Department of Family Welfare
Nirman Bhawan
Maulana Azad Road, New Delhi -110001

All the different organisations listed above are actively involved in the preparation and distribution of different kinds of resource materials like manuals and kits, flash cards and flip books, videos, posters, pamphlets, and so on.

Training Opportunities

ANM Training – Nursing schools attached to missionary and voluntary organisation hospitals are some of the best sources for training Auxilliary Nurses or even General nurse. These schools usually have their students sign a bond for a specified periods service in exchange for the free education. Many of these organisations take candidates sponsored by voluntary organisations. Kasturba Trust in Indore also runs such an ANM training institute.

Training of other field based workers - There are a large number of organisations providing training for field based MCH workers some of these are the State VHAs, CHETNA, SWACH, KRITI Resouce Centre SEWA-Rural, Comprehensive Rural Health Project (Jamkhed) PRERNA, (Lucknow) and so on. Many of these organisations also provide TBA Training.

Training of Managers - Training of managers for MCH programmes are less common and some of the organisations involved in providing such training are WAH! Programme, Institute of Health Management, Pachod and SEWA-Rural.

Addresses of the organisations referred to for the first time in this section are:

PRERNA	19, Laxman Puri, Faizabad Road Lucknow-226016, Uttar Pradesh Phone : 386715, 387884 Fax : 387884
IIHMR	Pachod District – Aurangabad-431121 Mahrashtra Phone : 02431-21419,21382 email : ihmp@giaspn0l.vsnl.net.in
CRHP	Comprehensive Rural Health Project, Jamkhed, Dist- Ahmednagar, Maharashtra –413201. Phone (02421) 21322, 21323 Fax- (02421) 21034
Kasturba Trust	Kasturba Trust, Indore, Maharashtra

Resources on the Internet

Canadian Women's Health Network- www.cwhn.ca/resource
Centre for Reproductive Law and Policy- www.crlp.org
Childbirth.Org- www.childbirth.org
Estronaut: A Forum for Women's Health- www.estronaut.com
Family Health International- www.fhi.org
Feminst Women's Health Centre - www.fwhc.org
The First Nine Months - www.parentsplace.com/first9months
Global Reproductive Health Forum- www.hsph.harvard.edu/orgisation/healthnet
The Alan Guttmacher Institute- www.agi-usa.org
HealthWeb:Women's Health- www.biostat.wisc.edu/chslib/hw/women
MedNets - www.mednets.com
Medscape -Women's Health- www.medscape.com/Home/Topics/WomensHealth
Museum of Menstruation and Women's Health- www.mum.org
Online Birth Centre - www.efn.org/~djz/birthindex.html
Reproline:Reproductive Health Online - www.reproline.jhu.edu

Booklet prepared by -

Research and Text: *Alok Srivastava, Abhijit Das and Jashodhara Dasgupta*
Additional text and Review : Dhanu Swadi, Bela Ganatra, Siddhi Hirve
Illustration : Ganesh Dey
Layout : *Ravi*

UNDERSTANDING REPRODUCTIVE HEALTH

A Resource Pack

This Resource Pack is an introduction for those who wish to learn about different facets of Reproductive Health. Reproductive Health as a concept is relatively new and , despite the name, is not exclusively a 'health' subject. In its ambit it involves social sciences, medical sciences, women's issues, human rights, population sciences, demography and so on. Thus it could be of relevance to individuals with a wide range of interests. Reproductive Health is an issue of interest to Government planners and managers because of the overwhelming concern for population. Reproductive Health is also a matter of great interest to the NGO sector, because of their concern for the health of women. Concern for women, their rights, well being and health is the underlying theme for the entire Resource Pack.

This Resource Pack has been designed as a series of booklets so that the interested reader may straight-away refer to the issue of her/his interest. The matter and presentation of the material in the different booklets has been kept simple as well as provocative as it is meant for the first-time user. Each booklet has been divided into four sections - the first dealing with theory and concepts, the second with issues of relevance, the third on best practices in the field. Keeping the interest of the practitioner in mind there is also a small resource section at the end of each booklet.

The booklets in this pack are as follows -

Booklet 1	**An Introduction to Reproductive Health**
Booklet 2	**Understanding Numbers** : Population and Demography
Booklet 3	**Changing Paradigms** : RH Policy and Advocacy
Booklet 4	**Exploring New Frontiers** : Reproductive and Sexual Rights
Booklet 5	**Maternal health is still important**
Booklet 6	**The Promise of better health** : Women's Health
Booklet 7	**Beyond Family Planning** : Contraception
Booklet 8	**The Emerging Agenda** : Adolescents
Booklet 9	**Forging new partnerships** : Men's Health and Responsibility
Booklet 10	**Coming to terms with reality** : HIV/AIDS and STDs
Booklet 11	**Acknowledging ourselves** : Sex and Sexuality
Booklet 12	**Women have Minds Too!** : Exploring the interface between Reproductive Health and Mental health
Booklet 13	**Taking a stand** : Violence, Women and Health
Booklet 14	**Data Digest**

KRITI Resource Centre
for
Women's Health , Gender and Empowerment

The KRITI Resource Centre, is involved in providing training support, production and distribution of material, and engaging in creative partnerships with other instituions to strengthen their work of empowering women at the grassroots level, enabling women to lead healthier lives.The primary activities of the KRITI Resource Centre for Women's Health, Gender and Empowerment are as follows

TRAINING - **KRITI has considerable experience and expertise in trainings related to Women's Health and Gender and has provided training support to over 100 organisation as well as Government projects and departments in the states of UP, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Delhi, Rajasthan, Haryana and Himachal Pradesh. The Resource centre has been involved in partnerships with other gender training organizations like JAGORI, IWID, and the South Asian Network of Gender Trainers (SANGT).**

PRODUCTION AND DISTRIBUTION OF LEARNING AND COMMUNICATION MATERIAL *- KRITI is also involved in designing and producing appropriate material for the special needs of those involved in working with communities on these issues. Much of the material is in Hindi. Copiously illustrated material has also been produced keeping grassroots needs in mind. For the practitioners KRITI has produced newsletters, field manuals, training manuals and kits, briefing kits and information sheets on various relevant issues.*

RESEARCH AND DOCUMENTATION *- KRITI Resource Centre engages in field level documentation, to get a more holistic understanding of women's health and the socio-economic conditions that influence it. Some of the studies it has conducted and participated in include a study of traditional birthing practices, Abortion and women's health in rural areas of Uttarakhand, customs and practices around menstruation, the possibility of HIV/AIDS, implementing the Target Free Approach in Family welfare programmes in UP, quality of care of health care service is UP, violence against women and so on.*

ADVOCACY *- The resource centre is also actively involved with advocacy on the issues of Women's Health and Population Policies and Violence against Women. It is closely working with other networks and organisations working on these issues.*

SERVICES PROVIDED BY KRITI RESOURCE CENTRE

- Library and documentation centre
- Books, posters and other materials
- Training and internship
- Support for developing gender sensitive community based interventions/training programmes