CONTENTS

INTRODUCTION

For long women's health was considered important only in so far as women's child-bearing capacities were concerned, the basic focus being on maternal health. As a departure from this narrow approach, the whole concept of reproductive health emerged. Though it is not broad enough to encompass all the health concerns of women, it certainly is a great step forward from the earlier limited view.

While formal medicine has a separate section called gynaecology devoted to the health and treatment of conditions in women related to their reproductive system (not only child bearing), the concept of reproductive health has allowed space for the issue to be dealt within a public framework. At the same time, reproductive health goes far beyond mere gynaecology because it is also concerned with the social determinants of health and disease. Social science research shows that the health status of women correlates to their socio-economic condition and the extent of gender related discrimination inherent in the family and society. Acknowledging these constraints, reproductive health is concerned with enabling women to better health facilities (access, services and quality of care) as well as challenging and bringing about changes in social conditions.

These social conditions are not unique to India alone - they are almost universal. Only the manifestations are different. They are responsible for even the most acute of women's health problems not having being considered important so far. Research that is more gender sensitive than before is increasingly bringing to light the burden of reproductive ill-health that women bear in silence- from the shame of reproductive tract infections to the religious and political diktats against abortion.

This booklet aims to focus on some of the more common reproductive health conditions women face, along with their social dimensions. Also discussed are some pioneering experimental models in the country that deal with these reproductive health situations and an exhaustive list of resource organisations working on the subject.

SECTION ONE

Understanding Women's Health Problems

Determinants of Women's Health

Women's health has been a largely neglected area for very long, with some documentation being done on the subject only recently. The deeper one digs, the more complicated it seems. The easy way out is to define health or illness in bio-medical terms - even today most health-related professionals are taught that women's health is a matter of nutrition, or perhaps poor hygiene or bad obstetric practices. But a closer look reveals that this is inadequate to explain the myriad factors in women's lives that influence each other and in turn affect the health. In this section we will try to explore some of the major determinants of women's health.

Socio-cultural determinants

Gender – Gender roles and power relations within the community determine women's health status to a great extent. This includes the differential food allocation for girls and women, pressure to get daughters married, differential educational opportunities provided to girls *vis-a-vis* boys and so on. Violence at home is also a product of gender relations. Women's ability to negotiate contraceptive use with husbands, the ability to negotiate the number of pregnancies, or the decision to abort a female foetus, all depend upon the power a woman has at home and in the family.

Religion – Religion often lays down the law on how followers should behave. Strict codes are enforced on moral behaviour, bodily functions, contraception and so on. Many of these religious codes are detrimental to women's health and rights.

Traditions – Traditions are somewhat different from religion in the sense that traditional codes may not be sanctified by religion, but they are equally strong and depend upon the regional and local mythologies. Dietary practices

The Linkages between gender and health

Gender refers to the socially and culturally defined differences between men and women (sex being the biological difference). It includes the different roles that are ascribed to the two sexes, the expected behaviours and also includes the differential power and control vested in each sex. Nominally gender does not indicate a hierarchy but in actual practice men and women do not have equal access and control over various kinds of resources and a strict hierarchy exists between the two. This hierarchy is clearly evident in Indian society. Women are expected to eat only after the men of the house have eaten, girls are provided fewer years of formal education, women are expected to stay at home and there are strict rules even about visiting the natal home. It would be a mistake to surmise that these differences will automatically reduce over time. While gender roles, expectations and behaviours do change over time the assumption that the difference in hierarchy reduces is somewhat naïve, witness the increase in female foeticide especially among developed states like Punjab, Haryana and Gujarat.

The subordinate status of women in society deeply influences their health status. This is clear from the few examples given above. The principal responsibility of women in many societies including own is usually restricted to childbearing. This over emphasis on one biological aspect has led to such situations as early marriage and repeated child-bearing and its attendant complications. Son preference , another strong trait of Indian society has led to the heinous practice of sex-selective abortion and repeated abortions and its attendant complications. Women's workload in many places is considered minimal , but a careful daily analysis reveals that women hardly have a moment to spare in the course of the entire day while men are entitled to their share of relaxation after a days hard work. Women's subordinate status has also led her to be an easy target of family planning programmes in our country with the bulk of sterilisations being tubal ligation operations. To add to the situation described above women have very little autonomy to decide what they should do for keeping healthy. Many women's reproductive health issues, which are related to her genitals are considered dirty and shameful and hence women not only feel uncomfortable in openly discussing their problems, but they refuse treatment from male medical providers. Medical providers, themselves are products of the society in which they live and thus carry with them the usual social and cultural biases regarding women and their abilities. In short the gender differences between men and women are reflected in

- Vulnerability to illness
- Health status
- Access to preventive and curative measures
- Burden of ill-health
- Quality of care

and restrictions such as on the mobility of women and age at marriage are instances of traditions which have great implications for women's health.

Educational Status – The impact of women's educational status on maternal health and child survival is being studied by demographers in order to understand whether the goal of population stabilisation is easier to achieve with an educated group of mothers. Similarly, the health of women themselves is profoundly affected by their level of education.

Bio- Medical determinants

Biology – Women's biology or the anatomical, physiological and genetic make-up of women determine many of their health conditions. The fact that osteoporosis is more common in elderly women is primarily due to the fact that the stability of bone depends on female sex hormones which are affected by menopause. This leads to various fractures in elderly women like the fracture of the hip-bone or the wrist. Women menstruate, women have babies and so their need for iron is far more than men's. As a result, even with the same levels of nutrition women have lower haemoglobin and much more anaemia. Diseases like cancer of the cervix are specific to women because of biological reasons.

Economic Determinants

Poverty – Poverty is a very important determinant of women's health. This is not only the general poverty of the whole family but also the relative poverty of women within the household. Women have much less access to and control over economic resource and this makes women the poorest of the poor. Poverty affects birth conditions and outcomes, health status in childhood, social status, educational status and so on. Women do most of the housework , which is unpaid. Thus their economic contribution is undermined and when it comes to healthcare-related measures – food, money for medicine, rest and so on, women receive less priority. Sanitation and

personal hygiene, two very important determinants of women's health again depend upon the economic situation of the woman. The long and arduous work hours that women have to keep affects their mental health as well. Economic vulnerability often forces women into accepting situations of violence and unsafe sex.

Environmental degradation and women's health- Environmental degradation a reality in most of the world's poorer nations and is certainly the case in India. Degradation of the environment is linked with to workload of women, as it seriously affects their health. All over the world including India, women bear the lion's share of the domestic workload. Rural life is heavily dependent on natural resources. Forests provide timber, firewood, leaf-litter and water. The supply of all of these is dependent on the status of the forests. The fields also produce fodder and kindling in addition to crops. Cow-dung is zealously collected as an important source of fuel. Collection of all these is primarily the task of women. With increasing deforestation and environmental degradation, these resources are getting scarce and so the task for women is getting harder. Advances in farming technology are reducing some of these natural products – for example crop residue and cow-dung – leading to increased burden on poverty-stricken women to arrange for substitutes.

Work and health - The heavy workload of economically weaker sections of women contributes to their poor health status. New industries like the garment industry depend mostly on women because they are considered more productive, disciplined and adept. Women are joining the workforce in great numbers. However, the newer work patterns expose women to different health risks – heavy load lifting, repetitive work, accidents, pollutants and so on. These contribute to conditions such as miscarriages, general weakness, bodyaches and joint pains, uterine descent and so on. Working outside the house also exposes women to risks like sexual harassment that too have health implications. Rural women on the other have such a heavy workload that they often do not even get time to look after themselves, such as bathing or attending to personal hygiene.

Comparison of Bio-Medical and Social understanding of Health

Bio-Medical Approach	Social Approach
• Anatomy • Physiology • Pathology • Disease Agents • Susceptibility and resistance • Investigations • Therapy • Quality of services	• Poverty • Environment • Gender • Religion • Cultural Beliefs and Traditions • Education • Violence • Self-Concept • Access to services

Violence as a determinant of women's health

It is important to consider the importance of violence as a determinant of women's health. Women are exposed to a continuum of violence right from the time they are conceived. This violence takes place in all spheres of her life- at home, the workplace, in the community and of course in situations of conflict. All these types of violence against women are linked to the same familiar causes: their lower social status, the notion that women are the 'property' of men, and that it is acceptable for men to exercise control over them by any means.

Domestic violence- This kind of violence against women has been called the 'hidden epidemic', because of its widespread prevalence. But there is reluctance to take action against such violence when it takes place in the privacy of the home. Statistics gathered over the last decade or so have brought to light how widespread it is and how profoundly it affects the health of women. Domestic violence includes battering, rape, sexual abuse, burning and homicide. The physical and psychological consequences of such violence are serious physical trauma, pelvic pain, miscarriage, burns, attempted suicide, depression and other psychiatric morbidities.

Unfortunately, most health systems and planners at all levels have been slow to respond to this 'hidden epidemic', not considering it a health issue at all. Women's health activists in many countries demand that the health sector:

- Regard domestic violence as a public health issue
- Undertake more specific research on its causes, consequences and methods to prevent it
- Disseminate information about domestic violence to health workers or conduct training to strengthen their ability to recognise the signs of domestic violence

Violence in displacement and conflict situations- Women are specially vulnerable in situations of armed conflict or mass population movement. Women are forced to leave their homes as refugees and are often separated from the men in their families, and have few means to protect themselves from violence. Armed conflicts use women's bodies as a battlefield in their struggle to appropriate institutional power and are therefore a political phenomenon. Sexual assault on women is seen as a victory over the enemy. Thus all situations of armed conflict leave women vulnerable to sexual exploitation and sexual violence that may lead to physical injury, unwanted pregnancies, reproductive tract infections (RTIs), sexually transmitted infections (STIs) and of course a whole range of mental and emotional disturbances.

When women are found to leave their homes and live as refugees, they suffer other health consequences as well. There is hardly any privacy for mundane acts like bathing, going to the toilet or for maintaining menstrual hygiene. Pregnancy and childbirth also become extremely risky in such situations. There are no services for safe abortions. In a nutshell, the total healthcare delivery system is unavailable.

The relationship between violence and health is covered in *Booklet 13-- Taking a Stand: Violence, Women and Health*

Common gynecological morbidities in India

A number of community-based studies carried out in the past ten years have revealed the types of gynaecological problems women face and their prevalence. Common conditions and their prevalence are summarised in Table 1.

Table 1

Prevalence of self-reported and clinically diagnosed gynaecological morbidities: six community–based studies in India

Women Reporting	Percentage
Self reported conditions	
• Menstrual problem	33 – 65
• Excessive discharge	13 –57
• Lower abdominal pain	9 – 21
• Low back pain	5 – 39
• Painful intercourse	1 – 7
One or more conditions	55 – 84
Clinically diagnosed conditions:	
• Vaginitis	4 – 62
• Cervicitis	8 – 48
• Cervical erosion	2 – 46
• Pelvic inflammatory disease	1 – 24
• Prolapse	<1 – 7
One or more condition	26 - 74

From: Koenig M, Jejeebhoy S et al. 1998, Investigating Women's Gynaecological Problems in India: Not Just Another KAP Survey. Reproductive Health Matters. Vol 6 No.11 May (84 – 96).

What is immediately clear from this table is that a large proportion of women either feel they have a problem or are clinically proved to have a problem. This number is as high as 74 % or 84 % of the total number of women in the study. Thus, the incidence of gynaecological morbidities is widespread.

Common women's health problems

There are a large number of gynaecological disorders that affect women. In this section we shall look at some of the more common problems, focussing on how they are affected and mediated by social, cultural and economic factors.

Reproductive tract infections (RTIs)

What are RTIs - Reproductive Tract Infections (RTIs) are common diseases with profound social and health consequences for women. One of the world's most neglected health problems, RTIs are related in important ways to basic sexual and reproductive health and to the acceptability of family planning programmes. RTIs include a variety of bacterial, viral and protozoal infections of the lower and upper reproductive tracts of both sexes, most of which are sexually transmitted infections (STIs). Women can be infected not only from sexual intercourse but also from the use of unclean menstrual clothes, unsafe childbirth or abortion techniques, and insertion of leaves and other material into the vagina that are meant to increase a male partner's pleasure, prevent pregnancy or induce abortion.

Female RTIs originate in the lower reproductive tract, (external genitalia, vagina and cervix) and in the absence of early treatment they can spread to the upper tract (uterus, fallopian tubes and ovaries). Though spread of RTIs from lower to upper reproductive tract takes place spontaneously, procedures like IUD insertion, abortion and child-birth can cause greater risk because instruments are introduced through the cervix during these procedures.

Why women are more vulnerable to RTIs- Though men also suffer from Reproductive Health problems, the number and scope of Reproductive Health risk for women is far greater due to a number of reasons. First, they alone are at risk of complications from pregnancy and childbirth; second, they have to bear the burden of using contraceptives and running the risk of suffering from potential side-effects or endure the consequences of unsafe abortion; third, due to their biological make-up, women are more vulnerable to contracting and suffering complications of many sexually transmitted infections. For example, the risk of acquiring gonorrhea from a single coital event in which one partner is infected is approximately 25% for men and 50% for women. Moreover, women suffer more serious long-term consequences from RH problems including all STIs and pelvic inflammatory diseases (PID).

In societies where a belief in male supremacy coexists with restrictive social structures that limit women's economic, social and legal independence, men often maintain strong control over women's sexuality. Due to double standards of sexual behaviour, sexual coercion and gender discrimination, women are frequently powerless either to avoid intercourse with an infected man or to insist that he use a condom or remain monogamous. Both within and outside marriage women do not have any say in their partner's sexual mobility. Apart from not being able to negotiate condom use, they cannot insist on getting their partner tested or treated for STIs.

Barriers to seeking treatment for RTIs - The general perception about RTIs in society is that it is dirty, something to be despised and not talked about. Hence, seeking treatment is deterred by social attitudes. RTIs are associated with social stigma, taboos and ostracism. Fear of social consequences is reinforced by low self-esteem of the sufferers, illiteracy, and the fear of violence from or rejection by partners and family members. Fear of exposure and embarrassment is a major deterrent to seeking STI treatment. RTIs have an additional element of shame and humiliation for many women because they are considered unclean. The invisibility and taboos surrounding RTIs and the belief that they should be endured, create a culture of silence within families and communities that can severely compromise women's health. In addition, the fear that treatment will be very expensive also comes in the way of seeking medical help.

Abortion

What is Abortion – Biologically, the ending of pregnancy before the embryo or foetus can survive outside the uterus is called abortion. Abortion can either be induced or spontaneous. Induced abortion can be safe or unsafe depending on who conducts it, how it is done and where it is done. Spontaneous abortion refers to the premature natural ending of a pregnancy. It is often nature's way of screening out unfit foetuses. Spontaneous abortion can be threatened or inevitable, complete or incomplete. One in six pregnancies ends in abortion, 75% of them before 12 weeks.

Far removed from this biological definition, abortion is a battleground between women who demand a right over their own bodies and the pro-life and religious establishments who oppose it vigorously. Abortion is also a tool in the hands of patriarchal society to systematically eliminate girls and women.

Abortion as a health, social and political issue – A major health problem of women is induced abortion. Induced abortion is resorted to in the case of an unwanted pregnancy - unwanted for whatever reason. It could be son preference, contraceptive failure, being unmarried or single, sexual coercion or rape, abandonment or an unstable relationship.

In large parts of our country where people either do not have access to contraceptives, or choose not to use them, abortion is resorted to as another form of contraception. This is by no means a desirable state of affairs. For no matter how well or how safely the abortion is performed, repeated abortion has inherent risks. Hence it should not be seen as a means of fertility regulation. At the same time, it is the responsibility of the state in India to provide access to safe abortion. Unfortunately, despite being included in the new Reproductive and Child Health programme, this remains a promise on paper. Women can obtain abortion from government healthcare providers, but in reality this is provided only if they are willing to pay for it. Since most abortion seekers would like to maintain privacy and confidentiality, service providers exploit their vulnerability.

Women are often forced into situations where they have to undergo repeated pregnancies despite not wanting to do so. They have to take recourse to abortions secretly, for fear of rebuke from the family. They choose to go to the most easily accessible and confidential services that are often provided by the ***dai***, or the ANM. The abortion is induced in very unsafe ways and she has to bear the health consequences. On another front, women are targetted for selective abortions after sex-selection tests are conducted. This practice continues in many parts of north and western India, despite being illegal.

While abortion services are legal in India, they continue to be illegal in many countries of the world. Availability of safe abortion services has remained a demand of women's health activists for a long time. Women are victims of situations where they need to go in for abortion, but socially, religiously and politically they are considered the perpetrators of a crime. One needs to look no further than our neighbouring countries where abortion is illegal for evidence of this. In Nepal, till a couple of years ago abortion was illegal,

many of the women in jail being poor women who were desperate for an abortion.

Consequences of unsafe abortion - Maternal morbidity and mortality due to complications of unsafe or illegal abortion constitute a major public health problem. Seventy per cent of maternal deaths in developing countries are caused by one of five obstetric complications, of which unsafe abortion is one. Unsafe abortion accounts for about 15% of all maternal deaths. Twenty million unsafe abortions take place each year -95% of them take place in the developing world. Such illegal abortions are highly risky, and may result in serious complications or death. Complications of unsafe abortions kill at least 7000-8000 women every year. Long or short term disabilities that women experience due to unsafe abortion include severe bleeding, injury to internal organs and infertility, sepsis and poisoning from aborting medicines which also lead to renal failure.

Abortion related morbidity and mortality is a matter of great concern to all in India. It is estimated that about 65 lakh abortions take place every year in India, out of which 25 lakh are estimated to be spontaneous and 40 lakh induced. Despite being one of the first countries in the world to have legalised abortion (MTP Act of 1971) a large proportion of induced abortions are performed illegally by unqualified persons and/or women themselves. As mentioned earlier, about 15 % of maternal mortality is due to abortion alone.

Infertility

What is infertility - Medically, a couple is considered possibly infertile if they have failed to conceive within one or more years of regular unprotected coitus. A frequently held view is that 75-80 % of the couples achieve pregnancy if they want to within one year of regular unprotected sex. Another 10% do so by the end of the second year. About 10 –15 % couples are unable to conceive. The incidence of secondary infertility is also very high, which refers to those couples unable to have subsequent children. But if you ask a childless woman what infertility means to her, she will not relate to any of these dry statistics, because infertility for her is perhaps the biggest curse and the cause for most of the misery in her life.

Causes of infertility - There are three main causes of infertility: physiological, pathological and social. Infertility due to physiological reasons occurs before puberty, after menopause, during menstruation, pregnancy and lactation. Pathological causes of infertility are attributed to both men and women. In men, reasons for infertility are poor quality of semen (not enough sperm, weak sperm, not enough semen etc) or the inability to deposit semen in the vagina, impotence and premature ejaculation. In women, pathological causes of infertility are failure to ovulate, blockage of fallopian tubes due to infection and so on. Lack of knowledge about women's fertile period, and not having opportunities to cohabit during fertile period, or prolonged absence of the male partner are some of the social causes of infertility. Among the reasons of secondary infertility, the most common are tuberculosis of the uterus, sexually transmitted infections (STIs), malaria, reproductive tract infections. According to a WHO report, 50-80 % of cases

of infertility are caused by STIs, with serious marital and social consequences.

Although researchers have differing opinions on the male-female factors responsible for infertility, it is very clear that men and women share equal responsibility for infertility. However, the popular social belief is that infertility is a 'women's thing' or a 'women's problem'.

Social consequences of infertility for women - Since infertility is seen as a woman's problem, the female half of a childless couple is subjected to harassment. She is the one who is victimised and abused by society, further jeopardising her already fragile social status. Generally men are not held responsible and often the woman is ignored, abandoned, divorced or simply thrown out of the house by her in-laws. She is not even well received at her natal family. She is called names, considered inauspicious and her presence in social or religious gatherings prohibited.

Some other health problems include

Prolapse of the Uterus - This condition is one of the commoner problems that women face and it refers to the gradual hanging down of the uterus. The woman has an uncomfortable feeling that something is coming down her birth canal, and it can lead to urinary problems and even ulcers on the mouth of the uterus. While advancing age can cause the ligaments that hold the uterus to slacken, there are a number of other factors that can cause younger women to face this problem. Some of these are general debility, repeated birth, bearing down on the abdomen during labour and heavy workload immediately after delivery. Many of these factors are a daily reality for millions of women in our country.

Lower Urinary Tract Pain – This is a very common problem with women of all classes and sections of society. Often dsmissed as cystitis or Urinary Tract Infection, the condition is aggravated and triggered by several factors,

many beyond the woman's control. While infection of the urinary bladder or the urinary passage (urethra) can be a cause, the problem is aggravated by situations like low intake of water (women often drink less water so that they do not have to void too frequently because it is difficult to get privacy for this act), intercourse (an act which is often dictated by the needs of her partner), infections of the lower genital tract (often a result of poor general and genital hygiene, which is difficult to maintain without toilets or any privacy), trauma during childbirth and so on .

Breast and Cervical Cancers – There are a large number of gynaecological malignancies, but breast and cervical cancers are not only the two most common cancers in women but their prognosis and survival rates are dependent on social and economic conditions. Breast cancer is commoner in developed countries while cervical cancers are commoner in our country. The survival rates from both these cancers are very good if they are detected and treated early. This is facilitated not only by increased personal awareness of the condition but adequate medical facilities for detection and care. Breast cancers are easily detected as lumps by self-examination of the breast and regular physical examination and mammography, giving a good chance of survival. Cervical cancer on the other hand is more common among poorer women having early childbirth, many and frequent births and low genital hygiene. Early detection is impossible because the facility for screening is not available and its symptoms (irregular vaginal bleeding, vaginal discharge,) are often ignored.

Women's health in later years

Menopause

Menopause is not a problem but, like menstruation, it is often perceived as one. Here we will discuss some of the important issues related to it. Though menstruation has gained some importance in research worldwide, menopause still remains a less understood topic.

What is menopause **-** Menopause means the permanent cessation of menstruation at the end of reproductive life. This is a gradual biological process occurring between the ages of 45-55 years. It occurs because of decreased secretion of female hormones (oestrogen and progesterone), which interferes with ovarian function, and results in inhibition of ovulation and menstrual flow. Alongside, atrophic changes take place in the ovaries, fallopian tubes, uterus, vagina, vulva, breast, bladder and urethra.

Menopause and health **-** The actual experience of menopause is not quite the same as the medical description. The experience of each woman depends on variables such as her age, cultural background, health, type of menopause (natural or surgical), desire for more children and so on. Many women view menopause as a signal of major change in their lives - either positive change such as freedom from the need for contraception, or negative change such as experiencing mood swings or feeling "old". Culture also plays a significant role in women's menopausal experiences. In some Asian cultures where women reach menopause without much notice, there might be regret at the

end of the reproductive years. Others might be happy to find that so many headaches are over. The correct attitude is to take menopause as just a point in the continuum of life. A woman's health at this time is largely determined by the conditions of her health prior to menopause, the reproductive pattern she underwent and her lifestyle and environmental factors.

In a majority of women, apart from cessation of menstruation, no other symptoms are evident. But in some secondary symptoms like hot flashes, (profuse sweating for 1-2 minutes usually at night) vaginitis, endometritis, anxiety, headache, insomnia, irritability and depression can occur. Feminists say these changes are incorrectly attributed to menopause. Research increasingly shows that women are no more likely to be depressed at mid-life than at any other time.

Treatment of menopausal problems

Treatment of menopause-related problems can be done in two ways -- non-hormonal and hormonal. In non-hormonal treatment improved nutrition, exercise and supply of extra calcium in the diet are supposed to be helpful. Hormone replacement therapy (HRT) is the practice of prescribing oestrogen and progesterone-containing drugs to replace the amounts of these hormones no longer being supplied by the ovaries due to menopause. HRT must be used with caution. Despite certain improvements in the symptoms of hot flashes, vaginal atrophy and osteoporosis, there are many side-effects of HRT treatment. The most common being breast-tenderness and fluid retention. The secondary level side-effects of oestrogen are vaginal secretions, skin rashes, loss of hair on the head, hair growth on the body, pigmentation, intolerance to contact lenses, vaginal spotting or bleeding. Side-effects reported after progesterone use are breast tenderness, abdominal bloating, aches and depression.

Health concerns of the elderly

Advancing years lead to many changes in the lives of women, especially in India. Their roles change from being a person who has to obey many masters – both human and ritual – to one who has gained enough independence to define many of the rules of life. There is reduction in physical workload, but there can also be a sense of vulnerability, especially if the woman is a widow. At the same time the process of ageing also affects many of the vital functions of her body. The health of the elderly woman is the result of the interaction of many such physical and social factors.

Some of the major health problems that elderly women have to face are described below. For biological reasons, the bones start weakening in women soon after menopause. Poverty aggravates the condition when she cannot afford enough calcium to slow the process. Elderly women easily become victims of fractures that don't heal easily. Weight- bearing joints like the knees and the lower back, which have borne years of high stress, fall prey to arthritis. The respiratory tract, which in rural women is subjected to smoky

wood fires day in and day out, starts losing its vital capacity. Eyes fall victim to the natural process of ageing and cataracts develop. Hearing is gradually impaired, and mental faculties start slowing down. Emotional and behavioral problems also crop up in many cases.

When the elderly develop health problems, an additional cause for concern is whether there are adequate provisions both within the family and society to take note of these and provide support. As women grow older, they slowly lose some of their autonomy and need to be cared after more actively. Their physical and emotional needs change. The family has to be sensitive when she needs active medical help. With progressive nuclearisation of families even in rural India, elderly women are losing out on family support which was earlier accessible.

SECTION TWO

Important issues for operationalising women's health

Role of traditional and home remedies in Women's health

There has been an increasing trend among voluntary organisations to adopt traditional herbal and home remedies as an integral part of women's health. This has even led to the Government of India giving space to what it calls the Indian Systems Medicines in the Reproductive and Child Health programme.

There are a number of reasons given by votaries in favour of traditional and home remedies. One is that they are more holistic than modern medicine, which tends to treat individual ailments in isolation. Traditional methods include physical, social and spiritual aspects of treatment, also integrating lifestyle and diet with therapy. The second is the issue of accessibility. In many cases modern medicine is not available. Even if the drugs are available, a reliable doctor is not. Home remedies, as the name implies, are available domestically. Many traditional remedies utilise local fauna and are therefore easily available. Other herbs can be grown in the garden. Financially too, local remedies have the advantage of usually being cheaper.

Another factor in favour of herbal and home remedies is that they do have many effective cures for a large number of problems afflicting women. While these therapies may differ from place to place, multi-centre studies of the past few years have proved that they work. Finally, traditional and home remedies build upon women's existing knowledge and experience. Many women have known their use as children or even as adults, whereas modern medicine has made inroads into their consciousness only lately. While modern medicine does come with its magic of instantaneous cure through injections, traditional and home remedies are part of our heritage. Many of the lifestyle changes that have occurred have led to the devaluation of women's knowledge. Reinforcing effective traditional and home remedies can be a means of imparting value to women's knowledge.

Nevertheless, there are limitations on the use of traditional and home remedies, something that even their promoters acknowledge. Traditional medicine includes some formal systems (such as Ayurveda, Unani, Tibetan and Siddha) and informal systems (exorcism, faith healing, etc.). The therapies promoted must be tested for efficacy. It is often a thumb rule to consider all therapies that appear in classical texts as tested. On the other hand many of the votaries of these therapies agree to testing but disagree on the methods advocated by western science. A large multi-centric study was carried out by women's groups to test the efficacy of traditional and home remedies (Shodhini study), but the methodology used was completely different from the classical clinical trials.

The other reservation is about the universal applicability of traditional medicines. Many traditional practices are harmful in certain conditions, and must be used with great care. The line dividing practice and therapy can often be a very thin one. A third reservation about traditional systems of medicine is that they are situated in a specific cultural context but, as discussed earlier, the position of women in traditional cultural contexts is only inimical to her health and rights. The conclusion is that traditional and home remedies have a definite role in improving the status of women's health, but they should be promoted only after the various socio-cultural determinants of women's health have been fully understood.

Women's access to healthcare

Access to healthcare is dependent on a host of factors. It has to be timely and allow the individual or group to achieve the best possible health outcome. Access is also affected by attitudes to health and healthcare, gender, and social and cultural factors. An important factor is the condition of the health service and its level of care.

Women often possess a very low sense of self worth and are thus reluctant to pay much heed to their ailments, particularly if they feel it would inconvenience others. Seeking healthcare is also a financial decision, in terms of the money it costs and work-time lost. Whether the patient will be able to seek help depends on the distance to the health care provider, the sex of the provider and opinion about the provider's competence. After the woman actually goes and meets the health care provider, the issue arises of how competent the provider is in understanding her problem and dealing with it. The atmosphere in most clinics and hospitals is such that it hardly provides women with a sense of security, privacy and care. Even the most qualified doctors often arrive at clinical diagnoses without understanding the real problem. In such a situation, the outcome is hardly satisfactory. In any case, the healthcare providers most women meet are far from being the most qualified.

The kind of service delivery environment best suited to women's health needs has already been described in the first booklet on women's health.

Understanding the Language of Women

Where it is culturally inappropriate for women to discuss problems of the reproductive system, where women have been socialised to think that their reproductive organs are dirty and polluted, and where women have to suffer and live with their reproductive health problems in silence, they develop new ways of coping and expressing their problems. For the health worker it is important to understand this language. Where functions and problems of the reproductive tract are concerned, women have a reluctance to discuss details with someone else, a phenomenon so widespread that it is referred to as the 'culture of silence'.

The present structure and functioning of the health system does not provide women either an enabling environment or privacy to facilitate positive health-seeking behaviour for problems of the reproductive tract, especially sexually transmitted infections. This leads to delayed identification, misery, pain and further complications. Women are known to accept vaginal discharge, itching, menstrual discomforts, ulcers, discomfort during intercourse, or even chronic pelvic pain and painful urination that accompany some reproductive disorders - as an inevitable part of their womanhood, something to be endured along with other reproductive health problems. In some situations women complain of vague aches and pains, or weakness, when their real problem lies elsewhere. Women also tend to refer to their problems obliquely, and it is only after sustained questioning that the real nature of the problem becomes evident.

Persons trained in healthcare often tend to think in terms of diseases and their possible causation. Women, on the other hand, refer to their disorders as illnesses, symptoms and problems. They have their own system of understanding causation, which often involves a complex interaction of social customs and beliefs, religious transgressions, what they perceive as health-related behaviour. You need to be culturally attuned to understand the problems of women. For the sensitive health care provider, it is a challenge to understand the individual and from there the real problem, because only after that can healing truly begin.

Women health care givers

In recognition of the need for having lady doctors to treat female patients, states like Uttar Pradesh have special *zenana* (women's) hospitals at the district level. Local cultural traditions in north and central India make it difficult for women to seek help from male practitioners. It results in situations such as male practitioners often having to diagnose gynaecological disorders by examining the radial (wrist) pulse. Female doctors are rarely found in rural health centres and even auxiliary nurse midwives (ANMs), the backbone of the community-based public health system in India, are known to play truant. In such a situation, even those women who would like to consult a healthcare provider have few options. As an alternative, many community-based projects run by voluntary organisations have been systematically training local women as healthcare providers for females. The women, in many cases traditional birth attendants, are being trained in the

basics of anatomy and physiology and then taught the use of herbal medicines or, in some cases, modern methods of treatment.

However, the mere presence of women doctors and nurses does not guarantee quality healthcare for women. With a woman care-giver the chance of a gynaecological examination are higher but it does not mean better care necessarily follows. Medical science is extremely patriarchal in its perception of women and their health problems. Women healthcare providers trained in this system naturally assimilate this, resulting in situations where women healthcare providers behave insensitively with women in labour, berating them for their illness or scolding them for coming when it is too late. In such a situation the trauma of going through the health- care delivery system may be more severe than the illness!

It is important even for women healthcare providers to be considerate, patient and sympathetic to the client. This is possible only if the provider understands the woman's background and the complex social factors that have influenced her condition. Care must be taken that even during the training of local women as health care providers, they understand these determinants. It may be easier for rural women to understand these factors, as the same conditions operate in their own lives. However there are examples where the empathy that traditional birth attendants (dais) had for women, was replaced overnight through a single training event in a hospital.

Women healers are not uncommon in rural India. Though they may not command the respect that *vaids* do, they are an important resource for other women in the community. Very often it is the traditional birth attendant (dai) who is also the healer, many of them possessing a fund of knowledge about gynaecological problems. In an effort to improve women's access to healthcare, many voluntary organizations are strengthening these healers through additional training in new skills and perspective.

Empowering women for health

Health is an aspect of women's lives over which they have little or no control. Movements for empowering women to take charge of their health have started in several parts of our country by various organisations. Two key features of this approach are described below.

Self-help **–** This stems from the realisation that women have been dispossessed of knowledge about their own bodies, by both society and the medical profession. The goal of self-help is to put information and control in the hands of women, developing a healthcare system that meets their needs. Teaching women about the manner in which their bodies function and the use of home and herbal remedies are the two cornerstones of this approach. This not only allows women to understand the body and its problems better, they are also more likely to obtain appropriate healthcare earlier and on their own terms.

Advocacy for health **–** Knowledge about the body and herbal remedies for simple complaints are a major step towards women gaining control over their own health, but not the final step in this direction. Women will continue to need the public healthcare system to meet other health needs. Unfortunately, this system, even at its best, is unable to deliver many of the services required by women. Keeping this reality in mind, women in many parts of the country have organised themselves into groups and are demanding better treatment and services from the public system.

Rights based Approach to women's health

In the nineties there was a change in development approach -- from meeting identified *needs* to a '*rights* based approach'. This was drawn from the UN Declaration of Universal Human Rights and the International Covenant of Economic, Social and Cultural Rights. The 'Right to Health' approach was reinforced by the many national and global movements to reclaim a woman's right to choose what was best for herself and her health. Struggles around abortion rights are one example. The Rights Based Approach was also founded on the mandated accountability of state health systems to protect and promote women's health. Stronger definitions and claims to entitlements in the realm of women's health were provided by treaties upholding women's rights such as the Convention on the Elimination of All Forms of

Discrimination Against Women (CEDAW) and the historical consensus on reproductive rights at the International Conference on Population and Development (ICPD).

While the exact characteristics of the 'rights based approach' are still being examined and definitions are being debated, the UN Commission on Human Rights defines it as "an integration of the norms and standards contained in the wealth of international treaties and declarations into the plans, policies and processes of development". In concrete terms this would mean that the objective of a health intervention would be defined in terms of particular 'rights' - as legally enforceable entitlements. An example is "the right to attainment of the highest standard of reproductive health", drawing from the ICPD. Additionally, when we use rights based approaches, there has to be a high level of accountability in terms of a clear focus on who is responsible for protecting, promoting and providing the right.

In struggles across the globe to assert and claim rights, women have constantly redefined what a given right stands for, and sought to ensure legislation to safeguard the extended definition. For example, the human right to life has been extended to include the right of women who choose to be mothers to "go safely through pregnancy and childbirth" with an assurance of survival. In some contexts it has been used to substantiate the right of women to be free of life-threatening gender based violence. Depending on local realities, international standards could be translated into more specific or related but distinct national laws and policies.

At the national level, adequate laws, policies, institutions, administrative procedures and mechanisms of accountability have to be strengthened. This is essential so that if a woman suffers denial and violations of her right to health, she can easily access redress or complaints mechanisms. Moreover, marginal or vulnerable groups should have a high degree of access to information and meaningful participation in development processes and institutions. This would also mean that minority or indigenous women, rural women or women with special needs would be able to have a voice in designing and monitoring policies and programmes for their health needs.

SECTION THREE

Working on Women's Health

Different approaches of working on women's health

Working with women and their health has for long been one of the main areas of activity for NGOs. Over the years, many organisations shifted their focus from a strictly maternal and child health orientation, to gradually include other aspects of women's health. NGOs were among the first to draw attention to the serious problem of reproductive tract infections (RTIs) that women suffer in silence. Over the last ten years or so, NGOs have tried a number of novel experiments all over the country to assist women achieve a better health status. Dealing with RTIs has been a key element in most of these experiments. Some of the common approaches are described below.

Clinic-based approach – This approach is being tried out at a small number of projects where special clinics are being operated for treating women with RTIs. Work at the clinic is supported by community-based health education to raise awareness and for referral of symptomatic cases.

Community-based approach – This is the more widely prevalent approach, where the community and the paramedical workers are trained in health education and primary treatment using either herbal medicines or modern drugs. The strength of this approach lies in mobilising women in communities to recognise their own situation and take steps towards changing it. The process of change is very slow, but there is enough evidence to show that it does occur. Once women learn to accept their own bodies and its processes as natural and not something to be ashamed of, they show a keenness to learn more about it, taking active measures to keep healthy. Once women are willing to learn more, many take up the challenge of learning herbal remedies, growing and making medicines, actively engaging with others in the community to change their attitudes and so on.

Clinic–cum-community-based approach – In this the community-based approach is strengthend by a referral system. It is only possible where the organisation has an in-house or on-call gynaecologist. Often the gynaecologist is asked to attend a camp, with community-based workers involved in screening and selecting cases for the gynaecologist's visit.

Strategies for change

Different strategies have been adopted to enable women to access better services and gain more control over their health. Some of them are:

Organising women- Almost all organisations working in the area of women's health have organised the women of the community into groups or mandals. These groups are a important forum for health education, discussing new ideas with women and beginning the process of new learning. They are also an important vehicle for facilitating change in attitudes and

behaviour. When women learn new things about themselves and start challenging some of their most strongly held notions, the peer group provides a secure atmosphere for making these experiments.

Raising awareness about the body and its processes - This forms one of the core strategies for change. Different methods such as modular courses, informal camps, regular meetings and self-examination are used to raise women's awareness of their body and its functions. From early childhood, women develop negative feelings about their bodies, and these efforts by organizations allow women to start knowing and appreciating their bodies. Thereafter, women are willing to be more assertive in keeping their bodies in good health.

Building local capacities – This involves the training of local women in different aspects of women's health, so that they not only help themselves but other in the community. In some projects local women are now competent even in the use of the speculum for gynaecological examinations. In some places traditional birth attendants' (dais) skills have been upgraded, in other places young people have been trained as health workers. The idea is that women in the community should obtain some degree of self-sufficiency in dealing with their own problems, before visiting a doctor.

Use of herbal and traditional medicine - This aspect has been discussed in detail earlier.

Training for women's health

One of the main challenges in implementing a women's health programme which takes into account their needs, vulnerabilities and social realities, is to develop a strategy to train and reorient different members of the team who will take up this work. It includes training managers, field workers and the community. While most formal experiences are through strictly hierarchical models where teachers exercise all the knowledge and power in relation to the learners, here the facilitators' role is very different. The field workers, manager and the nurse have to slowly build the confidence of women to learn to accept their bodies and start a process of questioning many of their previously held notions. Thus these workers also need to go through training that will help them to develop sensitivity and empathy towards the women's situation. Even for technically trained persons like doctors, it may involve developing new skills in communicating with women. Experiments have already started in developing training modules for middle level managers, field workers, doctors and nurses to equip them to deliver more sensitive and need-based services to women.

Some innovative community-based women's health programmes

There are a large number of organisations carrying out innovative work on women's health. A brief description of the work being done by four organisations is given here. A more comprehensive list is provided in the Resource Section.

AIKYA – It has been at the forefront of using and documenting the use of herbal remedies for women's gynaecological problems. Partner in a countrywide documentation exercise through the Shodhini network, it has been actively involved in training women healers in the use of herbal remedies. At the community level it organises village level health groups called 'arogya sanghas'. Women are also encouraged to learn to heal themselves by making their own remedies.

MASUM - It is a Pune-based rural women's collective. Its goal in addressing the sexual concerns of women is to get women to fight for their rights at all levels rather than negotiate as the last resort. The major reproductive health intervention of MASUM has been running a feminist health centre Streevadi Aarogya Kendra. The centre has a consulting gynaecologist, a full time nurse and visiting health worker. The centre provides clinical facilities and follow-up services. Through health education the staff is committed spreads the idea of rational drug therapy. In this programme exercise and quality of life are stressed upon more than taking pills.

RUWSEC – It has been a pioneering organisation in developing interventions in the area of women's health. It operates in Chingleput district of Tamil Nadu. Today it has a comprehensive women's health programme that integrates women's health with their education and development. It trains village health workers in providing the first level of care and health education, while a referral clinic provides the second level of care. Services provided include MTP, surgery, gynaecological clinic and screening for STIs.

SEARCH – It is a pioneering organisation that works with tribals in Maharasthra's Gadchiroli district. The organisation has been one of the first in the world to draw attention to the burden of reproductive morbidities faced by rural women. Its Reproductive Health programme has four components – participatory research, mass education in sexual and reproductive health issues, community-based Reproductive Health care and referral services. *Dais, arogya doots* and ANMs are trained to treat common gynaecological problems and also advise referrals.

Addresses of all these organisations are provided in the Resource Section

SECTION FOUR

Resource Section

Further Reading

Some of the works we found useful in the preparation of this booklet are:

Andina, M. et.al.1998. Trust: An Approach to Women's Empowerment. Los Angeles: Pacific Institute for Women's Health.

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Germain, A. et.al. 1992. Reproductive Tract Infections. New York: Plenum Press.

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O'Sullivan, S. 1987. Women's Health: A Spare Rib Reader. London: Pandora Press.

Pachauri, S 1999 Implementing a Reproductive Health Agenda in India : The Beginning. New Delhi: Population Council.

Padubidri, V.G. et.al.1994. Shaw's Textbook of Gynaecology. New Delhi: B.J. Churchill Livingstone.

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Stein, K. et.al. 1998. Critical Issues in Reproductive Health: Abortion Expanding Access to Safe Abortion Strategies for Action. New York: International Women's Health Coalition.

VHAI. 1993 Women and Health: Gynaecological Disorders. New Delhi: VHAI.

VHAI. 1999. Infertility. New Delhi: VHAI.

VHAI. 1999. Menopause. New Delhi: VHAI.

Women's Health Action Foundation. 1995. A Healthy Balance. Amsterdam**:** Women's Health Action Foundation.

Resource Organisations

A large number of organisations work on women's health either as grassroots implementing agencies or as support organisations. Contact details of some of these organizations are given below.

Action India Community based Project ,Herbal, Resource Materials	5/24 Jangpura B, Behind Rajdoot Hotel New Delhi110 014 Phone 011-26467470,24314785 Email-actionindia@vsnl.com,
ARCH Community-based Project, Research	P O Mangrol, Taluka Rajpipala Distt. Bharuch393 150(Gujarat) Phone 02460-240140, 240154
ARTH Research and Community-based interventions	39, Fatehpura, Udaipur 313004 email: arthsoc@sancharnet.in
Aikya Community-based project, Training, Herbal	377 Jayanagar, 42nd Cross Road, 8th block Bangalore 560 082(Karnataka) Phone 080-26645930, 8432363 Fax 080 26631564 attn. Aikya
CHETNA Research, Resource Materials, Training	Lilavatiben Lalbhai's Bunglow, Civil Camp Road, Shahibaug, Ahmedabad-380 004 (Gujarat) Phone : +91 (079)2868856,2866695 Email: chetna@icenet.net Website: www.chetnaindia.org

CINI Research, Community based project, Training, Resource Material	Child In Need Institute (CINI) PO Pailan, Via Joka Kolkata 700 104 Phone: 91 (033) 497 8192/ 8206 Fax: 91 (033) 497 8241 Email- cini@cini-india.org Website - www.cini-india.org
Deccan Development Society Research, Herbal, Community-based Project	Flat No.101,Kishan Residency 1-11-242/1,Street No. 5,Shymlal; Building Area Begumpat Hyderabad-500 016(A.P.) Phone:- +91-40-27764577,27764744 Email:- ddrural@sanchar.net
IWID Training	Sabla and Kranti A/201 Vasant View D'monte Lane Malad (W) Mumbai 400 064 Phone & Fax- 022-8886237 E-mail - kranti@bom5.vsnl.net.in
MASUM Community-based Project, Research, Training	11 Archana Apartments 3rd Floor, 163 Sholapur Road, Hadapsar Pune- 411 028, Maharashtra Phone- +91-20—6875058 E-mail- masum@vsnl.com
RUSWEC Research, Community based project	Plot No. 12, Peria Melamaivur Village road Vallam Post, Chengalpattu-603 002(T.N.) Phone 04114-230682
SAHAJ Research	1 Tejas Aparts. 53 Haribhakti Colony Old Padra Road Baroda-390 015 (Gujarat) Ph No.-+91-265-340223 E-mail: sahajbrc@icenet.net
KRITI Resource Centre Training, Research, Resource Materials	C-1485,Indira Nagar Lucknow –226016,U.P.,India Ph. No. +91-522—2341319,2310747 Email:-kritirc@sahayogindia.org www.sahayogindia.org
SAMA Training, Research, Resource Materials	J-59 1st Floor,Saket, New Delhi –110017 Tel:-+91-116968972,6562401 email:- samasaro@nda.vsnl.net.in
SARTHI Community-based project, Herbal	P.O. Godhar West, Santrampur Taluka Via Lunawada, Panchamahal-389 230 Gujarat Phone 0265-340223, Fax 0265-330430
SEARCH Community Intervention, Research	Indira Chowk, Gadchiroli, Maharashtra-442665 Ph.No.:-07138-25406-8(O),25412 (R)

SEWA Community-based Project, Training, Resource Material	Opposite Victoria Garden Ellis Bridge, Bhadra Ahmedabad-380 001 (Gujarat) Phone 079-5506477,5506444 Email:-mail@sewa.org Website- www.sewa.org
SEWA- Rural Community Intervention	Jhagadia District Bharuch, Gujarat 393110
SUTRA Community-based project, Training, Material preparation	Jagjit Nagar via Jubbar Solan 173 225 (H.P.) Phone 01793- 8725, 8734
VGKK Community-based project, Government	B.R. Hills 571441 Yelandur Taluk Mysore District (Karnataka) Ph 08226-84025 Fax 08226-84004
TATHAPI Training, Resource Materials	The Tathapi Trust 425bp.77 Mukundnagar Tilak,Maharashtra Vidya Peed Colony Gultekari Pune-411037(Maharashtra) Phone:-+91-20-4270659 Email:- tathapi@vsnl.com
Women's Centred Health Project (WCHP) Innovation within the government system	1st Floor, BMC Office Building, Nehru Road, Vile Parle(E) Mumbai 400 057 (Maharashtra) Phone 022-6162436

List of Web-sites on Women's Health

Here is a selection of international websites offering information about women's health issues:

www.genderhealth.org – Center for Health and Gender Equity (CHANGE) website offers information on reproductive health issues.

http://www.reproductiverights.org/ Center for Reproductive Rights is an independent, non-profit organization "dedicated to ensuring that all women have access to appropriate and freely chosen reproductive health services.

www.med.stanford.edu/CBHP/ -Community Breast Health Project is a clearinghouse for information and support to improve the lives of people touched by breast cancer.

www.fhi.org - Family Health International (FHI) is a non-profit organization working in the areas of AIDS/HIV/STD, family planning, and reproductive health around the world, with a focus on developing countries.

http://www.fwhc.org/ - Feminist Women's Health Center provides information about abortion, birth control, breast cancer, menopause, and other women's health issues.

www.hsph.harvard.edu/Organizations/**health**net/ - The Global Reproductive Health Forum offers working papers and other information about reproductive health issues. The South Asia Project is concerned with gender and women's health in South Asia.

www.mum.org - MUM: Museum of Menstruation and Women's Health offers an interesting, often humorous exhibit devoted to menstruation.

www.umiacs.umd.edu/users/sawweb/sawnet/health.html - Provides links to articles on the health of South Asians. Includes issues related to women's health.

www.reproline.jhu.edu - ReproLine: Reproductive Health Online is 'designed for use by policymakers with a technical and/or clinical background,' and for individuals, particularly teachers and trainers.

www.rho.org – Program for Appropriate Technology in Health offers this website for reproductive health program managers and decision-makers working in developing countries and low-resource settings.

www.womenshealthmatters.ca - Women's Health Matters is a Canadian site offering information about a wide variety of women's health issues, and has well-organized print and online resources, with particular emphasis on Canadian resources.

Here is a list of India-specific websites on women's health:

www.indianchild.com/womens_health_india.htm - Provides information on various women's health issues relevant to India

www.thp.org/reports/indiawom.htm - A well-researched article on the status of women in India

www.worldbank.org/html/extdr/hnp/population/iwhindia.htm- Summary of a World Bank publication Improving Women's Health in India

www.medivisionindia.com/women/index.phtml- Provides technical information for the lay-person.

in.dir.yahoo.com/Health/Women_s_Health/ - Yahoo India directory of women's health

www.khoj.com/Health_and_Medicine/Women's_Health/ - Sify khoj directory on women's health-related information on the web.

http://w3.whosea.org/women2/ - A WHO publication on Women's health in South east Asia (includes India).

Booklet prepared by -

Research and Text –Alka Agarwal, Abhijit Das
Additional text and review – Jashodhara Dasgupta
Pictures - Ganesh
Layout - Ravi

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