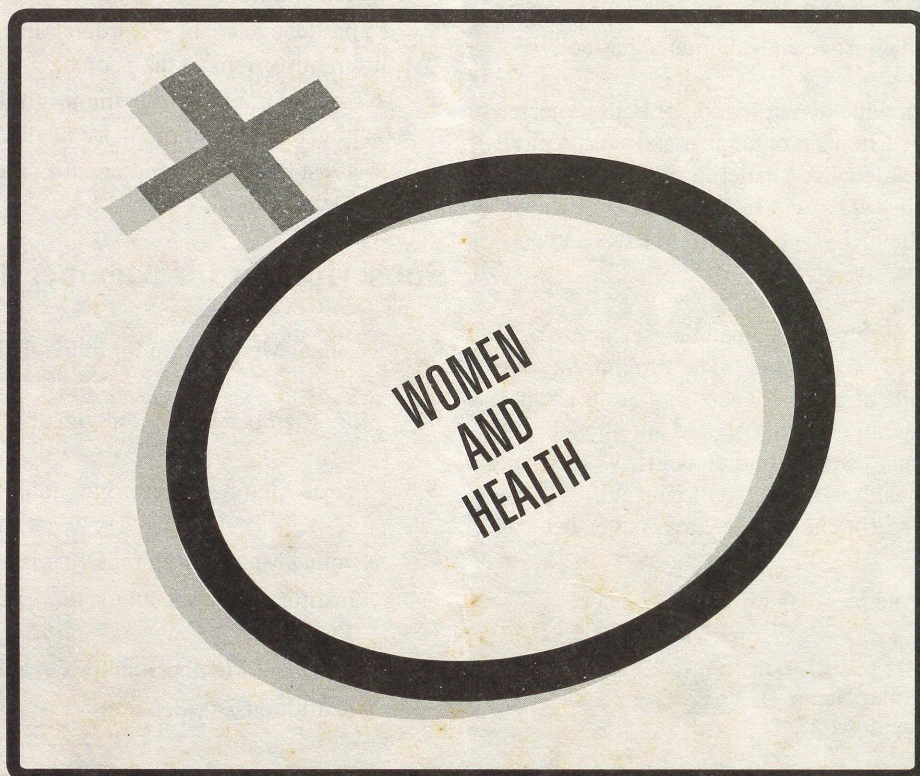
Vol. 3, No.3, March '96

PERSPECTIVES



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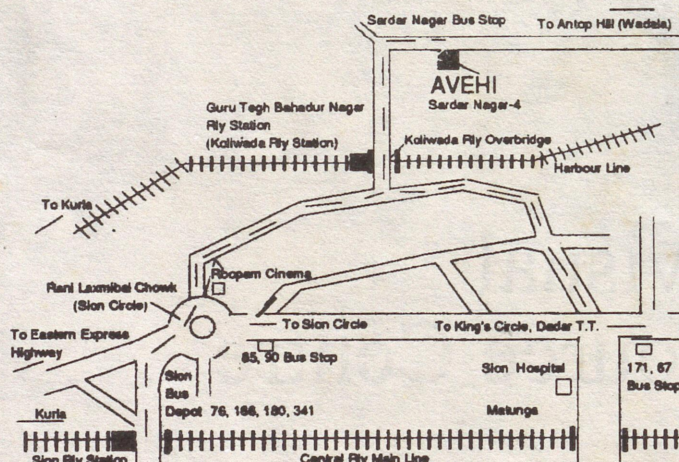

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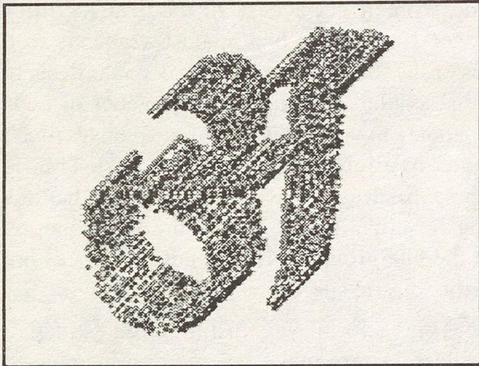

PERSPECTIVES
Vol.3. No.3. March 1996

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EDITORIAL

The French feminist Julia Kristeva has said that women "are one half the sky ".However , in the developing world, rarely do women account for fifty percent of the overall population.

Societal neglect, coupled with a low self-esteem generated by a misogynist patriarchy, results in poor health and a low life expectancy. In a life span which is shorter than that of the average man, women have to also contend with physical abuse and mental cruelty.

The Indian constitution guarantees gender equity but this is rarely practised by society. The subordinate status of women cuts across caste, class and religious barriers - all women experience exploitation and oppresion, the difference is only in the degree.

Right to life and good health should be actually experienced by all women. However, this cannot be imposed from above by activists or medical practitioners. The realisation has to come from within. An awareness that society owes them a better deal has to be generated among women. They have to move beyond societal norms of feminine behaviour into spaces of female self-development. To reach the goal of self-development they could pass through the Feminist - stage of protest but that is a means rather than the end.

Third - world women do not need to mimic Western Feminist - protest, as such situations tend to be culture - specific and often have little relation to economically depressed women in the developing world.

This issue of Perspectives has highlighted the excellent work being done by medical personnel, researchers and activists in raising the self-awareness of women vis- a - vis their own bodies. The female body is the property of men in most patriarchal societies and women have to repossess their bodies and declare them independent of male control. They need to move out of male- ordained enclosures into spaces of mental and physical freedom. The path is strewn with difficulties, choked with aborted female foetuses, butchered girl children, burnt brides and abused women, but it will have to be trod. And it is being trod by our intrepid contributors, who have narrated their experiences with absolute candour and often very touchingly. We salute them and may they continue with their good work.

I'm sure you, our reader, will also be moved by the texts and sub-texts of these women. Do write in your reactions and suggestions. As I keep on saying, lets make Perspectives truly interactional.

Our next issue is on " The Rights of the Child". If society gives a raw deal to women, the lot of children is little better. Every child has the right to childhood but in the developing world, a child is a child only till the next baby is born. Harsh economic conditions force parents to send children to work. Very often the child is the sole bread-winner in a family. Robbed of its childhood, a child is often pushed into anti-social and illegal activities. The streets of most big cities are choked with abandoned children, children on drugs and child prostitutes.

We invite contributions from our readers in this area. Also, let us know what you'd like forthcoming issues of Perspectives to focus on.

Before I end let me thank those of our readers who have responded to our last issue. Their letters are in the 'Readers Respond' section.

Some of our readers have also written in asking for a Marathi translation of Suhas Paranjape's "From Innocence to Knowledge : The Environment Issue". In response to these requests, a Marathi translation has been done and will be available from the AVEHI office for a small fee of Rs. 3/- . So you could write in and request for a copy.

Dr. Nilufer E. Bharucha

Dr. Nilufer E. Bharucha is a Professor in the Department of English, University of Bombay. She is a life-member of AVEHI and is actively concerned with social issues.

REFLECTIONS

AS A WOMAN RESEARCHER IN HEALTH

Roopashri Sinha

My fist research diary notes : " Hearing the sound of a baby's heart beat through the foetoscope made me want to whoop with joy, celebrate life and the life giving force.

Gradually I observed in hospitals, conversed with doctors, nurses and social workers and learnt that the woman is an easily dispensable item on the family's list. Legal notes saying, "knowing fully well the consequences of maternal death of my wife, I do not want to donate my blood. I take full responsibility" are not at all uncommon.

Another jotting from my diary says : " The case of a eight year old who was raped by a youth from the same village was brought to the Primary Health Centre where we were researching. The child was kept in an empty, unlit room from evening to midnight with the mother holding her, her father waiting for the police and the villagers peering through the broken window panes. The staff remained distant and secretive with only one ANM braving to go and console the child and her mother. The others shuffled in and around the room speaking in hushed tones because the doctor was informed about the incident by the family. I cannot forget the whimpering of the child, the helplessness of the family, the doctor's exploitation of the situation and the voyeuristic and sadistic pleasure of the people."

As a researcher, I have witnessed happenings in the community. Some joyful, some confusing and many more which made me question, my choice of a profession. However, I realize today that field research did transform several theoretical and abstract ideas and distant events with their power of immediacy. This has been a step ahead in my process of self-discovery. It has made me more aware of belonging to the ' Half of Humanity ' which is neglected, made invisible and whose basic human rights are trampled upoin innumerable times. Maria Mies calls it " a war against women ".

As a woman researcher, the need to unravel layers of this invisibility is strong. Several other efforts have brought acknowledgement to women's lives, their work and contribution to the family, society and nation.

Probably the greatest invisibility of women prevails in health issues. The well being of the entire family is far more dependent on the capacities of the woman than that of any other member of the family. Yet she herself faces obstacles in achieving even the simple state of freedom from illness. She cannot take time off from household simply because there is no one else to shoulder that responsibility and she has very little decision - making power. Her work outside the house is in addition to household thereby putting tremendous pressure of time and resources on her. Her access to health care is reduced considerably due to the distances to health care centres, the non-availability of sufficient time to visit the centre at the right time, the absence of health care facility at a reasonable cost and mainly becasue her illness is not considered important enough to deserve time, attention and money.

As a newcomer to health research I went through Scully and Bart (1973) who reviewed general Gynecology textbooks published in the US from 1943 to 1972. They say, " there is a persistent bias towards greater concern with the patient's husband than with the patient herself."

Much later, helping women get access to medical facilities became an eye opener for me. The bias against women is seen not only in attitudes of the medical person but also manifests in the physical facilities available to them. The number of beds allotted to women patients in various wards of hospitals is much lower than the beds available to male patients. This is corroborated by Veena Shatrughna, who has observed that in a Hyderabad teaching hospital burns cases are high among women patients in the age group of 15-45 but more beds are allotted for men in the plastic surgery wards.

The woman thus faces biases form every institution and structure in the society. All these factors make her more vulnerable to various chronic and acute illnesses which she carries and suffers till they become acute and fatal.

In the government framework women's health has been reduced to the MCH (Mother and Child Care) and Reproductive Health lately. Even within this limited concept of health, the morbidity levels are quite high.

Every year about 75,000 to 100,000 women in the reproductive age group die due to causes related to pregnancy and child birth.About 75 % of deaths are caused due to direct obstetric causes and 25 % due to indirect obstetric causes like anaemia, hepatitis, injuries, violence etc.The NSS Survey 42nd round showed that about 81 % of births in rural areas and nearly 47 % of the births in urban areas take place at home. About 33 % rural and 26 % urban births are unattended.

The maternal mortality rate (MMR) in India is extremely high and is estimated to be 500 per 100,000 live births.The report of the Registrar General of India 1991 points out that mortality due to maternity constitutes 10 % of the mortality among women in the reproductive age group. There is total neglect of simple preventive measures such as giving tetanus toxoid, supplementary feeding, folic acid and iron supplements.

Reproductive Tract Infections (RTI) which can be tackled by a fairly simple prevention and treatnment technology continues to affect women. About 15-40 % of infertility in Asia is due to RTI infection. RTIs underline 10-50 % foetal wastage including abortions, still births, prematurity and growth retardation of foetus and 30-50 % prenatal infections. RTI can lead to cervical cancer, HIV / AIDS, ectopic pregnancy, pelvic pain, backache, and dyspareunia as well as emotional distress.

About 12 % of maternal mortality is due to abortions alone.About 11.2 million abortions take place in the country every year, only 6.7 million have been officially reported. The present abortion rate is 452 per 1000 live births. The number of approved centres for Medical Termination of Pregnancy (MTP) have increased from 2149 in 1976-77 to 7121 in 1991. Most Medical Termination of Pregnancy facilities are urban, and only 1800 out of 20,000 Primary Health Centres provide MTP services.

In addition to these health problems there are many deep seated, long - standing discriminating practices;poverty, socio-cultural taboos and the 'culture of silence' affecting women's health. Discrimination which begins at a very early age for most Indian

women in health terms means low food intake and nutrition resulting in higher than desired weights. Women have hardly any energy reserves left for emergencies.

Anaemia alone is directly responsible for nearly 20-30 % of maternal deaths. Nutritional anaemia reported by Indian Council of Medical Research indicates that 1/3 rd of women have haemoglobin levels below 8gm/dl.Another study reports 50-70% of pregnant women and pre-school children suffer from anaemia.

Even when a woman is working and earning, her health status does not necessarily show any improvement. Over 90 % of the women who work in the unorganised sector receive low wages, insecurity, hardly any other benefits for long ardous work hours. Whether a woman is doing heavy manual work like construction or seemingly light tasks like domestic work, home based work or agriculture, her existing health problems are compounded further.

Present situation is one where the majority of health services are geared to the urban, the better off sections of society and where social support systems are fast depleting.For the 3/4 of Indians who live in rural areas, there exists only 35 % of the nation's hospitals, 44 % of the dispensaries, 17 % of hospital beds, 27 % of qualified allopath, 41 % of its indigenous system practitioners.

The failure of the public health system to provide basic health services to a majority of the population has led to very high expenditure that ranges between 7-9 % of household expenditure. For the 40 % of the people who live below the poverty line, this expenditure implies money taken away from basic food requirement.

A survey by the National Institute of Nutrition showed that the per capital consumption of cereals dropped sharply in the eighties by 14 gms, the intake of pulses, the only protein source for many dropped even more sharply. Given the sharp increase in food prices, reflected in a 20 % increase in the food price index in the nineties, it is clear that as a direct result of Structural Adjustment Programme more people eat less.

In these deplorable conditions the woman gets sucked in the quick sand of neglect, more neglect and further neglect .Women's health is inextricably enmeshed in the household, family and her status in the society. It cannot be analysed outside this context.

The conventional data does not capture the real health status of the woman. A step ahead towards a more realistic, honest recording of her health status would be when we consider the displaced, homeless,stigmatised, disabled women in our data; when we learn to incorporate facts like the one given by the Crime Records Bureau of the Home Ministry. " Every six minutes a crime is committed against women in India. A rape takes place every 47 minutes. A woman is abducted every 44 minutes while another is subjected to cruelty by her husband and nearly 17 dowry deaths are reported everyday."

__Roopashri Sinha__ has worked as a researcher for the past nine years. She has done extensive field research and also participated in action research. She has also undertaken health education activities in villages and contributed as a resource person to training of educators / community workers. Presently, she is working with CEHAT, Bombay and is the coordinator of the Women & Health Cell, Medico Friend Circle.

Photo : Mukund Sawant, TISS

WOMEN'S EXPERIENCES WITH FAMILY PLANNING

Manisha Gupte

Women bear the major brunt of the population policy all over the world, be it to increase or to reduce fertility . In India, rural women are made targets in a family planning campaign, because they lack visibility, articulation and political power. Women's lack of choice and low access to resources need to be documented in their own words and, keeping this in mind, we have attempted to articulate some feelings that rural women in Maharashtra have tried to express. While the reality of women's lives is neatly ignored, unsafe contraceptives that take away choices are peddled to them ' for their own good', as it were. Ironically, women's real need for safe contraception stays unfulfilled, either because they recoil from government pressure or because real choices are not yet available to them. I hope that the following article will be able to bring out these nuances, as far as possible through women's own experiences, which I have documented and presented here.

The Price of death

In our socio-economic study of women's work, fertility and access to health care in two villages, we accidentally stumbled upon the direct relationship that one's children's death has with one's fertility. Besides the agony, guilt and sense of helplessness that a woman undergoes after a child's death, she also immediately pays a high personal price by bearing more children to replace the dead one. In both the villages, we found that for every dead child a woman had to produce two more children, on an average. Abortions, miscarriages and still births are not included in this figure. We can only dare to imagine the extent to which a woman stretches and exerts herself to create a counteracting buffer by undergoing an enormous number of conceptions. The desired family size of three children (two sons and a daughter), and the social consequences of children dying (including exorcism, desertion and mental illness) set up a trap from which few rural women can dare to escape. "God gives, God takes," as women say, is the only temporary escape from insanity.

When children die, other childless women suffer, too. They are the first suspects of having performed voodoo or witchcraft. Deserted women, widows, menstruting women - all come next in the line of suspicion. In one village, a one day old child suddenly started to turn blue. In my presence a woman exorcist was summoned and she said that the grandmother who had gone to wash the baby's clothes at the pool had perhaps not noticed that some menstruating wanton had defiled the water at the same time. She then advised that some exorcised and "charged" materials be placed in the backyard of another childless woman who wished the baby ill. The social and political factors affecting illness and death thus go unquestioned and a web of superstition takes its place, making one victim fight the other.

Fear of the unknown

Health services, as well as the ' family planning' services, are based on an incomplete knowledge of people's perceptions of body, anatomy, illness and cure. On the other hand, people are also kept in the dark about the interventions that are going to be performed on their bodies, especially through contraception. Numerous justifications may be offered for these lapses, but that does not help to improve the situation. Women, who bear the major brunt of the population control measures, feel unnerved and ill at ease with contraceptives. They attribute all kinds of side effects to birth control methods, and their suspicions are further strengthened when the doctor refuses to entertain even the most genuine symptoms and sequalae.

Through all our group meetings, women say that 'camps' create more side-effects than individually performed tubectomies. Some women narrate their horrific experiences of the Emergency period of 1975-77. One woman described how she had been picked up from the jowar fields and tubectomised. Another recalled how she had literally been forced into a waiting vehicle and taken away to the tehsil hospital. She was sterilised at midnight in very unhygienic conditions. "There were more than fifty women like me at the hospital, all scared. We were treated like animals and were literally thrown out after the sterilisation." When asked whether this experience had had long term repercussions she countered: " Just think of yourself in my place. What would have happened to you ? "

Not surprisingly, then, women who undergo sterilisations against their wishes , or who have not been mentally prepared to accept the interventions about to be performed, suffer more. Menstrual chaos and lower backache feature as the most common complaints after tubectomy, and often these sequelae last long enough to justify other complicated interventions on their bodies. The government health services turn a deaf ear to any problems related to contraception, either because they disbelieve the women, or because they do not want to give the programme a bad name, and so the women are left to fend for themselves.

The private doctors, who are not interested in contraceptives because they are not lucrative. suddenly come to the forefront, and suggest hysterectomy (surgical removal of the uterus) as the solution to the women's problems. We have met many women who have undergone hysterectomies after years of suffering, post tubectomy. "If you have one operation, the other is bound to follow. They are like sisters." Whereas all the tubectomies had been performed in the public health services, all hysterectomies are invariably performed in private clinics. Each hysterectomy costs Rs.4-5000, while the daily wage earned by the women is never more than Rs.15 per day.

Little choice

Within the limited choice that the people exert within the target-oriented FP programme, tubectomy is the most 'preferred' method. Condoms pose a disposal problem in the villages, where there is no garbage removal system. The low bio-degradability of condoms also puts a damper on its usage. Copper-T or 'tambi' is also not a very popular method. Often health workers register false cases of barrier methods and of Copper-T. We have heaps of condoms and Copper-Ts,which were found in various parts of the village, and have witnessed large-scale incinerations of pills and condoms in the Public Health Centre (PHC) premises. A clever guess is that these devices feature as completed targets. Once, I asked a local nurse how she fulfilled the Copper-T targets. She told me: " I call the women for a cup of tea, give them the incentive money and enter their names on the ' protected couple' list." When I asked her what would happen if a surprise check was conducted, she replied: "We tell the women to say that the

'tambi' fell off. Even the doctor knows that we are filling up false records. He doesn't care, as long as our targets are completed. If we honestly report a high rejection rate of 'tambis' inserted, we get a shouting. So we learn to report low failure figures." This nurse considered me a good friend as I had let her use my name as a 'tambi' acceptor whenever she ran short of her target goal.

Pressure to meet FP targets

Reeling under the pressure of targets for population control, the village based health workers are in an unenviable position. In March 1987, Manda Padwal, an Auxiliary Nurse-Midwife (ANM) in rural Maharashtra, commited suicide after a reprimand from the medical officer to complete her target of sterilising 20 tribals within the next seven days, at the close of the financial year. When we investigated, we found that she had been the sole earner in the family, with a disabled younger brother. The doctor said that the suicide was a result of sexual frustration, because Manda was unmarried and she was anyway prone to exhibit bizarre behaviour due to this condition.

In numerous instances, both during our visits to PHCs all over Maharashtra and in our area of work, we have seen the humiliation that health workers undergo during the monthly staff meetings. The doctor, just having received a scolding from the district authorities, comes down relentlessly on his own staff. Since all health workers do not want to go Manda Padwal's way, they are left with no choice except to harass people (read women) in turn.

ANMs and village women thus play an unending game of love and hate, each party trying to outsmart the other whenever possible. The fact that the ANM is herself a frightened young woman, living alone in a strange village, is forgotten, because only her hard, determined quality is seen by the local women. "How can we be friends with her ? She taunts us when we get pregnant; she tells lies about the side effects of 'tambi'. I can't trust her." On the other hand, an ANM said: "You expect me to help the women? I am beaten by my own husband. He comes every month to take my salary away and batters me, saying that I am having affairs with the doctor, the Multi-Purpose Workers (MPWs) and the men in the village. He has another wife, but he won't let me leave because of my steady income. If my pay is withheld for family planning reason (incomplete targets) he says that I am giving the money to a lover."

Often we were caught in the cross fire between these warring women. The nurses reprimanded us for telling women about the expected side effects of contraceptives, and the women thought we were the nurses' agents. For over a year, during our stay in the villages, we were seen as family planning officers because, in the villages, health services are synonymous with population control. It was only after we stayed there for some years without any 'case' to our credit, that women started to confide in us about their actual need for birth control and asking us how to exercise choice within the limited available options.

Benefits, rights: unheard of

Today, the pregnancy centre that we manage regularly registers women's demands for birth control, and women insist that our workers (all of who are local women) accompany anyone who goes to the PHC for a tubectomy. "Of course I don't want too many children. But I feel so suspicious of the nurses. I don't feel safe and relaxed." This individual sentiment expresses the mass paranoia that the mindless, target-oriented population control programme has generated among the women while, at the same time, leaving their legitimate need for safe and reliable contraception unmet.

Though a 1983 state government circular grants maternity benefits of a partial kind to all women workers on the state-sponsored Employment Guarantee Scheme (EGS) sites, we have not come across a single case in our cluster of villages so far where any woman has availed of the same. In fact,women said: "If we deliver in the afternoon, we get paid only for the morning's work that we put in." Most women work until the last week of their pregnancy and return within a month or two of the delivery if the drought continues. "Is there a choice? The fields are not irrigated and so our lives are spent carrying and dumping stones." Women were even surprised to hear that some maternity and post-tubectomy benefits had been granted to them by the state.

In one instance, we witnessed a woman who had recently delivered being motivated for sterilisation.Everyone except her participated in the conversation. The woman in question sat behind the curtain, with the infant in her lap, and listened to what the family members had to say. The MPW wanted to complete his targets immediately, whereas the girl's parents were waiting to hear from her husband. The girl's father-in law wanted to give the case to the health worker in their village, and so he was not ready for the operation in the girl's natal village. The local MPW threatened to sever all his relations with the girl's parents and said, " If ever there is any health problem in your family hereafter, do not bother to call me. I have no time for ungrateful people."

It has been our constant observation that, though sterilisations are mostly performed on women, they have the least say in the matter. This alienation from their bodies could partially explain the trauma that accompanies the surgery and makes them vulnerable to future invasive interventions as well.

The suspicion that women harbour about health workers is also not entirely unfounded. In one instance, a male health worker was motivating a woman in my presence. He looked at me with a flourish and said to the woman: "Now you don't have to worry. Here is a lady doctor from Bombay who has decided to live in our village. She will perform all the 'operations' henceforth." I countered him saying that this information was not true. Later on, still sulking, he questioned me about why I had been so 'indiscreet' in front of the woman and made him lose face. In turn I asked him how he expected the woman to believe him. Would she not find out the truth once she came to the PHC? "That's my business," he said, "Once she is inside the operation theatre, she can hardly run away. Now you have lost me a perfectly good case."

False promises

Women have also complained about the false promises given at the time of sterilisation. "Our children were promised free medicines until the age of twelve years. Later on we realised that they didn't even have enough ' triple' (immunisation) doses. We have never received the medicines or the free health check-ups they promised."

It is a common sight to see health workers discuss a woman's eventual sterilisation, over her head, during the ante-natal care (ANC) check-up. A certain nurse will croon over a pregnant woman or taunt her, saying. "After all this care, don't have your operation at your mother's village, after your delivery. Don't betray me." Noticing my presence, the nurses would also hurriedly add something like "There is no difference between girls and boys, you know. They are equal, so don't postpone your operation just because it's a daughter! " It probably doesn't matter that the mother is not asked her opinion at any point or that nurse has never questioned her own no-win position. Girls and boys are certainly equal.

Once I saw a nurse in tears and I was surprised, because the usual day for nurses to cry is the day of the monthly staff meeting. She bitterly complained about how her male colleague had slyly taken away her case. "I had 'cultivated' this case all through the pregnancy. How dare she agree to go with the MPW? Just let her come to me for the child's immunisation. I'll give her a good dose of her own medicine."

Stealing a case

A communitry health guide from a neighbouring village reported how it was very difficult to motivate a woman to insert a Copper-T and how he had, instead, taken a few women to the taluka place (hospital) for tuberctomies. All of them were 'stolen' by the local MPW; on one occasion, he managed to motivate a man for vasectomy. The same evening, the Block Development Officer's (BDO) car came along and took his 'case' away.Asked why he allowed such snatching, he said: "They are all big officers. I cannot do anything, except complain to the medical officer when he questions me about my incomplete target figures."

Another motivated Community Health Guide (CHG) from a nearby village said that it was no longer very difficult to motivate young couples to stop after two or three births. Women were mostly sent for sterilisation, and the few men who agreed to undergo vasectomies preferred to wait until the end of the financial year, when the incentives are the highest. The major problems as narrated by him was "The MPWs and the ANMs snatch away our cases. They justify it by saying that, as CHGs, we don't have to complete targets officially. Once the 'case' is taken to the health centre, they tear off the forms filled in by us and fill in new ones with their own names as motivators."

Who is bigamous?

To understand the true extent of the "minorities" threat - which suggests that members of minority communities are primarily responsible for the population explosion through their customary large family size and the practice of bigamy - we decided to conduct a census of our own village. Our findings were unexpected, to say the least. Among the 182 households (with a total head count of 859 individuals) we found that every tenth Hindu household was 'officially' bigamous, with more than one woman openly using the same man's name and that the entire community accepted these marriages as rightful and unstigmatised in any way Ironically, whereas 10 per cent of Hindu men, spread over all age groups, educational levels and castes, were openly bigamous, none of the 21 Muslim households in the village are officially bigamous.

The average household size of Hindu families is 5.0, whereas that of their Muslim counterparts is 5.4, indicating that there is no considerable difference, especially since we found that small households (kitchen units) in the village are not merely a representation of reduced fertility, but also of opportunities (or lack of opportunities) for migration to the cities for better prospects. The study was conducted in 1992 by the author.

Myths and biases are excellent breeding grounds for planned coercion and so we find, even in well-meaning circles, the agreement that the growth of 'certain populations' needs to be curtailed. Coercion on women, the minorities, the working class, villagers and the illiterate are thus justified. A cursory glance at reality may help to dispel some of the eugenic biases we unnecessarily gather.

Unsafe contraceptives, no-choice situations

About three years ago, a young adolescent girl came to the PHC for her first delivery. Her old grandmother stayed the night with her. This old woman confided in the nurse about her own vaginal discharge. The internal check-up revealed a foul, frothing, black discharge. Then the grandmother told the nurse that she had never got her IUD (probably a Dalkon shield) removed. She had got it inserted when her youngest son, the father of the girl in labour, was born 40 years earlier.

This woman certainly does not represent the typical picture regarding invasive contraceptives, but surely there are a few more like her, somewhere on the Indian sub-continent. The agony is compounded by the fact that women's access to general health services is also very low, it being further reduced by the constant nagging for family planning. In this context, it is both undesirable and unconceivable to consider introducing long-acting hormonal contraceptives, such as injectables and implants in the Indian Family Planning Programme. The absence of choices, low access to all resources, including health services, low self-perception of women and the anti-people stance of population policies, would only compound the miseries of the common woman.

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The observations made in this article were recorded over a period of five years - during her involvement in a study undertaken for the National Commission on Self Employed Women and Women in the Unorganised Sector, during the author's extensive travel in rural Maharashtra to visit various PHCs and NGOs engaged in rural community health care and, of course , during their project work.

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THE VEIL : Women's Empowerment and the Collective Exploration of the Self and Body.

Anjali Monteiro and K.P.Jayasankar

My odhni three yards long
With its corners four,
Four are the sides
Of my world.
The four corners
Of the courtyard
Between every two corners,
A wall...
Corners walled in,
The walls like a veil,
Suffocation inside the veil,
Life suffocates...

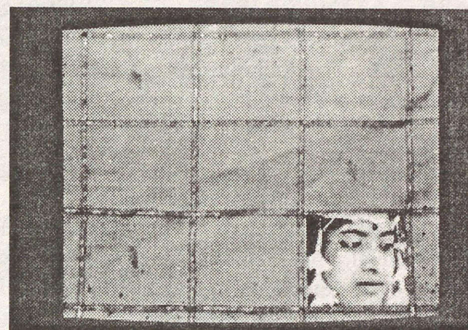
The opening song of the video *Odhni*: A Collective Exploration of Ourselves, Our Bodies establishes the circumscribed space of the veil, its four corners demarcating the boundaries of the domestic space where women are only wives and mothers. The video presents the journey of a group of women, as they go through a process of exploring their self-images and bodies.

The starting point of *Odhni* was a project to produce a video relating to women and AIDS awareness. With this in focus, the authors initiated a discussion with a group of women who were involved in a process of rethinking of dominant familial norms. Right at the very outset, rather than disseminating information awareness related to AIDS, it was decided that more basic issues related to gender, power and sexuality needed to be addressed. After a series of discussions, the group decided to try out the use of video to share, with other women, their experiences of collectively exploring their own feelings of pain, shame and anger, as well as their hopes and desires. A workshop was held for a three day period and the entire workshop was recorded on video by the authors. The starting point of the workshop was a game that took participants back into their past lives, facilitating the reliving of difficult moments and a sharing of feelings and experiences relating to sexuality and their bodies.

Having begun to collectively share their feelings, desires and dreams, the participants felt that they could begin to look at themselves and their bodies anew. Through an exercise in body mapping ! (it involved a collective process of marking out various body parts on a life-size outline of a woman) they explored the different areas of their bodies, areas where they experienced pleasure and pain, areas they felt comfortable or ashamed to talk about.

In a social and cultural context, where the notion of a ' good woman' involves a denial of desire and sexual expression on the part of women and compliance with patriarchal familial norms, the recognition of body and self-hood as a collective experience was profoundly empowering. The women began to experience a new ease, as it were, with their bodies, as they participated in creative theatre and dance, song writing and singing.

Prior to the workshop, we did not have any clear cut idea about the kind of video that would emerge. We had merely decided to record the interactions, and then see what could be done with them. At the end of the workshop, we (the authors / producers)



were left with 700 minutes of footage, and a feeling of panic . How were we to condense all that went on in those 3 days into a 20 minute capsule? How could we 'tie' it all together in a coherent fashion, given the diverse range of experiences, feelings and activities that were shared? How could we express the **specificity** of this experience, without attempting generalizations about 'Indian women' ? While the workshop experience had meant intense involvement and exhilaration, the editing process called for a distantiation from the material, looking at it in terms of coherence, intensity of expression and production values.

During the workshop, we interpreted the metaphor odhni through improvisations using songs and choreography. This became the unifying metaphor for the video. The introductory game served as a device to structure the presentation of experiences. Once this structure was arrived at, it was easier to work with the material. After making a preliminary version, we shared it with the group. They felt that many of the activities that they had enjoyed, like singing, dancing and acting, should also have been included in the video-they would have liked a much longer programme. On the other hand, we, as producers, were concerned with the quality of the final production, with whether it would sustain audience interest, and these considerations had mediated our choice of what to include. And it was we who took the final decisions.

In the video, the end product of the entire process, expcerpts from the workshop are interwoven with song and commentary. Starting with the circumscribed space of the *odhni,* it uses a game with photographs to structure the retelling of past experiences and the sharing of feelings. This structuring device perhaps makes the workshop appear like a very coherent and intensely focused exercise when, in practice it was much more loosely structured, moving back and forth, with long moments of waiting and silence, as the group struggled to cope with the self-consciousness of being recorded on video. The second part of the video is organized around the activity of body mapping and ends with a recurrence of the odhni motif. The video attempts to convey both the feelings of empowerment that the collective interaction generated, and at the same time, the limits of these.

In making *Odhni*, the authors attempted to break with the genre of development communication. Instead of an "us", making a video to create awareness in a "them", there was an attempt to

embark on a collective journey to interrogate our selfhood, in particular our relation to our own bodies and sexuality. The workshop and the video also attempted to initiate a process of questioning of gender identities and the relations of power that produce and sustain them, resisting the temptation of positing an ' utopia' of ideal identities and relations, with the realization that there is no moment of liberation, no teleological passage to truth beyond power. The idea was to put forward a collective resistance without portraying these experiences in a voyeuristic manner. This again presented a peculiar dilemma:

How does one talk about sexuality and yet remain incognito from the voyeur. In other words, we wanted to control the use of the video, to ' protect' the identities of the participants, which was a double-bind situation. This dilemma was particularly acute while editing the video: we wanted to produce a programme that would be used by bonafide audiences; a programme that would sustain 'interest', a programme that is not voyeuristic, a programme that would, above all, **subvert** constituted identities and yet, **protect** these identities ! This was the point where, the fundamental dividing practice of development communication, made a reappearance. With a few exceptions, there was a qualitative difference in the sharing of experiences on video by the 'us' (consisting of the authors and the middle-class resource persons) and the 'them'. We tended to theorize and generalize about experiences and feelings, to be conscious of the probable implications, for our identities as 'good women', of our recorded discussions. At the same time, we expected them to switch to a confessional mode for the camera, enabling them., in the process, to question the formation of their identities. Many of our statements were intended to commit them to this process. On the other hand, off-camera interactions, which went on till late in the night, witnessed a breaking down of these dividing practices, as we shared our most intimate experiences and feelings with them.

The camera became, as it were, a marker of the dividing practices that we employed for creating our own identities. By and large, we did not dare to step beyond the bounds of the circumscribed spaces of our metaphorical *odhnis*. Paradoxically, they, who did not theorize about liberation and empowerment, and who, in their everyday lives, might use *odhnis*, were the ones to cast them away, coming perilously close to subverting their constituted selves. That is how we stumbled on the dual connotation of *odhni*; as a marker of tradition, oppressive and claustrophobic; the other as a comforting metaphor of security and shelter, home to our constructed identities. Is there a moment of truth beyond these metaphors of power ?

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***Odhni** : A Collective Exploration of Ourselves, Our Bodies, [VHS(PAL), English, Hindi, 23 mins, Tata Institute of Social Sciences, Bombay, scripted and directed by Anjali Monteiro and K.P.Jayasankar] was produced for the project ' Understanding Sexuality: Ethnographic Study of Poor Women in Bombay', which was a part of a larger programme on Women and AIDS, sponsored by theInternational Council for Research on Women. The video serves as a reference point for this paper.*

WOMEN AND HEALTH

Parimala Subramanian

Health is defined in the Constitution of the World Health Organisation as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. To this has been suggested the addition of Spiritual well-being in 1983 by the World Health Assembly. Total Health, having the highest possible standard of health and well-being is as important and necessary to women as to any other segment of the population. It is a Universal Human Right.

The level of women's health is one of the major factors determining their ability to contribute individually and collectively to a nation's development. Women do in fact provide most of the health care, both at individual family level and community level. Primary health care strategies recognise that women need to be ' supported' so that they can do a better job for their own sake and for the good of their families, communities and nations. The need for the 'Support' stems from the fact that inspite of all the declarations of Women's Decade, the year of the Girl Child, and the activities of the Women's Day both at local and international levels we realise that we a have a long way to go before we in India can claim to have reached the status of Equality with our male counterparts. The presumption of an inferior status for women and the persistent devaluing of women's contributions to society shows up in relation to health as in other sectors. One of the most devastating consequences is that millions of women accept poor health as their lot in life. In India sex discrimnation begins at birth and prevades throughout a woman's life from childhood through adulthood to old age. This is proved by a few of the following observations.

Sex Ratio

Women in this country have never really comprised 50% of the total population. There has always been a male preponderance, with the imbalnce increasing every decade. In 1901 for every 1000 males there were 972 females. In 1991 the female numbers dropped to 929. The inherent biological strengths of the female babies seem to be subjugated to other antisocial forces operating in India's cultural context. It is worth noting that in Kerala where women have reached a high level of social status through education, the ratios are reversed, and we have 1034 women per 1000 males. States like Bihar, Manipur, Orissa, Uttar Pradesh and Rajasthan with lower female literacy have low sex ratio. Female Education does indeed seem to have the Key to development.

Life Expectancy

Indian males have always lived longer than Indian females. Though life expectancies have gone beyond 55 years, the Indian male still lives a year longer than the female.{[57yrs (M)][56 yrs (F)] }. In developed countries females outlive men by nearly 10 years.

Reproductive Health

Women's reproductive health problems and their right to reproductive health were brought to the world's attention during U.N. decade for Women, at the Mexico Population Conference in 1984 and the Nairobi Conference on Women at the end of the decade. There has been no significant reduction in maternal

mortality rates in the past two decades. However it is heartening to note that the Safe Motherhood Initiative launched in 1987 offers hope for the future, for it has ramifications not only in the field of health but for people concerned with development, socio-economic progress, population, children well-being and human rights. The technical reasons for cause of maternal deaths have been the usual well known ones - hemorrhage, sepsis, toxaemia, obstructed labour and the complications of abortion, but on looking beneath these immediate causes when we try to ask why did they occur or prove fatal we would find one or more of the following answers as summed up by the Safe Motherhood Initiative :

Women die in Childbirth because -

1. They received no prenatal care.
2. They have too many children.
3. They were afraid to go to the hospital.
4. They could not afford transportation.
5. They did not know that their condition was dangerous but could be treated.
6. They were afraid to use contraception.
7. They were malnourished as little girls.
8. There was no blood available at the health facility.
9. The untrained traditional birth attendant thought she could handle the complications.
10. They live too far from a hospital which can provide emergency care.
11. They seek illicit abortions to end unwanted pregnancies.

For every woman who dies due to maternity causes it is estimated that 10-15 women are handicapped in one way or another. There must be a commitment to stop these deaths. We must be able to mobilise political will and community involvement, to implement specific programmes to stop these tragedies. We need to increase the peoples' sensitivity to other sensitive social issues like rape, prostitution, dowry harassment that affect women's health. This brings us to issues of mental health problems that affect our women. Continued anxiety states and mental depressions are common. It is said that women attempt suicide much more frequently than men. The reasons given for suicide by women in India center more on family matters-physical violence or psychological abuse by the husband, problems with in-laws, the stigma of divorce or pregnancy outside marriage. However it must be accepted that improving psychological and emotional health of communities is not generally a priority of health care systems in our country. Psychological medicine and psychiatric treatment are usually one of the smallest services within the system. Psychospiritual counselling needs to be strengthened.

Improving women's health is not just a matter of providing maternal and child health and family planning services. It must include educational programmes and social reforms. Unfortunately the greatest impediment in the realisation of her constitutional, legal and social rights has been the woman herself. The Government needs to be complimented for its supportive stand on 'Improvement of Women's Status'. Empowerment of women do need social and legislative reforms - but waiting for a day when all this will be accomplished by external agencies alone is a well nigh impossibility. Women must realise that the empowerment must come from within. Each Human Being is a Body, Mind, and Soul. Gender is for the body, the qualities of masculinity and feminity come from within the deeper mental concept. A balance of masculine and feminine traits is a function of neural mentation and the inner strength comes from the inner energy source - the spiritual roots - to which every human being must strive to get rooted to know and understand the deeper meaning of life, health and healing. This knowledge alone will raise a woman to her rightful place as equal to man - The Ardhanareeshwar concept must be conceptually understood. It is important for women to realise that they must mobilise themselves to develop themselves - it is their Univeral Human Right.

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BIOLOGY, MEDICINE AND WOMEN - SOME THOUGHTS

Swatija and Chayanika

Science which ought to be another cultural expression of society at large has on the one hand remained the expression of those with power within the society and on the other with its universal characters in some sense helped to reach out and help those disadvantaged by society on the whole. Women represent a large section of the marginalised doubly oppressed within their own caste, class, community positions. Their relationship with science as it is practised has been particularly ambiguous. Science has been understood to be a very male discipline, controlled totally by reason and intellect -- both abilities that society believes women lack in.

At the same time women differ from men in their biology, in their body's ability to reproduce. This has led to a very typical relation between women's roles in society and their overall social status. It has also resulted in a typical viewpoint in science. These attitudes of society reflect very clearly in the way biology and medicine have in particular looked at women and have been exposed and discussed by many feminists since the decade of the 70s,. Some of these aspects will be the focus of this article.

Health care in the past had been women's domain, dominated by knowledge that women had about their body and about nature and its resources. The advent of modern medicine in a way liberalised this knowledge from the hands of the practitioners to make it more accessible to many more people but at the same time discredited the knowledge that women had generated over their years of experience. Along with this there was an active attack and aggression on women healers, on those women who were strong enough to have power of knowledge.

Medical science or modern medicine has its roots in the massacre of lakhs of witches and the systematic killing of traditional healing methods. This is a well known and explored fact about Western society of the 17th Century. In the Indian context there is no such history of witch hunting but erosion and systematic exclusion of traditional knowledge has been an experience here too.

A group ' Shodhini ' working in seven Indian states has been involved in collecting information about herbal and other remedies practised by women healers. The women practioners working in the rural area, having knowledge about the herbs

have prepared the herbarium sheets of the herbs. They have also created nurseries for the plants which are rare in particular areas or in danger of becoming extinct. Exchanging knowledge base from different geographical areas and also trying out the remedies along with self-help clinics where women also could do their own examinations has been another part of the project.

It is an effort to reclaim the knowledge base of women, an effort to empower through knowledge that has been acquired over the years through a great deal of observation and skills. It is also an effort to make health and health care more accessible, within reach and in tune with our cultural context.

Yet in the era of intellectual property rights this effort too has its drawbacks. Where knowledge itself is losing out on the collective and social aspects and is becoming the property of individuals, there is a need to be cautious. Today a supremacy is being given to the intellectual abilities of individuals, the social situation and contribution to the evolving of the knowledge is being ignored all the time. At such a time a process of documenting a lost heritage of ages, a treasure of information gathered and enriched by many women, compiling of such material has become problematic. With the kind of material interests the drug companies have, any such initiatives could lead to further snatching away of knowledge and practices from those who have cherished and treasured it for so long. Such is the situation of the knowledge base today which denies the historicity and social development of the old civilisations.

It is within this scenerio that women have been struggling to regain their lost knowledges. The efforts are individual and collective in the broad and fluid framework of what can be called the women's movement. Along with reclaiming what is lost there are efforts at analysing and understanding what is replacing this. A critical look at the way in which the so-called objective and rational sciences are looking at women and women's issues and understanding of biology and research conducted within the discipline has been the main focus of many Feminists.

Research based on biases of the scientists and their ivory tower models of research has missed out on various basic characterstics of life. The research model for lateral brain development theory (which is at the basis of allocating certain gender based skills) also does not take into account the normal and social norms which have been otherwise proven to be the cause of brain development or rather ability development. The trauma and the change in the life of girls after menstruation plays a remarkable role in their abilities to do mathematics. As far as language abilities and rational thinking goes this does have lot to do with the social and family atmosphere. All these factors are conveniently missed out and wrong methodologies evolved to arrive at results that suit the status quo structure of society keeping both men and women trapped in manhood and womanhood respectively.

Evolution, the most basic theory of biology, has been full of such a subjective vision of a Victorian mind, that of Darwin. Progress and development were defined and understood through values like competition in society. These also became the values and the basis of the theory of evolution. Accepting the supremacy of human species and the resultant androcentric vision also is part and parcel of such a Victorian attitude. The difference between the sexes and the accepted hierarchy between them was also an outcome of the prevalent world view in society in the Victorian era. Later theories have pointed out these connections between the basic concepts of the theory and the societal attitudes and structures. Yet there is also a trend to justify the very same social practices using the theory which has been evolved based on them.

The other aspect that has been questioned has been that of the Cartesian model, the mechanical view point. Most of modern medicine has developed in this fashion and based on a rationale where the body is looked as a machine and treated accordingly in a very mechanistic way. An example of this is how women's bodies are looked at. The human body is a male body and the woman's body appears as an anomaly with different organs related to reproduction.

The implications of this are manifold. Women's bodies appear in text books only when there is any mention of reproductive organs. These representations are also very alienating. Special attention to women which also is very limited and unrepresentative of women's actual experiences is paid only as far as reproduction goes. That this specific biological and social function could alter women's biological responses and would warrant special attention is something that does not even occur as a question in the whole approach. A health group working in Rajasthan as part of Women's Development Programme was thus compelled to work on their own book called ' Sharir Ki Jankari '. Eighty women have worked on this book and have attempted to find answers to their own questions.

Drugs are tested only on male bodies. The justification for this is that since women reproduce, no risks can and should be taken with their bodies.On the other hand this great concern for women's capabilities to reproduce is not at all reflected in the way their bodies are made the testing ground for every technology related to reproduction. This special function is then looked at very mechanistically and attacked in very possible way with total disregard for the overall impact on women's bodies and lives.

This understanding of the women's body goes further in its reductionist approach where the understanding of the menstrual cycle has been seen in a mechanistic way as a product of few hormones and their cyclical interaction. Because of this and the world politics of population control and societal norms there has been a great stress on women to opt for contraceptive methods which are harmful and long acting. With total disregard to women's experiences and needs, their fertility has been tampered with, their bodies have been experimented upon and their roles further entrenched into those of being reproducers.

Where knowledge should have the power to make things easier for more number of people the way that science has developed today it has led to accepting and in a sense justifying women's role in society through particular representation of their biology. This has necessitated a questioning of the knowledge and more importantly the process by which it is being acquired.

The women's movement has also moved on. Evolving our own approaches based on women's experiences and enriched with knowledge acquired over the ages there have been attempts at self determination. The attempts in Rajasthan through writing and depicting in ways familiar to women to the work done on

traditional knowledges related to medicine by ' Shodhini ' are just some of the examples. There are others also scattered all over the country. It is these attempts that give hope that the future would have an emergence of a new way of looking at biology and women's bodies and that this would help evolve a positive relationship of women with their bodies. Something that would help to counter social pressures and not get further bogged down in stereotypes.

Swatija trained in microbiology and anthropology and ***Chayanika*** *a lecturer in physics are active in Forum for Women's Health activities and have been working as a research team for the past few years. Besides health they have also worked together in the area of History of Science in India and Feminist Science.*

FEMALE SOCIALISATION FOR REPRODUCTIVE ROLE : IMPLICATIONS FOR HIV/AIDS PREVENTION

Shalini Bharat

The rapid increase in the number of people infected with HIV has generated tremendous concern regarding people's sexual behaviour underlying HIV transmission. There is a great pressure mounted on governments,NGOs and social scientists to launch public education campaigns and design intervention strategies for preventing the spread of HIV infection. Sexual behaviour modification underlines major HIV/AIDS prevention programmes. Condom use, mutual monogamy, non-penetrative sex, partner reduction and treatment of all sexually transmitted diseases are the key components of these prevention programmes. However, the socio-cultural context in which sexuality is defined and constructed and in which it operates, is being ignored in these programmes. The strategies are being suggested in a social vacuum with the assumption that there is both knowledge and preparation enough with the young to make effective personal choices about safer alternatives to deriving sexual satisfaction. It is important to recognise that while suggesting safer sex practices as strategies to prevent the spread of HIV/AIDS, attempts are also required to understand the socialisation process which prepares young people to assume their reproductive and sexual roles. Conscious choice of a safer method of sex and its negotiation with the sex partner are possible only when people have been prepared to meet the challenges of a sexually active life. This paper discusses some issues in the socialisation of girls with specific reference to the onset of menstruation which signals sexual maturation among girls.

In the Indian culture, as in most other cultures, women's reproductive role is at the centre of her existence. A woman's worth is tried and tested by her ability to procreate. Conception, pregnancy and child birth are, therefore, significant events in her life. Understandably early socialisation of girls stresses on grooming them for their roles as mothers and wives. While there is some literature available on the ways in which female gender identity is constructed, there is very little material discussing socio-cultural factors influencing menarche and still less available on the ways in which girls are prepared in terms of knowledge, skills and attitudes to take on their reproductive function. Menstruation, is the first significant milestone in the reproductive history of women with meaningful and powerful consequences for them, and yet this milestone is supposed to merely 'happen' to them. There is silence, secrecy, fear and even shame surrounding it. And as young girls mature into sexually active persons and enter matrimony and motherhood, they learn to internalise their fears, anxieties and sufferings associated with their reproductive function.

Six focus group discussions were held with young girls and women in the age group 14 to 23. The participants belonged to the lower and lower middle class communities in Bombay. Between 6 - 8 girls / women participated in each session and the language of discussion was Hindi. Each session lasted about 90 minutes.

The subject of menstruation was introduced in the group in order to set the tone for subsequent discussion on sexuality, reproductive health and HIV/AIDS. The idea was to have a warm up by talking about an episode from their life that all of them had intimately experienced and one through which they had first become aware of their sexuality.

The age at menarche for most of the participants was between 12 and 14 years. One girl started her periods late , at 17 years.

Photo : Mukund Sawant, TISS

Discussion

Listening to young girls and women talk about their experiences with menstruation, and the ways in which they were oriented to this important phase in life that bore significance for their adult roles, the 'culture of silence' was striking. The concept of 'culture of silence' has been discussed in relation to women's sexual and reproductive health particularly in the context of developing countries. However, it is clear that not merely women's health issues, but the very events related to sexual and reproductive functions are surrounded by silence and secrecy. The embarrassment and shyness that is felt while talking about it in a

group situation makes it clear that girls are not used to discussing the topic of menarche except perhaps with their own friends. Outside this circle, which is as well or as poorly informed or mis-informed, they don't feel encouraged to ask questions and clarify doubts. Although it is the mothers in whom the daughters confide when they first have their periods, further dialogue or communication between them remains conspicuously absent. Girls' 'shame' about their emerging sexuality and polluting bodies and mothers' 'fear' about their daughters' sexual vulnerability, make the 'culture of silence' still more pronounced.

Another factor that contributes to the silence surrounding the topic of menarche in India is the "ethic which gives priority to experience over theoretical knowledge" (Van woerkens, 1990). Thus, girls observe and learn from their surroundings by picking up cues and hints. They imitate the behaviour of the older women and learn that topics such as menstruation, sexual relations, conception etc. are not to be spoken, atleast not with young growing up daughters. And thus this model of knowledge transmission on sex topics continues to be followed in the next generation and the 'culture of silence" perpetuates.

The above made observations have relevance for sex education and in the time of AIDS, for its control and prevention .

Several of the messages that are being given out in awareness campaigns like, urging people to use condoms during sexual intercourse for example, can hardly be expected to be taken a serious note of by the young girls of lower income groups who participated in the focus group discussions when they do not have channels of communication available to seek clarifications. To quote an example, some of the participating girls said that Nirodh was a 'pill' to prevent pregnancy. They said they had seen its advertisement on T. V. where it is shown as a small packet. Obviously after seeing an advertisement of Nirodh they do not know where to get more information and so when they receive messages like "use Nirodh" they are not clear who should use it- man or woman. And they are not sure whom to ask such questions. A young married girl during the course of discussion said that though she had heard about Nirodh which a man can use, she had not seen it so far and that she felt shy to ask her husband about it. The shyness in talking about contraceptive devices, and similar other issues can be traced back to the onset of puberty stage which was similarly handled with silence and secrecy by those around her. In a climate where talking about sex and Nirodh or any other condom is difficult, negotiating for its use with the partner is certainly more complicated when girls are discouraged from enquiring about sexuality and lack skills for communicating on this subject. Unequal power balance in gender relations further complicate the matter.

The prevention and treatment of STDs which have high correlation with HIV transmission are the most difficult problems for women to openly discuss and seek treatment for, due to the accompanying stigma. Going by their previous experience of not being able to have open talks with mothers on a biological fact of life such as menstruation, it is hardly surprising that women maintain confidentiality about their reproductive health problems. AIDS prevention strategies emphasising early treatment of STDs will thus fail with women who have not been prepared with skills to communicate on aspects of their private life.

To conclude, it is recommended that it is imperative that young adolescent girls be prepared adequately in terms of both knowledge and skills for their reproductive and sexual roles. They need to be educated about their bodies, body changes during puberty their reproductive functions and sex and sexuality to take on the challenges of a sexually active life. Above all, the shame and anxiety surrounding their sexuality needs to be removed so that they are empowered to openly dialogue and communicate on issues pertaining to their sexual and reproductive health and participate in HIV/AIDS control and prevention programmes.

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MOTHERS, INFANTS AND BREASTFEEDING : AN APPROACH TO UNTANGLING THE KNOTS

Lakshmi Lingam

Introduction : Women's health is often equated to maternal health. Research and action in the area of women's health have highlighted the limitations of this equation which undermines women's health needs during the entire cycle. In the serious engagement of working towards the decline in infant mortality, 'maternal health and child survival ' is an umbilical connection in research, action and programme formulation. The identification of this association is significant for the purposes of programme formulation and target orientation. However, the limitations in understanding the 'mothers' and what constitutes 'maternal health' necessitates looking at mothers as women who play multiple roles. Women's multiple roles specifically the work role (domestic work or income earning work) impacts upon and in turn is impacted by the maternal role.

This short paper provides an approach to untangle the knotted umbilical connection. More thinking in this direction is necessary to attain clarity.

Much of the research in the area of breast feeding and infant feeding practices in India, are carried out by medical professionals to study the benefits on various aspects of child survival or, carried out by demographers to study the association of breast feeding and natural infecundity. Studies, have identified :

* the decline in the breast feeding duration
* a strong inverse relationship of education to duration of breast feeding
* short postpartum amenorrhea (PPA) for educated women;
* shorter period of exclusive breast feeding among working mothers and an early initiation to bottle feeding;
* prolonged duration of exclusive breast feeding and late introduction of supplementary foods among poorer socio-economic status mothers from rural and urban areas;
* the discarding of colostrum and negative beliefs related to its efficacy;
* the incidence of bottle - feeding, breast-milk substitutes and low knowledge relating to bottle hygiene, and substitute milk preparations among lower socio-economic strata;
* higher incidence of diarrhea episodes and respiratory tract infections among bottle fed babies and
* gaps in knowledge and information among health service providers about the advantages of colostrum and breast feeding.

The majority of the studies focus on the outcomes of breast feeding with the least focus on the women. Women are referred to only as mothers to the neglect of the multiple roles and responsibilities, which impact breast feeding practices. Therefore, barely any research has been carried out to identify the specific reasons that women may give (a) about short duration of breast feeding and (b) the adoption of bottle feeding or milk substitutes. A needs assessment would be possible by eliciting (a) women's sources of information and support, (b) their evaluation of the efficacy of the existing support structures and (c) their listing of priorities.

In addition, most studies pose broad issues such as, the influence of urbanisation, women 'giving up' traditional way of life and taking up employment, the breakdown of the joint family, the influence of media, etc., as causal factors responsible for this phenomenon. On the one hand, such generalizations carry a hidden ideological baggage that assumes :

(1) women's sole responsibility is the home and child care, and as a corollary, (2) seeking income-earning work is incompatible with breast feeding and child care. These assumptions reveal the insensitivity of researchers to the stock of evidence at the macro and micro level that highlight : (a) the crucial significance of women's incomes to households (b) the positive association of women's education (schooling) and employment to health seeking behaviour, declines in infant mortality rate and child survival, (c) the growing incidence of women-headed households and (d) the steady decline in employment opportunities for men and women, etc. On the other hand, such observations do not facilitate the identification of areas that require support structures of affirmative interventions.

It is important to zero in on the mothers and infants that require support structures. In order to proceed further, conceptual clarity is required. The aspects that need conceptual clarity are :

(a) Women's work and maternal roles are to be seen as interactive and complementary rather than competitive and incompatible;

(b) Women are not a homogeneous group. They are stratified on the basis of class, community, region, education, employment status and family type, resulting in different needs and support requirements.

(c) The diversity in their backgrounds, perhaps, account for the different notions of motherhood, self-esteem, notions of breast feeding, of being 'modern' , of 'convenience', 'modesty', 'lactation failure', 'healthy baby' and so on. (This area is least researched).

Based on the information on different duration of breast feeding and timing of introduction of bottle-feeding and supplementary foods, mothers can be categorised as practicing :

(1) exclusive breast feeding and timely (recommended timing) introduction of supplementary foods;

(2) exclusive and prolonged breast feeding

(3) exclusive bottle feeding

(4) bottle feeding and timely introduction of supplementary foods.

(5) mixed feeding (bottle and breast)

In order to identify the infants that are likely to be 'at risk' and the mothers that require support structures on a high priority basis, certain observations may be reiterated here :

The health benefits of breast feeding are well established. However, too short, or no breast feeding can place the infant at greater risk of exposure to diseases. That is, health benefits do not automatically increase with increase in the duration of exclusive or unsupplemented breast feeding. Similarly, though bottle fed infants miss out on the health benefits of breast milk and are more susceptible to infections, not all bottle fed infants are at risk. There is sufficient empirical evidence to prove that educated mothers having shortened duration of breast feeding, at the same time have healthy children. The above phenomenon can be explained by educated mothers being able to successfully provide health substitutes to breast milk by virtue of their access to resources (incomes), knowledge, and the enhanced ability to change their immediate environment (Barrera, 1989). It needs to be clarified here, that a case is not being made for bottle feeding but for identifying high priority groups to initiate need-based support structures.

To sum up, infants are at risk when:

(a) women practice exclusive bottle feeding without safety precautions (sterilizing bottles and nipples, using boiled water and following directions of formulae preparation);

(b) women practice mixed feeding without following safety precautions with regards to bottle feeding and

(c) women breast feed exclusively for prolonged periods beyond 6 to 9 months (risk of undernourishment and growth stunting).

Most of the causes of death during infancy and childhood , are attributed to malnutrition which results in loss of immunity and, therefore, the susceptibility to various infections and diseases. The root of malnutrition lies as much in poverty and gender discrimination (which determine the access to food) , as it also lies in beliefs, attitudes and feeding practices in relation to food. Colostrum and breast milk are undoubtedly vital sources of immunity and nutrition to infants especially during the first year of life. The recent National Family Health Survey, 1992-93, had observed that breast feeding in India is near universal with 95 % of infants breast fed. However, the findings which need attention, are: (1) only 10 % of infants are initiated to breast feeding within the first hour and 26% began breast feeding within 24 hours of birth : (2) 64% of women squeeze the first milk from the breast before breast feeding; (3) 22 % of infants below the age of 4 months are also fed water along with breast milk; (4) less than 1/3 of infants receive solid / mushy foods along with breast milk at the age of 6-9 months .

The beliefs against early initiation of breast feeding, the introduction of water when it is not necessary and the delayed introduction of solid/mushy foods causing malnutrition among children are causes for concern. All the above issues need to be addressed in health communication messages to women and other care givers in the family and the neighbourhood.

***Dr. Lakshmi Lingam** is a Reader in Women's Studies Unit, Tata Institute of Social Sciences., Bombay.*

REPORTS :

PELVIC INFLAMMATORY DISEASE

Usha Ubale

Pelvic Inflammatory Disease (PID) is an infection and inflammation of the upper genital tract and pelvic organs which is caused by bacteria or virus. The infection usually enters through the vagina and cervix and becomes active in the uterus, fallopian tubes, the ovaries, the pelvic cavity lining or more than one place at a time.

PID is said to be a silent epidemic. A large number of women suffer from the disease but do not seek treatment. This is partly due to social factors such as shame and guilt associated with disease of the genital tract and also due to the tendency of women to be so totally involved in their family affairs, that they neglect their own health. Also very little information is available on this subject in developing countries. Hence it goes undetected and is undertreated.

PID is very easily cured if detected and treated early. Chronic PID causes a number of problems of infertility. Therefore timely intervention would go a long way towards amelioration of the suffering of these women. This is an area of health which needs consideration from the medical as well as social aspect particularly the latter as this disease has its origin in our social structure, cultural practices and behavioral patterns like spread of STD due to multiple sexual partners, early onset of sexual activity, premarital and extramarital sexual practices, infected partners. The risk of PID also increases after abortion due to improper use of contraceptive like intrauterine devices etc. PID also leads to primary or secondary sterility, ectopic pregnancy,chronic lower abdominal pain, thus treatening the reproductive potential of women. Frequently complaints related to PID like lower abdominal pain, vaginal discharge, backache and fatigue are not reported by women. Most of the women interviewed by our Auxillary Nurse Midwives (ANM) felt that " safed pani ! Ye to sab ko hota hai." Similar views were expressed about "Kamar me Dard" and "Ashakti" or "Kamjori" Hence these complaints are ignored, under reported and hence undertreated. This leads to an increase in maternal morbidity. Reduction in maternal morbidity being one of the objectives of India Population Project V(World Bank Project),Municipal Corporation of Greater Mumbai undertook this Participatory Research Study in collaboration with Liverpool School of Tropical Medicine.

30 ANMS were selected from different health posts which were in the catchment area of our Study Centres. Criteria for selection were interest, willingness and dedication. Training component was a major aspect of the study. The ANMs were originally doing a different type of work i.e. motivation for family planning and immunisation. Interviewing skills and communication skills were taught in a phased manner. Inputs about reproductive and sexual health, PID was given. Sexuality, and socio-economic & cultural factors affecting women's health were discussed at length. Research skills, observation skills, listening skills, documentation skills, and presentation skills were achieved by the ANM s at the end of training sessions. There were changes in attitudes, and outlook to Women's Health, Creative Problem Solving and Stress Management was achieved. The ANM s have reported that they have got close to women and feel empathetic with them. They have learned how to listen to women, draw them out and how to talk to them about sexual issues. In their personal lives they have learnt how to manage their own emotions and tensions. They have now realised the need to look at positives in people first.Their relationships at home, with patients, with collegues and superiors has been improved. Their decision making power and ability to speak out about issues has improved. An excellent outcome of this project has been the transformation of Health Workers into Social Workers. The concept of "Reaching out" is being internalised by the staff.

A link has thus been developed between community women and health care providers. Community women are being encouraged to talk about their sexual and reproductive health problems other than family planning and immunization. Our sample women have been expressing satisfaction for giving them an opportunity to talk about their problems. A thinking process in the existing health policies has begun within the BMC system. The realisation that given a chance, and freedom of expression from higher ups, the commitment of supervisory staff improves.

Thus the project serves the need for providing a platform for women to express their problems related to sexual and reproductive health within the existing structure and making the health services more women friendly, thereby decreasing the dependency of women and thus empowering them.

***Dr.Usha Ubale**, Incharge, PID Project, Bombay Municipal Corporation.*

WOMEN IN PROSTITUTION : THE CASE OF KAMATHIPURA

Alka Gadgil

There are about 12,500 women in prostitution in Kamathipura. The sex industry is mostly brothel based with the women procured from all over India and Nepal and sold to the brothel keepers. Each woman entertains about five clients a day, at approximately Rs. 50 per client. Thus the entire sex industry creates a daily turn over of Rs. 3.5million.

Long gruelling hours of work, appalling living conditions, lack of adequate nourishment, squalid surroundings, entertaining numerous clients, pave way for physical afflictions like anaemia, jaundice, tuberculosis and sexually transmitted diseases. STDs give way to pelvic inflammatory diseases and other gynaec complications.

Long standing history of sexually transmitted diseases and the threat of AIDS among this group motivated the Bombay Municipal Corporation to start a project in the red light area of Central Bombay i.e. Kamathipura and Khetwadi in April 1992, with the assistance from WHO.

From the onset, we were wary of singling out women in prostitution as the so called target group for AIDS awareness. During the baseline survey we found out that these women have been blamed, researched, studied and tested several times by doctors, researchers, health activists, journalists and film makers. The present situation in the red light area is that organizations, press, social workers, have been addressing them with information on AIDS and therefore they feel overrun by only talks on AIDS.

It was important that we equip them with information about HIV and AIDS and about protection through the correct use of

condoms. But we were aware that AIDS was not their sole problem. They had other grave health problems, about which they were more concerned and were trying to solve them as best as they could. Therefore we decided to chalk out a health programme with their help which would address their immediate health concerns along with AIDS and STDs. With the help of a voluntary organization called ' Prerana ' these workshops were carried out in which potential peer educators were identified and trained.

The objectives of the programme were :

1. To educate women in prostitution about their health problems (AIDS being one of them) and those of their children.

2. To develop communication skills which will help them to educate their peers about these health problems,resulting in a sustained network among these women about their own health issues.

In the workshops the women participated to a great extent in the sessions on diarrhoea, scabies, gynaec problems and T. B. In the discussion on birth control methods it was found that family planning missions have left this group untouched. Many women end up going in for abortions several times. It is difficult to get access to big public hospitals for abortions. Therefore many women prefer to go to private dispensaries which charge exorbitant fees.

The session on AIDS created a turmoil in the groups. Many women said that there was no point in telling them about the use of condoms because it is men who should use it. In their profession the clients have more power; they are helpless against the demands of the clients. They said that their 'gharwalis' were not very co-operative hence they have to comply to the demands of the client. The 'gharwalis' are only interested in money. One woman aggressively stated that in front of the press and the foreigners the gharwalis promise to allow only those clients who will use condoms but in reality they will not stop from beating them if they refused a client who would not use condoms.

In the course of working with the women in Kamathipura, we have learned some valuable lessons :

1. We have found that though peer based intervention approach may have proved successful in other settings, it cannot work in absolutely marginalized communities like prostitutes in Kamathipura.

2. It is necessary to recognize that these women have a right to information on health hazards. Such information should be given to them without the precondition or expectation that they will then disseminate the information to the rest of the community.

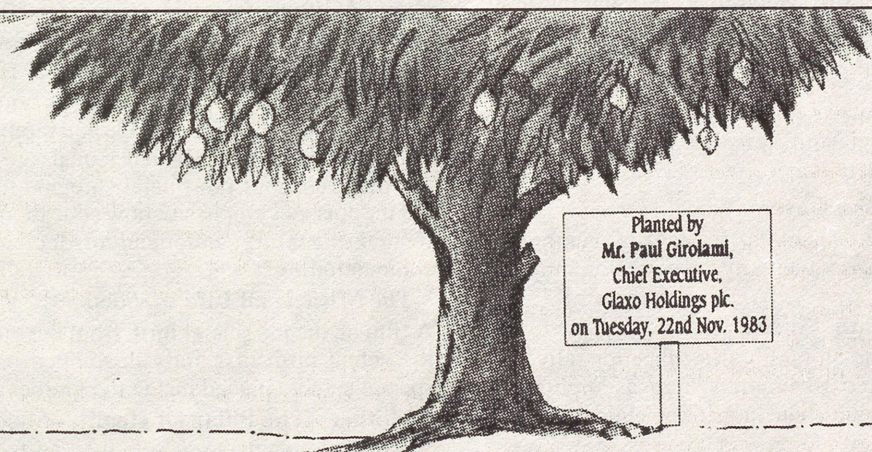
3. Women have time and again voiced the need of starting what you can call ' Well Women Clinic' in the area. It is difficult for them to get access to the big public hospitals and dispensaries.

4. It is necessary to have back up services as far as health education programmes are concerned. Without such an action component, education campaigns remain incomplete.

5. Finally research into female controlled methods of contraception as also protection from HIV transmission when using a diaphragm and microbicides should receive priority.

Alka Gadgil *is development communicator and freelance writer; was Deputy Project Manager, Communication for Bombay Municipal Corporation's AIDS Project.*

(First published in AIDS IN INDIA; Newsletter of NACO, March 1995.)



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RESOURCES

AVEHI Library has 90 programmes on Women & Health listed in the following sections :

WOMEN : Health

HEALTH : Diseases, Family Planning, Mother and Child Health, Policies / Programmes / Services.

EDUCATION : Adult Literacy, Sex Education.

In addition 72 programmes in areas related to Women's Health are listed under :

WOMEN : Inequality & Discrimination, Self Development & Emancipation & Organisations, Movements / Programmes.

The films ' Rihaee' by Aruna Raje Patil and ' Umbertha' by Jabbar Patel are included in the Feature Films Sections.

A brief synopsis of some of these programmes is given below:

*** Ab Der Kahe Ko & Ata Ushir Kashala ?** - Video

Shot in rural setting, the film shows the connection between early marriage, multiple pregnancies and the common cancer of cervix and uterus in women. Motivates women viewers to have a regular medical and cancer check-up after 35 years of age.

*** Adolescent Girl : Mysteries of Adolescence** - Educational Kit

The purpose is to clarify the doubts in the minds of growing children, parents and teachers; to allay the fears, confusion, doubts and anxieties of adolescents.

*** Anaemia and Women's Health** - Educational Kit

A multimedia kit to educate women about the serious consequences of anaemia, one of the commonest nutritional disorders in women. Includes a training manual, charts, flip chart, a game, songs and a playscript which give information on all aspects of anaemia - causes, symptoms, diet, prevention and cure.

*** Anaemia Due To Iron Deficiency : Your Role In Its Prevention** - Video

Anaemia is very common in women, particularly during child bearing age. The film explains this in detail and suggests a diet that can be easily followed.

*** Anaemia : Main Sab Jaan Gayee** - Video

An informative film about anaemia, its causes, symptoms, prevention and treatment. Discusses why anaemia is common in women.

*** Apni Tarakki Apne Haath** - Slides

An introductory programme on family life education. Gives an overview of issues related to women such as inequality, discrimination, literacy, health and nutrition, child care, self employment etc.

*** Bai** - Video

About the problems faced by a poor woman residing in a slum with a drunkard husband and three children. She earns her livelihood by doing odd jobs. A big chunk of her earning is taken away by her husband for drinking and gambling. When she learns she is pregnant again she decides to get operated and improve her lot. The film describes how she achieves this.

*** Bal Janma Suchitra Pustak** - Flashcards

Describes the whole process of childbirth .

*** Chakori** - Video

This is the story of a young deserted wife of seventeen; of how she breaks the 'chakori' - the cycle - of her hopeless life to become an independent person.

*** The Challenge** - Video

A documentary about a village in Rajasthan where women get trained in setting up hand pumps; they spread awareness among villagers about waterborne diseases. The incidence of these diseases is reduced by their effort.

*** Ghoda Gadhav Zala** }
*** Lagnacha Karu Naka Vighna** } - Video
*** Laxmi Nighooni Geli** }

These 3 films on family planning use Marathi musical form.

*** Healthy Mother - Healthy Child** - Play script

A puppet play on nutrition needs of a pregnant woman.

*** Jag Sakhi (12 Parts)** - Video

Through real life stories of women from different parts of India, this series of 12 films projects the difficulties faced by illiterate women and how literacy and education arm women with the self-confidence to improve their lives. Each film has an informative part on topics such as health, legal rights, appropriate technology, social issues, social forestry and programmes for women. The case study in the end deals with awareness, self development and social action.

*** Kahani Amchi Stree Dharmachee (Story of Womanhood : 5 parts)** - Slides

The purpose of this series is to engage both women and men in a dialogue on existing images of women, on man-woman relationship, on the need for creating alternatives-all this in the context of the issue of health and reproduction.

Kahani Nahan Ki (Puberty & Womanhood)
Kahani Janamki
Kahani Nau Mahino Ki
Phikar Kare Ma Banne Wali Ki
Gharva Basaye Man Chaha

*** Katha Hi Vijayachi** - Video

The story of Vijaya and her friend Paru. Presenting two opposite pictures of rural women regarding age of marriage, education, choice of life-partner, when to have the first baby, and economic independence.

*** Khilti Kaliyan, Episodes 8, 12, 13, 15, 16** - Video

On subjugation of girls from infancy till marriage and consequences of early marriage and motherhood ; on importance of training dais; on child and personal care during lactation period; on importance of pre - natal care and the role of the husband. All the episodes emphasise how education of women equips them to make mature, independent decisions and also to fight subjugation.

*** The Miracle Of Life** - Video

A film on the miracle of birth from the moment of conception to the actual birth of a fully developed baby. Filmed through a special camera placed inside the mother's womb.

*** Mother - The Pillar Of Health** - Slides

It is the woman, the mother in the family, who sees to it in every way that all other members stay in good health. What of herself ?

*** Nari Tu Narayani** - Video

In nine parts, the story of women who once suffered silently but who have now formed a co-operative and improved their lives.

*** Odhni : A Collective Exploration Of Ourselves, Our Bodies** - Video

In everyday lives, women generally find little time and space for themselves. Can women come together to share their pain, their desires, their dreams ? Women of different ages, backgrounds and life experiences come together to explore themselves and their bodies. Through this exploration and acceptance, the women discover a new strength within themselves. Experiencing their own power helps them in raising a critique of who they are and what they are supposed to be......

*** Pani** - Video

Describes emergence of local leadership. The village women give lead to their menfolk in securing adequate water supply for the entire village.

*** Physiology Of Women** - Video

About the physiology of pregnancy.

*** Pramila Grows Up** - Flashcards

Depict the physical changes occuring during adolescence in a girl.

*** Prateeksha (The Wait)** - Video

This docu-feature film, set in the deserts of Rajasthan, underlines the socio-economic factors responsible for the poor health status of our people and poignantly depicts the abysmal state of our health delivery services in the semi-urban and rural areas. Will be particularly useful for those working in the area of women and health

*** Put The Iron Back** - Video

A film on iron deficiency anaemia focussing on women and children

*** The Role Of Informed Choice in Family planning** - Slide Show

Informed choice means acknowledging people's right to make decisions that affect their lives,where individuals decide whether or when to have children and how to implement their decision. The show which has an international focus can be adapted to suit the local conditions for which guidelines are offered. It is designed to trigger discussion.

*** Something Like a War** - Video

Women take a critical look at the Govt. family planning programme in this film.

*** Time To Act** - Video

Film about cancer of the breast and uterus. Also teaches self-examination of breasts.

*** Why Did Mrs. X Die ?** - Video

Maternal deaths are usually explained away as due to some medical complication during pregnancy or childbrith. Through the case study of Mrs. X the film brings out the factors other than medical ones, which are avoidable and which are responsible for deaths like that of Mrs. X. Low. socio-economic status, poverty, malnutrition, anaemia, illiteracy, social injustice, lack of access to antenatal care and family planning methods are some of the causes of death.

OTHER RESOURCES

***VHAI Voluntary Health Association of India**

Has A.V programmes and printed material on Women & Health

Address : Tong Swasthiya Bhavan,
40, Institutional Area,
Behind Qutab Hotel
New Delhi 110 016

***Chetna**

Regularly develops need based A.V. programmes and also publications in three languages - Gujarati, Hindi and English on Women & Child Health. Publishes a quarterly Newsletter "CHETNA NEWS" to provide readers with information useful for strengthening service delivery,to share field level experiences of CHETNA, advocate and promote innovative programme interventions related to health education, training and nutrition awareness. Address: See ' Parichay ' section.

***Video Sewa** : Video films including ' SEWA Movement ' in 2 parts; "VIDEO SEWA Women's Alternative"; ' Jagruti ' , a tape on SEWA's health activities and films on health and other topics. Address: See 'Parichay' section.

***Video on Streehitakarini's activities** available at its office. Address: See 'Parichay' section.

PUBLICATIONS

***Akshara** : A Women's Resource Centre. It grew out of activism and the need for theoretical material into a library specialising in information on women.The Akshara Library offers lending and reference services with a collection of over 3,000 books, about 10,000 documents and 25 journals from India and abroad; in English and Marathi; with a focus on the women's movement, health, labour and development issues; can be used by students, activists, journalists, researchers. academicians and those interested in women's issues; open from Tuesdays through Saturdays between 11 am and 7 pm;

Other Activities: to support campaigns of the women's movement; research and documentation; training in information management and gender and development; publication of educational and other material; translations; space for discussion;

Address : 501 Neelambari, Road No. 86, Opp. Portuguese Church, Dadar West, Bombay 400 028,

Tel. 430 9676, Fax. 431 9143

***Beyond Illness** - Book

by Swatija Manorama, Chayanika Shah

This book is written as a pilot project towards developing an alternate feminist vision of biology. The present book is a manual for trainers of community health workers in urban areas. It tries to widen the scope and vision of health workers and to define health in a much more holistic way.

It also emphasises the self-help types of alternatives which are important along with creating an understanding of our own body. This book is an outcome of the experience of the authors while working with practising health workers. The limitations and also needs of the women health workers and their day to day problems have been tackled in the book.

For copies write to
Comet Media Foundation
Topiwala Lane Municipal School,
Lamington Road,
Mumbai 400 007.

***" Na Shariram Nadhi ! My Body is Mine "** - Book

by Sabala & Kranti

This book portrays the empowering process of a self-help training experience in women's health. It documents women's collective development of skills in analytical understanding, life-story taking, self-exam, healing and counselling. It deals with issues that adversely affect women's health such as class, caste and gender oppression in family and society, medicalisation of health, coercive and women targeting policies of the government and social stereotyping . 'The 'body' finds its rightful place in the personal and political framework. The book is also a friendly and practical guide for seeking alternatives.

Available through the authors at
A-201, Vasant View,
D' Monte Lane, Orlem
Malad (W)
Mumbai 400 064

***Streehitkarini Publications**

"Where there is No Doctor" in Marathi 'Aple Jevan', 'Aple Bal Va Sukhi Sansar", 'Loksankhyecha Bhasmasoor', Health And Sex Education in Adolescent Girls And Boys', 'Community Participation in Family planning'

Address : see 'Parichay' section

PARICHAY

We give below a select list of N G O S and groups working in the field of WOMEN'S HEALTH in Bombay, Pune and Gujarat.

ALERT INDIA - Population Education Centre

For last 3 years Alert - India has been working in Mulund to Vidyavihar and Eroli to Turbhe areas in Bombay on women's issues and population health problems. In Vikhroli Mulund area it runs a project ' Population Health Centre' which organises programmes along with community health workers on issues like 'malnutrition in women and children', 'status of women and their role in the society ', women's health etc and provides training for them. They also work in areas related to women's health such as literacy, environmental sanitation, women's economic problems etc.

Address : Anthony Samy,
Chief Executive, Alert - India, 6-B, 3rd floor,
Sion (W), Mumbai 400 022. Tel. 4072558, 4097191
MedhaHegshetye,
Programme Officer, Vasti Arogya Kendra,113, Shri Diamond Centre, L. B. S. Marg, Vikhroli (W), Mumbai 400 083.
Tel. 5774742, 5790285

C E H A T

Centre For Enquiry Into Health And Allied Themes.

Established to conduct research in health and allied themes CEHAT believes in conducting research which is relevant to the grassroots activists and has an impact on policy so that progressive change can take place. The areas of interest are understanding health policy, health financing , delivery of health care through private and public health systems, violence, occupational health, ethics and human rights. It aims at working closely with the poor, under privileged and marginalized sections of our society. Since women are at the lowest rung of our present system, CEHAT has naturally focused its work on conditions affecting them.

Two recent studies currently taken up by C E H A T are

*Women and Abortion *Household Expenditure On Women's Health In Maharashtra.

Address : C E H A T,
310 Prabhu Darshan, 5, Sainik Nagar,
Amboli, Andheri (W), Mumbai 400 058. Tel. 625 0363

CHETNA Centre For Health Education,

Training and Nutrition Awareness

CHETNA's mission is to contribute towards the empowerment of disadvantaged women and children to enable them to gain control over their own, their families and communities health .

It implements a variety of community based activities in the field of health and nutrition education for women and children in rural, tribal and urban slum areas of Gujarat and Rajasthan.

It addresses the needs of children and women throughout the different stages of their lives through the activities of its two resource centres, Child Resource Centre, 'CHEITAN' and Women's Health and Development Resource Centre 'CHITANYAA' .

Activities of the resource centres focus on awareness raising and sesitising , capacity building of organisations through conducting programmes on training of trainers, documenting experiences, developing / disseminating need based education and training materials, networking and advocating on issues related to children and women.

CHETNA's Documentation and Information Centre address the needs of individuals, G O S, N G O S and academicians working on women's health and development concerns. CHETNA's publications and audio visual material is widely field tested and is available in Gujarati, Hindi and English at cost price.

Address : CHETNA
Lilavatiben Lalbhai's Bungalow, Civil Camp Road,
Shahibaug,Ahmedabad 380 004, Gujarat. Tel. 868856 / 866 695
Fax. 91 - 079 - 866513 & 91 - 079 - 420242

FORUM FOR WOMEN's HEALTH, BOMBAY

We started off with the campaign against sex-determination and preselection tests in 1986. The state legislation against pre-diagnostic tests came into force in 1989. So also now the central government's legislation. We have worked for it and so we had got limited success on paper. By then we had felt the need to widen our scope of activities in general to medical technologies and in particular to contraceptive technologies.

We changed our name in 1993 to 'Forum for Women's Health' (FFWH) and since then have been actively working for dissemination and generation of information as a strategy of the campaign against population policies and contraceptive technologies.

We have been part of International Campaign against Anti-fertility Vaccines. We are conducting a campaign since March 8, 1996 requesting concerned people to be signatories to a letter to the WHO Research Team to stop the research on anti fertility vaccines.

For details and participation you can drop in on Mondays at our weekly meetings.

Our Address
C/o. Chayanika Shah, 2, Vishwadeep,
95, Bhau Daji Road, Mumbai 400 019. Tel. 4010482.

MASUM Mahila Sarvangin Utkarsh Mandal

Masum was formed in 1987 as a development group aimed at helping women help themselves. It had its origin in health care through people's involvement and it is a prime example of an organised response by women to felt needs.

Its activities include training for self employment through

handloom, weaving and tailoring; health activities(Health Centre and Lokseva Aushadhalaya) savings and credit programme, preschools and creches; simple technology inputs, such as smokeless chulhas, school health programmes, environment consciousness raising competitions and other activities among the schools.

Most of its beneficiaries are women from the poorest households of the region. Masum works in twenty villages. (roughly 30,000 population) of the eastern part of Purandar taluka in Pune district of Maharashtra. Most of its activists are from among artisan women belonging to oppressed castes.

Address : Ms. Manisha Gupte,
Masum, Feminist Health Centre, 11, Archana,
163 Sholapur Road, Hadapsar, Pune 411 028 Maharashtra.
Tel - 0212 - 675058

SEWA - Self Employed Women's Association

Sewa is an organisation and a movement of self employed women. For past 24 years it has been working in the unorganised and self employed sector which constitutes more than 93% of India's work force and which provides employment to almost 60% of women. It works in Gujarat, Madhya Pradesh, Uttar Pradesh and Bihar, and has a membership of about one lakh poor self employed women who work in more than 20 trades, like bidi rolling, ready made garments, agarbatti, vendors, contract labourers, weavers, handicraft workers, agricultural labourers, milk producers, forest workers etc.

Its two main goals are full employment and self reliance for all self employed women whereby women will have regular work and income to provide for their own basic needs like food, health care, child care and shelter. It believes that by women becoming self reliant in economic sense as well as in terms of decision making and control they can shape and influence society. SEWA works for empowerment of women towards social change.

Its activities are :

* Union activities.
* Sewa Co-operatives (Milk Co-operatives, Artisan and Service Co-operatives.)
* Supportive Services.
* Advocacy.

SEWA's Supportive Services include SEWA BANK (Esablished 1974), Social Security Insurance, Child Care (creches anganwadis), Lokswasthya's Health Care Programme, Legal Aid, Housing Services, Literacy & Training, Capacity Building.SEWA Academy provides training to self employed women for capacity building, leadership, communication, documentation, research.It trains its organisers in journalism and audio visual media. Films are produced for VIDEO SEWA by self employed women and daughters of SEWA members who have been trained in production (See 'Resources' section).

Lokswasthya is a co-operative of women health workers, dais, doctors, pharmacists which provides primary health care to SEWA members. It also arranges referral services in hospitals. Its main work is to conduct intensive training for SEWA members who then provide health care and health education in their neighbourhoods and communities in their villages. Some of the trained women themselves become trainers who train other SEWA members in the basics of primary health care and health education. The Co-operative also sells rational generic drugs to patients.

Address: SEWA, (Self Employed Women's Association),
SEWA Reception Centre, Opp.Victoria Garden, Bhadra, Ahmedabad 380001., Gujarat. Tel: 079 - 320477, 079 - 79837
Fax: 079 -320446

STEEHITAKARINI

A voluntary women's organisation established in June 1964, with the aim of bringing about an integrated development of women by assisting them to lead a healthy, free and full life. It believes that a woman is able to lead a healthy, full life only if she knows how to maintain her health, is able take her own decisions about family planning and to put them into practice and if she is able to reduce her economic dependence on others.

In 31 years it has implemented 33 important need based projects in the slum areas of Dadar and Elphinstone Road in Bombay where it has been working in a community with 1,25,000 population. Its varied activities include : Non formal education classes, Urban Family welfare Centre, Family Planning Programme which is accompanied by treatment of infertility cases, Pathological laboratory, Child development and child care programme, Well Baby Clinics, Nutrition centres and kindergarten classes and Training classes for Health Workers in the area who train other women in the community.

All the field work of Streehitakarini is done by women from the community who have been trained and motivated.

Address : Lokmanya Nagar Compound,
K. Gadgil Marg, Dadar, Mumbai 400 025 Tel. 422 0565

THE WOMEN AND HEALTH CELL, MEDICO FRIEND CIRCLE

The Women And Health Cell emerged out of the those ingrained by Medico Friend Circle , of dialoguing, debating and critiquing health issues in an open and informal manner. The MFC has been for the past 22 years, a voluntary group of medical and non medical activists and professionals from all over the country. It has been a radical critic of existing health systems which has inevitably meant a critique of the socio-economic and political situation of the country as well.

Address : Ms. Rupashree Sinha
Women & Health Cell,
Medico Friend Circle, 2/201, Bhagyawan Society,
Shastri Nagar, Kalwa, Thane 400 605 Maharashtra
Tel. 625 0363

UPDATE

"What's the buzz? - Tell me what's - a - happening."

Well, actually, quite a bit has been happening here at AVEHI since the last Newsletter - which is as it should be, don't you think ?

CAPART has set up a Communications Resource Network with the objective of assisting grassroot level organizations engaged in developmental work with information and communication materials for better & wider dissemination of knowledge and AVEHI is one of the members. With the grant sanctioned by CAPART, we have been able to purchase the much needed extra V.C.Ps and tape recorders for our expanding field work; a computer; relevant Audio-Visual programmes;and also dub commentaries and conduct training.

We have reinforced our Resource Centre with 21 video cassettes, 2 slide shows, 2 sets Flash cards,1 poster exhibition and have translated some programmes in the vernacular, and dubbed a few programmes.

We have also been able to expand the scope of our Training Programmes.

THANK you CAPART !.

THE FIELD SCREENINGS have been steadily increasing, and in fact with more members making regular use of our programmes, we will have to seriously think of expanding our staff !

THE TRAINING PROGRAMMES : AVEHI has conducted the following Training Programmes.

Five for Primary Level Teachers, two for Adolescents,one for NFE Teachers,two for Health Workers and one for Para Professionals.

We hope to be able to start regular Training Programmes for para professionals & professionals on proper selection and management of Audio-Visuals and Media Appreciation. Enquiries are welcome from both prospective participants and Resource Persons.

NETWORKING : AVEHI has been taking active part in various workshops and networking with other NGOs.

THE ABACUS PROJECT : has completed its five glorious years of producing the prototype and celebrated the same with a grand convocation function.Sincere congratulations to all the staff, volunteers, teachers and students who have made ABACUS what it is, and best wishes for its future growth and success.

THE AVEHI RECORDING STUDIO has started functioning and we have already had bookings, besides doing our own dubbing work. So why don't you come across ? Let us show you what we have to offer.

THE PROJECTS :

* The Rural Project : AVEHI's dream of extending its services and knowhow to rural areas has finally crystallised. AVEHI, in collaboration with S.N.D.T. University will be helping to set up an audio-visual Resource Centre in Udwada, South Gujarat and train local community workers.

* The Advocacy Video Production : With seed funding from W.H.O., AVEHI will be producing an Advocacy Video for supportive environments in Bombay. The areas covered may include Health, Environment, Literacy etc. and will also project how N.G.O.s like, AVEHI can help in improving these areas.

* Compilation of a catalogue of I.E.C. material on HIV / AIDS related issues available all over India :- UNICEF has requested AVEHI to compile this catalogue by August end which will be a most useful, handy reference book for all individuals / groups / organizations who are working in the field of AIDS Control. Any contributions are welcome, but must reach AVEHI immediately.

I have had my say - so till next time, here's cheers.

Dr.Uma Pocha,
Director, AVEHI

READERS RESPOND....

"The Newsletter has indeed transformed itself and is progressive enough to keep the messages straight. The content is also of a diverse nature and is useful to the members and readers. Please accept our congratulations for such a change ..... keep it up".

V. J. Raghuvanshi
Managing Trustee
YUVA
Ahmedabad.

AVEHI RECORDING STUDIO IS A NEW PROJECT WITH A DUAL PURPOSE : TO FACILITATE THE MEDIA WORK OF AVEHI AND OTHER VOLUNTARY GROUPS AND TO GENERATE INCOME FOR THE ONGOING ACTIVITIES OF THE ORGANIZATION.

FACILITIES :

MUSIC RECORDING AND AUDIO POST-PRODUCTION FOR ADFILMS, T. V. SERIALS, ALBUMS, DOCUMENTARIES, FILM, RADIO, ETC.

THE STUDIO HAS :

- A FLOOR AREA OF 26 FT. X 13 FT., (338 SQ.FT.)
- A COMPACT DIGITAL RECORDING AND POST - PRODUCTION FACILITY.
- A SPECTRAL AUDIO PRISMATICA WORKSTATION.
- FOSTEX RD-8, 8 TRACK DIGITAL RECORDER.
- OTARI DTR-7 DAT MASTERING / BACK-UP AND 1/4", 2 TRACK MASTERING RECORDER.
- ALLEN & HEATH MIXING CONSOLE.
- TC - M 5000 DIGITAL REV/FX PROCESSOR.
- DYNAUDIO SPEAKERS & AMP. ETC.

YOU ARE WELCOME TO BRING YOUR OWN ADD - ON EQUIPMENT LIKE GATES, REVERBS, UMATIC V. C. R s ETC.

AVEHI's service charges for Flims & Slide shows for a 2 hours slot (No service charge for organizational members for first 2 hours)				
SERVICE	MEMBERS		NON - MEMBERS	
	INDIVIDUAL	PROMOTER ASSOCIATE & ASSOCIATE	NON-COMMERCIAL	COMMERCIAL
Slide shows :-				
a. With Media Facilitator service & equipment	Rs. 10	Rs. 150	Rs. 30	Rs. 200
b. With Media Facilitator service only.	Rs. 10	Rs. 100	Rs. 30	Rs. 150
16 M.M. Flims & Video Cassettes acquired by AVEHI .				
a. With Media Facilitator service & equipment	Rs. 35	Rs. 150	Rs. 50	Rs. 200
b. With Media Facilitator service only.	Rs. 10	Rs. 100	Rs. 25	Rs. 150
16 M.M. Flims & Video Cassettes borrowed by AVEHI . (for AVEHI's service only)	Rs. 25	Rs. 150	Rs. 50	Rs. 200

Charges for screening beyond the Bombay Metropolitan Region		
	Non-Commercial	Commercial Category
Slide Show	Rs. 90	Rs. 600
16 mm flims without equipment	Rs. 75	Rs. 450
16 mm flims with equipment	Rs. 150	Rs. 600
Video flims	Rs. 75	Rs. 450

Video Cassette available at AVEHI

Dadaji Ki Kahani
20 minutes Hindi/English
Dadaji tells the story of Tobacco - its history, cultivation & effects on health etc. children are encouraged to reach their own conclusions about the harmful effects of tobacco.

AVEHI's Service charges for other AV material	
Audio Cassettes	Rs. 2 per day per cassette
Flash Cards, Flip Charts, Flannelographs & Educational kits	Rs. 5 per set per week
Posters	0.50 paise per poster per day (minimum of Rs. 5 per day to a maximum of Rs.20 per exhibition)
Puppets	Rs. 1 per day per puppet
Play Scripts	Rs. 5 per set per week
Overhead Projector	Rs. 250 per day
Collapsible adjustable Exhibition stands	Rs. 5 per stand per day

Rental of Hall at AVEHI for 1/2 Shift (4 hours)				
	Without equipment	With TV & VCR	With Slide projector	With16 mm projector
Educational Institutions and organisations which have funds alloted for educational activities	Rs. 150	Rs. 225	Rs. 250	Rs. 250
Voluntary Organisations	Rs. 100	Rs. 150	Rs. 150	Rs.175
Organisations like Lions Rotary, Giants Club and other professional bodies	Rs.300	Rs. 450	Rs. 500	Rs. 500
Corporate Bodies and Industrial Concerns	Rs. 500	Rs. 700	Rs. 750	Rs. 750
Discussions, Preview and pretesting by individuals	Rs. 150	Rs. 300	Rs. 300	Rs. 350

- On holidays and outside Office hours there will be an extra charge of Rs. 25 / - for 1 / 2 shift (4 hours) for the hall and Rs. 50 / - for 1 / 2 shift (4 hours) for the media facilitator.
- Our hall is not available for religious / social / political / communal functions or meetings.

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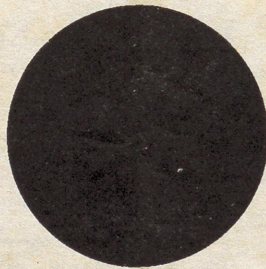
With Best Compliments From:



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