ADDRESSING WOMEN'S REPRODUCTIVE HEALTH NEEDS: PRIORITIES FOR THE FAMILY WELFARE PROGRAMME

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India's national family welfare programme has two stated objectives: to address the needs of families, notably women and children, and to reduce population growth rates. In reality, the Programme has not lived up to its title of "family welfare". The thrust of the programme, as is well known, has been disproportionately focussed on achieving demographic targets by increasing contraceptive prevalence and notably female sterilization. In this process, women's needs have been generally overlooked by the programme and the consequences of this neglect, in terms of poor reproductive health, are disturbing. There is an urgent need to reorient programme priorities to focus more holistically on reproductive health needs and on woman-based services, that is, services that respond to women's health needs in ways which are sensitive to the socio-cultural constraints women and adolescent girls face in acquiring services and expressing health needs.

What are the gaps in women's reproductive health and what are the priorities for reshaping the family welfare programme in a way that better responds to women's needs? The objective of this report is to present a profile of substantive needs in the area of women's reproductive health. This report is organised as follows: It starts, in Section I, with a brief overview of the demographic situation and the thrust of the programme in India in general. Section II points out gender disparities and the constraints women face in acquiring quality health services. Section III then focuses on the reproductive health situation and highlights the gaps between needs and available services. Section IV sets out priorities for policy. It raises the need for greater attention, in general, to reproductive health and services that are more focussed on women, both adult and adolescent, in India, and discusses specific areas of activities appropriate for further support.

Before going further into a description of the situation in India, and given the focus on reproductive health, it is appropriate, here, to define what is meant by reproductive health. A

reproductive health orientation means that people have the ability to reproduce as well as to regulate their fertility; that women are able to undergo pregnancy and childbirth safely; that obstetric and gynaecological disorders are addressed; that the outcome of pregnancy is successful in terms of maternal and child health and well-being; and that couples are able to enjoy sexual relations free from the fear of disease. Reproductive health is affected by a variety of socio-cultural and biological factors on the one hand and the quality of the delivery system and its responsiveness to women's needs on the other. A woman-based approach to reproductive health is one which responds to the needs of adult women and adolescent girls in a culturally sensitive manner.

I. Current Demographic Conditions

Over forty years after the inception of the family planning programme, population growth rate continues at over 2 percent per year, although provisional data for 1991 suggest a growth rate of slightly less than 2 percent. Even if this trend continues, as a result of population momentum, the number of couples in the reproductive ages is expected to increase from 141 million in 1991 to 170 by 2000, as a result of an age structure with a disproportionate number of young people. Currently, about 18 million people are added to India's population annually. And about 40 percent of the population comprises children under 14.

Life expectancy has now reached 61 years (projects, 1991-96), up from about 44 in 1960; and the crude death rate has fallen dramatically from 27 per 1000 population at the time of independence in 1947 to 9.8 per 1000 (1991) (Appendix Table A-1). While infant mortality has also shown dramatic declines over this period, from 225-250 to 80 per 1000 live births in the same period, mortality during infancy continues to be unacceptably high. Finally, the maternal mortality ratio continues to be among the highest in the world at 550 per 100,000 live births. Regional and gender disparities in mortality are striking. While nationally, life expectancy is slightly lower and infant mortality rates are slightly higher among males than among females, statewise figures tell a different story. As far as life expectancy is concerned, for example, life expectancy in 1991-96 is 61.7 years for females compared to 60.6 years for males. In Kerala, which reports the longest life expectancy, this differential is wider: 67.2 years for males and 72.4 for females. In contrast, in Uttar Pradesh, which reports among the lowest life expectancies in the nation, there is a reversal of the gender pattern: while males can expect to live a total of 57.1 years, female life expectancy is only 52.8.

Gender disparities are especially notable in those states in the case of infant and childhood mortality where, as a result of discrimination against girls in terms of feeding and health care, and, although infrequently, as a result of infanticide of females, their mortality rates tend to be higher than those of boys in certain states, notably those in the north: in Himachal Pradesh, for example, in 1989 the female infant mortality rate was as high as 92, compared to 59 for males. Sex disparities in mortality are considerably more apparent in the childhood ages when relatively unavoidable endogenous causes of death are no longer major killers. At the national level, in

1986, for example, mortality at ages 0-4 ranged from 34.7 among boys to 38.6 among girls, underscoring the poor status of females from birth onwards.

As a result, unlike in most other countries, the sex ratio of the population in India has always been adverse to women. At the time of independence, there were roughly 946 women per 1000 men; this ratio declined in 1961 and 1971, rose slightly in 1981 and fell again to 1971 levels by 1991 to 927. Underlying this adverse sex ratio is the poor situation of women, their relative neglect from infancy on in terms of health care and nutrition and consequently their higher mortality, relative to males.

Over the 1970s and 1980s there has been an increasing misuse of amniocentesis and other pre-natal diagnostic techniques to detect the sex of the foetus and abort it if it is female. Despite startling newspaper coverage which suggests, for example, that of 3000 abortions conducted following amniocentesis, over 2900 were of female foetuses, the exact number of abortions of female foetuses is difficult to estimate. Clinics advertise blatantly "It is better to pay Rs.500 now than Rs.50,000 later" (in dowry) and clinics offering these services do much of urban India and are even penetrating per-urban areas, particularly in such states as Punjab. And although laws have been instituted which forbid the revelation of the sex of the foetus, this law continues to be widely ignored and the Government has had little success in halting sex determination testing. The implications of this selective foeticide are obvious--high female foetal mortality rates, and consequently sex ratios at birth and of the population which are highly unfavourable to women.

As far as fertility is concerned, the crude birth rate has only recently fallen below 30 (28.5 in 1993) and according to latest SRS estimates available for 1992 the total fertility rate is about 3.6 (Appendix Table A-2). According to Family Health Survey the total fertility rate in 1990-92 was around 3.4. While fertility has been declining, persistent large family size preference and a strong preference for sons also keeps fertility high; even so, since the inception of the programme, some 90 million births have reportedly been averted and by 1990, 43.3 percent of all eligible couples were practising some form of contraception in 1993-94. And since the 1980s, over the last ten years, fertility decline has been more marked than in the past and contraceptive prevalence has been increasing at over two percent per year. Once more, however, regional disparities in fertility and contraceptive prevalence are striking: for example, the four large northern states reported a total fertility rate of 5.0 in contrast to a combined total fertility rate of about 3.2 in the rest of India and 2.0 in Kerala. The crude birth rate is 34.3 in the four large northern states and 26.4 in the rest of India; age at marriage extends from 17 in the four large northern states to 19 in the rest of the country.

II. Gender Disparities Underlying Unequal Access to Health Care

Women's unequal access to resources, including health care, are well known in India, in which stark gender disparities are a reality. While disparities in life expectancy may be narrowing, unequal sex ratios and higher female infant and child mortality rates in large parts of

the country continue to reflect the general devaluation of women. In other areas also, women remain at a considerable disadvantage in many areas in the quality of that life both within the home and outside it. For one, female literacy and school enrollment rates lag far beyond that of males in most states: enrollment ratios for females are lower and gender disparities in school enrolment are wider in India than in almost every other region of the developing world. Gross enrollment ratios suggest that even in the 1990s, only 88 percent of all girls aged 6 to 10 (compared to over 100% of all boys) are enrolled in school; by the upper primary stages, fewer than half of all girls (47%) compared to three quarters of all boys are enrolled. Of even greater concern is the fact that only about one in three girls aged 6-14 actually attended school, compared to about three in five similar aged boys.

Women's lack of control over economic resources is widespread. While the majority of rural Indian women are economically active, their work goes largely unrecognised and poorly remunerated. No more than one in five women are reported to be working, nor more than one in seven working women is in the organised sector. Where women work, they are about six times as likely as men to be marginal workers, they work fewer days per year, earn lower wages including a lower cash to kind ratio than that awarded to men. While there are several government sponsored poverty alleviation schemes (Integrated Rural Development Programme), women are highly under represented among the beneficiaries. For example, in 1987-88, against a target of 30 percent female beneficiaries anticipated by the IRDP, Rajasthan achieved as little as 15%. Women are considered unskilled, ignorant and poor debtors and hence unqualified, in practice, for credit facilities or for the upgrading of skills.

The above inequalities severely constrain the ability of women and adolescent girls to acquire good health and woman-centred health services. At the household level, these disparities translate into a lack of autonomy and control over household resources - both material and knowledge. Women have little decision making authority and freedom of movement; few women, including working women, have any control over the households' economic resources. Seclusion practices and other behavioural norms further reinforce women's lack of freedom of movement, self-confidence and their acceptance of self-denial, including in matters relating to health seeking and food intake. Violence against women, rape and incest are all part of women's lives and yet remain invisible in that there are few services that address these issues.

In short, women's poor reproductive health in India is affected by a variety of socio-cultural and biological factors. Underlying poor reproductive health among Indian women is their poor overall status on the one hand and an inadequate delivery system to cater to the needs of secluded, shy and de-valued women on the other. Thus, efforts to improve women's education, raise enrollment and attendance rates of girls in school and reduce the drop-out rate on the one hand and enhance women's income autonomy on the other are fundamental, in the long run, for improvements in women's and family health; no less important are improvements in the quality and breadth of services catering to reproductive health needs.

Gaps in the Programme: Women's Reproductive Heal

India's Family Welfare Programme, as is well known, has been disproportionately focussed on achieving demographic targets by increasing contraceptive prevalence and notably female sterilization. Women based services, or those responding to women's health needs in ways which are sensitive to the socio-cultural constraints women and adolescent girls face in acquiring services and expressing health needs, have been largely lacking. Since 1952, the Indian family planning programme has evolved through a number of stages, has changed its focus and has vacillated in terms of intensity and manner of commitment to it. In the early years, the programme witnessed a period of caution and its impact was hardly felt; in the decade 1965-75, the programme was strengthened and consolidated and the integration of family planning with maternal and child health services was introduced. It was also during this decade that abortion was legalised and the ratio of health workers to population was increased. At the same time, the Minimum Needs Programme was formulated which combined health and nutrition with fertility reduction and the incentive system was tepid up.

Following the declaration of national Emergency in 1975, family planning and politics became closely linked and, as is well known, the programme became aggressive and highly coercive. Subsequent governments have cautiously stressed the voluntary nature of the programme; however, despite its commitment to a cafeteria of methods and integration with maternal and child health, it continues, in practice, to be heavily biased in favour of sterilisation, financial incentives (frequently supplemented by additional incentives in cash and kind) and target achievement. More recently, there has been a recognition that the singular focus on sterilisation neglects the contraceptive needs of young couples, on the one hand, and the health needs of women and children on the other. The health system operates through a network of 20847 primary health centres and over 130,000 sub-centres; domiciliary services are expected to be provided by the large number of health workers (ANMs) attached to the various centres; despite this, outreach continues to be poor.

Health and family planning services in India have not been sensitive to the situation of women or to the constraints they face in seeking services or even expressing health care needs. Two major shortcomings of the programme are that it is designed centrally and that it is based on demographic targets. Women at the grassroots are the programme's main clients, but the programme all but ignores them in its priorities, in its service delivery and communication strategies. What is urgently required is a greater client focus, and more specifically a health and family planning programme that is based on what women want and need and appropriate and culturally sensitive ways of addressing these needs. By this we mean that such needs of Indian women as domiciliary services, sensitive probing of obstetric and gynaecological problems, interaction with service providers which is not threatening and above all, a more holistic approach to their health rather than the current stress on family planning.

The following sub-sections highlight major concerns in the area of reproductive health and justify a focus on woman-centred services to address these concerns. To reiterate, a reproductive health orientation means that people have the ability to reproduce as well as to regulate their fertility; that women are able to undergo pregnancy and childbirth safely; that

obstetric and gynaecological disorders are addressed; that the outcome of pregnancy is successful in terms of maternal and child health and well-being; and that couples are able to enjoy sexual relations free from the fear of disease. Woman-centred services require that strategies to deliver these services are responsive to cultural constraints inhibiting women's health seeking and which provide these services in an acceptable and unthreatening manner.

India's maternal mortality ratio is estimated at 555 per 100,000 live births (Mari Bhat *et al*., 1992) - about fifty times higher than that of many industrialised nations and six times as high as that of neighbouring Sri Lanka (UNICEF, 1991; Acsadi and Johnson-Acsadi, 1990). Within a global perspective, it is estimated that India accounted for 19 percent of all live births world wide, and for as much as 27 percent of all maternal deaths. Comparative data on maternal mortality are limited but what is available underscores wide regional disparities. For example, the maternal mortality ratio (maternal deaths as a proportion of births) is almost twice as high in the four large northern states (823 per 100,000 births) as in the rest of India (457). Maternal deaths account for about one percent of all deaths and two percent of all female deaths annually - but this translates into over ten percent of all deaths to women of reproductive age and 13.2 percent among rural women in 1987 (UNICEF, 1991). A large proportion of these deaths - up to two-thirds by some accounts - are preventable (Agarwal *et al.*, 1982; Bhaskar Rao, 1980; Pant and Mehendale, 1987; Roy Chowdhury *et al*., 1982; Mitra and Khara, 1983; Sinha, 1986; Bhatia, 1988). Leading causes of death include haemorrhage (which accounts for 16-22% of all deaths), toxaemia (10% - 12%), sepsis (8 - 13%) and complications of abortion (10%). A major related cause of death is anaemia, which accounts for 17 - 25% of all maternal deaths (Registrar General, 1987; Bhatia, 1988).

1. (a) A focus on reproductive morbidity and maternal health

Much more pervasive is reproductive morbidity and lack of care during pregnancy and childbirth, including both the obstetric conditions listed above and gynaecological conditions, such as reproductive tract infections, cervical cell changes and genital prolapse. Data on reproductive health and constraints to good reproductive health are notoriously limited. Generally, data on mortality and morbidity come from hospital studies, but little is known about their levels and patterns in community settings. Estimates based on hospital studies tend to over estimate maternal mortality; since hospitals are often seen as a last resort for women with difficult pregnancies or deliveries. On the other hand, estimates based on hospital studies will underestimate morbidity, because they miss the high proportion of women who envisage poor health and especially poor reproductive health as their lot in life. It is difficult, hence, to assess the magnitude of and the factors underlying women's reproductive morbidity.

There are a few community-based studies which have tried to fill this gap in our knowledge of reproductive tract infections and other aspects of reproductive health. For example, the Bang *et al*.(1989) investigation of rural, tribal women in Maharashtra, reports a high incidence of reproductive tract infections. Physical examinations found that some 92 percent had one or more gynaecological diseases: infections of the genital tract, including pelvic

inflammatory disease, vaginitis and cervicitis, contributed half of this morbidity. Despite this high prevalence, only 8 percent had undergone gynaecological examination and treatment in the past. High levels of reproductive tract infections have also been observed in other studies in rural and urban Gujarat (SEWA-Rural, 1994; Baroda Citizen's Council, 1994); rural and urban West Bengal (CINI, 1994); Bombay slums (Streehitkarini, 1994), rural and urban Madhya Pradesh (CORT, 1994); Rajasthan (CORT 1994). According to these studies, the infection rate varies between 42 to 67 percent.

Unsafe motherhood is still a reality in much of India and particularly in its rural areas (Jejeebhoy and Ramarao, 1993). Few women have access to antenatal care, high risk cases go undetected, anaemia is acute during pregnancy, deliveries are conducted largely by untrained attendants in unhygienic conditions and knowledge of health and nutrition needs during pregnancy and the post-natal period are poorly understood. Disparities in women's access to care at delivery are evident from the fact that nationally, only two in five births are delivered by trained attendants; and this proportion ranges from 25 percent in the four large northern states to over half (54%) in the rest of the country (Appendix Table A-3). The official programme for maternal and child health reaches a few pregnant and lactating women. Maternal health activities are unbalanced, focussing on immunisation and provision of iron and folic acid, rather than on sustained care of women or on the detection and referral of high risk cases.

Urgently needed is greater insight into underlying risk factors, into why women's reproductive health needs remain unmet. Equally important is the need to structure the reproductive health services to respond to the gynaecological and obstetric conditions women experience, and which take into consideration the social, cultural and economic constraints that women face in expressing these conditions and in accessing services for them. What are the leading reproductive morbidities observed in community settings? What are the leading conditions observed for different age groups - those in the reproductive ages, adolescents, women beyond the reproductive ages? What are the socio-cultural constraints women face in acquiring good reproductive health and safe pregnancy and delivery? What kinds of interventions can be designed to respond to these needs?

Health facilities at the community level are poorly equipped to deal with gynaecological and obstetric morbidities, since they have neither the diagnostic facilities nor the drugs to treat them. Moreover, service providers are not trained to detect such morbidities; nor to provide sensitive counselling. The prevention and treatment of common RTIs is not complicated and can be treated at the first level of care. What is needed at the primary health centre level are facilities for routine diagnosis of gynaecological conditions, improved obstetric care, sensitive counselling and sound referral services.

(b) Understanding the socio-cultural context of abortion

Improving access to safe abortion should also form part of an overall reproductive health strategy. Despite the fact that abortion is beyond the reach of most poor women, roughly five

million abortions continue to be performed annually; of these, only about half a million abortions are performed under the health services network while another estimated 4.5 million occur illegally (UNICEF, 1991). And the growing tendency to misuse sophisticated prenatal diagnostic techniques to abort female foetuses suggests the disturbing possibility of increased abortions and repeat abortions. As a result, complications resulting from unsafe abortion exact a heavy toll, and constitute a major source of reproductive mortality and morbidity: over 10 percent of all maternal deaths are due to abortions. Safe abortion services are available only in urban areas since registered practitioners are rarely available in rural areas: in 1984, for example, only about 1000 physicians of a total of roughly 15000 doctors trained to perform abortions worked in rural areas. Nor is information and counselling about legal termination services available to rural women; there is limited publicity about the law and there is a widely held perception that abortion is illegal. Also, abortion can involve a cost to the patient, and this cost can be prohibitive for the average rural woman. And finally, the quality of abortion services and care at approved centres can be impersonal and intimidating. Frequently, for example, women who seek abortion are denied confidentiality or are coerced to accept an IUD or sterilisation as a precondition for the abortion.

Despite this, little attention has been paid to research, advocacy and programme issues concerning abortion in India. Little is known about abortion practices and behaviour. There is, for example, a paucity of rigorous social science research outlining poor women's perceptions, needs and decision-making processes with regard to abortion, as well as their actual abortion behaviour and experiences. Also absent has been strong advocacy from women's groups, in large part because of their concerns for its misuse in relation to sex selection. Also, little attention has been paid to operational research on lacunae in current abortion services. Most disturbing, the programme has failed to integrate safe abortion into its family welfare services.

In short, much more attention needs to be paid to the context in which abortion occurs, and to the provision of safe and affordable abortion services as a part of primary health care. As far as understanding the context of abortion is concerned, we need to know why women resort to abortion, and especially illegal abortion in large numbers; we need to have a sociocultural profile of abortion seekers, the constraints they face in obtaining legal abortions on the one hand and contraception on the other and a woman's perspective of the quality of abortion services available. As far as services are concerned, above all, we need a reproductive health approach which incorporates the need for ready access to reliable information, sympathetic counselling and safe abortion services.

(c) Infertility

Little evidence is available on the levels and patterns of infertility in India. Evidence from the 1981 census (Ministry of Health and Family Welfare, 1990) and a village level study in Maharashtra (Bang *et al*., 1989) suggest that infertility may be more prevalent in India (6% - 7%) than in other developing countries (2-3%, Sai and Nassim, 1989). Factors underlying infertility include, among other things, women's poor health and nutrition status which can lead

to repeated miscarriages and foetal wastage, unhygienic obstetric and abortion procedures and even such debilitating diseases as tuberculosis. Infertility can have serious consequences for female well-being in a culture which prizes reproduction - preventing her from achieving her desired family size and exposing her to various kinds of emotional harassment or marital disharmony.

Again, little is known about the levels, patterns, determinants or consequences of infertility in India. Health services are rarely comprehensive enough to provide access to reliable information, sympathetic counselling and services to infertile couples. What is required is a sound referral system for infertile couples, along with primary health care which can provide basic information and counselling.

(d) Sexually transmitted diseases and AIDS

Information on levels and patterns of sexually transmitted diseases, which have severe implications for the reproductive health of both women and men, come predominantly from studies of patients of STD clinics and rarely from community-based investigations. The limited community-level evidence available suggests a relatively high prevalence of STDs: an intensive village level investigation of 650 women in Maharashtra (Bang *et al*., 1989) suggests that a disturbingly large proportion of women were suffering from syphilis (10.5%) and gonorrhoea (0.3%). Other estimates suggest that about a million men and women are suffering from HIV/AIDS with dangerous potential for its wider spread. In studies of patients attending STD clinics, as in the Bang study, syphilis accounts for the highest proportion of patients, male and female - the difference is that while the majority of male patients had primary syphilis, the large majority of women (over 75%) had secondary syphilis. Over the five year period 1986-87 to 1991, there has been a steady rise in HIV prevalence among men and women attending STD clinics, reportedly from 1-5 per 1000 to 5-10 per 1000; in Bombay, seropositivity rates among commercial sex workers rose from two percent to 30 percent within a span of two years (1988-90, Ramasubban, 1993). Even so, awareness of HIV/AIDS remains cursory; misperceptions abound about its transmission and even about whether or not it is curable (Mane and Maitra, 1992).

There has been a tendency for both research and services to focus on high risk groups - commercial sex workers, men partners, truck drivers, and within them, on high risk areas (Maharashtra, Tamil Nadu, the north eastern states and metropolitan areas). Relatively neglected are a potentially very high risk group - monogamous women with non-monogamous partners. While community level data are unavailable, studies of patients of STD clinics suggest that while the majority of male patients were infected by commercial sex workers and casual contacts and not a single male was reportedly infected by his wife, one-third of all female patients were reportedly infected by their husbands (Ramasubban, 1993). Also neglected are another high risk group -- adolescent and young men, who, although sexually active, tend to be largely ignorant of sexually transmitted diseases, their modes or transmission and prevention, and the extent to which they are life threatening.

Urgently needed is a primary health care system which caters to the growing problem of STDs; counselling and referral at the peripheral level along with improved diagnostic facilities at the primary health centre level. Also, needed are rigorous studies of the sociocultural aspects of sexual behaviour and the context of high risk behaviour and transmission of infection. At the same time, not enough has been done to educate the larger population - and especially secluded, invisible and powerless women - about STDs and HIV/AIDS, their prevention, symptoms, modes of transmission and treatment. On the one hand, strategies need to be devised, which are sensitive to women's lack of control over sexuality and which can provide information at the doorsteps of secluded women. On the other hand, strategies need to be devised to inform, sensitise and communicate with men, and particularly young men. Men are an important audience for such communication, both in their own interests and because of the role they play in conveying information--and disease--to women. Young and adolescent males are a highly vulnerable group, generally ignorant of STDs and their prevention and information strategies need to include these groups.

2 Risk elements and intermediate factors affecting poor reproductive health

(a) Malnutrition

Underlying reproductive morbidity and exacerbating women's vulnerability to obstetric, gynaecological and sexually transmitted morbidity is poor nutrition, and such consequences as anaemia and physical immaturity. Disparities in feeding patterns are evident from infancy (Das Gupta, 1987; Khan *et al.*, 1988); and studies which have monitored growth and nutritional status among children (Srikantia, 1989; Government of Maharashtra and UNICEF-WHO, 1991) confirm gender disparities in growth and sever malnutrition from an early age. Poor adolescent weight and height result; it is estimated (Gopalan, 1989) that 47 percent of 15 year olds in India have body weights less than 38 kg and 39 percent have heights less than 145 cm., recognised as obstetric risk factors. Another consequence is high levels of anaemia (Chatterjee, 1989): between 40 percent and 50 percent of urban women and between 50 percent and 70 percent of rural women are estimated to suffer from anaemia (UNICEF, 1991; Kapil, 1990; Mathai, 1989). While nutrition and iron supplementation programmes for pregnant and lactating women do exist, the little available evidence suggests that they neither reach their intended populations, nor have been successful in reducing the prevalence of anaemia among those they do reach (Ministry of Welfare, Department of Women and Child Development, 1991; UNICEF, 1991).

(b) The situation of adolescents, particularly adolescent girls

Adolescent girls, most of whom are out-of-school, constitute a sizeable proportion of the female population. They are particularly vulnerable and neglected, coming under the purview of government programmes only once they are pregnant - the majority are out of school and are neither serviced by educational or school health programmes nor by child health and nutrition services. At the family level too, girls are highly vulnerable: son preference is pervasive, resulting in gender disparities in health care, food intake, school attendance and labour

contribution of children in childhood, from an early age. Moreover, typically, marriage and childbearing are early and universal. There are strong cultural pressures on parents, especially in the northern states, to marry their daughters early; in addition, few economic advantages accrue to parents in delaying their daughters' marriages. As many as 6.2 percent and 43.4 percent of girls ages 10-14 and 15-19 respectively were already married in 1981 (higher in the northern states). India has been notoriously unsuccessful in raising the age at marriage of women: between 1971 and 1981, for example, the mean female age at marriage increased from 17.2 to 18.3 and six of the 14 major states recorded average ages of marriage below the legal minimum age at marriage. Early marriage leads to early onset of childbearing: 10-15 percent of all births annually occur to women in their early teens (Mathai, 1989; Kapil, 1990), occurring before the female is physically fully developed. Complications of pregnancy, per-natal and neo-natal mortality and low birth weight are much higher among adolescent women than among older women. And not only does early childbearing further deplete the already malnourished adolescent, but it also can result in severe damage to her reproductive tract (Ramachandran, 1989).

The sluggish pace of increase in age at marriage is an important factor underlying both the slow fertility decline and the poor reproductive health situation in the country. Efforts to raise age at marriage have to take a holistic perspective on adolescent girls - their education, enhancement of work oriented skills, as well as measures to delay their marriages and enhance their autonomy and sense of self-worth within their families. Measures to reduce drop outs of school among adolescents, and to provide non-formal education and training to school drop outs are fundamental for enhancing women's control over their own lives and ability to have a say in marriage choices. And recognising the link of early marriage and childbearing to both reproductive health risks and social development risks, measures to delay marriage or enforce the law pertaining to minimum age at marriage need to be taken more seriously. In short, adolescent childbearing can best be prevented through innovative and indirect interventions which cater to the health, educational and employment needs of adolescent out-of-school girls.

There have been few systematic efforts in India to address the needs of adolescent girls. What is essential are programmes which look to the overall development and "value" of the adolescent girl to her natal family. There have been few programmes aimed at retaining girls in school or giving them employment. In particular, the development needs of out-of-school adolescent girls have rarely been acknowledged or addressed: there are few programmes that ensure basic education, a vocational skill and the potential for income, and, at the same time, exposure to new ideas regarding family life and health (see, for example, Bose, 1988). In the 1990s, for the first time, one government programme, the Integrated Child Development Scheme (ICDS), extended its activities, although on a limited scale, to include adolescent girls. The ICDS programme originally intended to provide nutritional supplementation and health and nutrition education for pregnant and lactating women and nutritional supplementation and early childhood education for their pre-school aged children. It has recently expanded its services to incorporate programmes for out-of-school adolescent girls age 11-18. This programme operates through Girls' Clubs (Balika Mandals) and its activities are limited to the provision of nutritional

supplementation and health check-ups, along with some health education. There is, however, little attention paid to enhancing literacy, skill development or income generation. Adolescent programmes currently operate in 507 Blocks, are well attended, and are expected to be extended to additional Blocks. Although its activities are limited, the programme is notable because, for the first time, the health and nutrition needs of adolescent girls have been specifically addressed.

A comprehensive focus on adolescent girls - to improve their nutritional levels, access to health services and increase their ages at marriage - would thus address an important reproductive health need at an early stage in life cycle. Given the particularly constrained situation of out-of-school adolescent girls, such a focus would cater directly to the service and information needs of adolescents and their parents as well as indirectly through measures to enhance literacy, health and reproductive health education and vocational skill development. Such measures are fundamental for enhancing the situation of adolescents girls both within and outside the household and marriage and childbearing to both reproductive health and social development risks, measures to delay marriage or enforce the law pertaining to minimum age at marriage need to be taken more seriously. Finally, enhancing adolescent girls' control over economic resources is a fundamental means by which this vulnerable group can attain some say in their own lives on the one hand and become perceived as more vulnerable by parents on the other.

Sexual activity of unmarried young people is rarely considered a concern in the Indian context; neither research not action hence focus on the sexual information and contraceptive needs of young unmarried men and women. Yet there is a growing body of evidence which suggests considerable ignorance of sexual matters on the one hand and considerable sexual activity on the other, among young unmarried youth in both rural and urban areas. There is evidence, for example, of tremendous lack of awareness of their bodies and sexual behaviour, both among girls and boys; there is considerable interest among them in filling this gap in knowledge (Bhende, 1993). As far as sexual activity is concerned, a study in a rural and tribal setting of Maharashtra (Bang *et al.* 1989) reveals, on the basis of physical examination, that nearly half of all unmarried girls had experienced sexual activity. While these high levels are probably atypical for rural India as a whole, they are certainly suggestive of sexual activity among unmarried girls in rural areas. And in urban India, a recent study among students at elite schools in New Delhi finds that a large number of students are involved in high risk sexual activities -- about 60 percent of the male students, for example, are involved in sexual activities with commercial sex workers or older women in their neighbourhoods. Even girls are observed to be sexually active, though considerably fewer than boys. As many as 80 percent of all students are aware of AIDS/HIV and its modes of transmission; however, many fewer girls than boys are aware of the use of condoms in minimising the risk of infection. And even though a large proportion of boys are aware that use of condoms can minimise infection, few boys use condoms (Chaudhary and Francis, 1994).

What is therefore urgently required for both adolescent girls and adolescent boys are programmes which help deal with their own well-being, their health, their bodies and their sexual

lives. This is particularly important in light of the HIV epidemic and in light of growing evidence of both ignorance in sexual matters on the one hand and considerable sexual activity among young unmarried people on the other.

(c) **Contraceptive patterns**

Though contraceptive prevalence rates have been increasing over the decade of the 1980s (1980-81 to 1989-90) there has been a virtual doubling of the couple protection rate (a measure of contraceptive prevalence using service statistics), and 42 percent of all currently married women in the reproductive ages or 61 million women, practise some form of contraception. Again, regional disparities are wide: whereas about one in three currently married women of reproductive age currently practises contraception in the four large northern states (32.6%), about half of all women in the rest of the country do so (50.3%).

The emphasis is on terminal methods and female methods: few (only 12%) use a non-terminal method, reflecting the unbalanced focus of the family planning programme on terminal rather than reversible methods. As many as 30 percent (42 million) were protected by sterilization (mostly female), 6.3 percent (9 million) by IUDs, 5 percent (7 million) by condoms and under 2 percent (2.7 million) by oral pills. As a result of the emphasis on terminal contraception, young and low parity women remain unprotected from repeated and closely spaced pregnancies: only 16 percent of women below 30 practise any form of contraception, compared to 55 percent of all women aged 33 to 44. The average age of sterilization acceptors is over 30 and parity is over three; these have declined moderately at best over the last fifteen years. This selectivity by age and parity is one reason why the relatively high overall rates of contraceptive prevalence have not been translated into correspondingly low levels of fertility for the population as a whole. And the resulting repeated and closely spaced pregnancies at younger ages enhance chances of reproductive morbidity.

Many barriers to contraception remain even among women who have the number of children they want. First awareness of non-terminal methods is generally poor, and correct knowledge of their use worse. Second, though a cafeteria of methods is theoretically available, most women do not have the wide choice that the list of theoretically available methods implies. For the most part, the prospective acceptor is informed only of methods considered appropriate by the service provider and does not participate in the selection of the methods she will use. Third, male involvement is weak and needs to be more actively sought in terms of both male method utilisation - even though vasectomy is simpler, cheaper and safer than tubectomy, it continues to be neglected by men, women and service providers - as well as greater sensitivity to the effect of repeated pregnancies on mother and child. Fourth, services tend to be poor, impersonal, threatening or simply unavailable to women; domiciliary visits to secluded women or village level outlets for them have been, in practice, irregular and unresponsive to the needs of women; personnel have been observed to be quite uncaring of women's dignity (Khan and Ghosh Dastidar, 1985) and quite lax in offering either pre-acceptance counselling or post-acceptance follow-up. So it is not surprising that there is considerable unmet need for family

planning (currently married women who want no more children but are not using a method of contraception). Estimates of unmet need for India are of the order of 20%: if women who wanted no more children were able to avoid another pregnancy, it is estimated that maternal mortality ratios would fall by up to 40 percent in India (Acsadi and Johnson-Acsadi, 1990).

As of 1990, there were 141.9 million eligible couples in the country of whom about 61 million are protected by some means of contraception. In another ten years, India expects to have 170 million eligible couples and if an NRR of one is to be achieved, it is estimated that as many as 102 million eligible couples will have to be using some form of contraception by the year 2000. In other words, over the next ten to eleven years, India aims to double the number of its protected eligible couples. Given the current thrust of the programme and the socio-economic and demographic situation, this is an ambitious target, one unlikely to be met.

Today, awareness of the fact that fertility can be controlled is almost universal; unfortunately, only one method is widely known and that is sterilization. Also, a large majority of the population approves of family planning. These two criteria are necessary but not sufficient conditions to raise the demand for family planning services. More important, the extent of demand for any form of contraception is linked up with family size preferences. And in India, a family size of at least two sons and a daughter is considered essential to most parents (and some three to four children and two to three sons in the northern states). Since the composition cannot be made to order, actual fertility can be much higher than desired and, though awareness is nearly universal and attitudes positive, far fewer couples are motivated to actually limit family size, especially in the four large northern states, in view of the large preferred family size.

In short, though a large proportion of Indian women are motivated to limit or space childbearing, they are constrained from doing so for reasons which are rooted in the inadequacies of the programme on the one hand and by socio-cultural factors on the other. The focus on sterilization, target fulfillment and incentives has resulted in obscuring the spacing needs of women and their right to exercise informed choice. Service delivery strategies and quality of care have largely been insensitive to the needs of women, the constraints the average woman faces in seeking services, in voicing fears and side effects and their right to have complete pre-acceptance counselling including information on potential side-effects and complications and post-acceptance follow-up.

(e) **Quality of reproductive health services**

Little systematic evidence exists in India about standards of care in the family welfare programme or specific steps which can be taken to improve it. More attention has been paid to physical infrastructure, personnel and equipment than on quality of care especially from the woman's (client's) perspective. Quality of care comprises several dimensions: (1) availability of a wide range of contraceptive methods MCH and other services; (2) accessible, complete and accurate information about contraceptive methods, including their health risks and benefits; (3) safe and affordable services, along with high quality supplies; (4) well-trained service providers,

with skills in inter-personal communication and counselling; (5) appropriate follow-up care; and (6) regular monitoring and evaluation of performance, incorporating the perspectives of clients and beneficiaries. Thus far, these elements of quality of care have been largely missing.

The little available evidence on utilisation of maternal health services attests, for example, to the poor outreach of maternal health services: no more than 40-50 percent of all pregnant women in India are estimated to receive any ante-natal care (Singh and Paul, 1988; Starrs and Measham, 1990; Acsadi and Johnson-Acsadi, 1990) and at the time of delivery, no more than 20 percent of all women have some contact with medical or paramedical personnel. Deliveries are largely conducted by untrained personnel and under unhygienic conditions, both of which contribute significantly to poor maternal health. Maternity benefits are woefully absent for the large majority of women in the unorganised sector, a factor which compounds maternal ill-health; the recent talk of restricting maternity benefits in the organised sector to two children has serious implications for both maternal and child health.

The health delivery system has been largely insensitive to the reproductive health care needs of women and the constraints they face in expressing these--let alone the constraints they face in obtaining services. Doorstep services are essential for secluded women and these are rarely undertaken and where undertaken, focus largely on contraception rather than on reproductive health in general. Health workers themselves are poorly informed about reproductive morbidity (especially gynaecological conditions), can be insensitive in probing and recognising symptoms and are preoccupied with meeting contraceptive targets rather than offering a range of reproductive health services. And given women's lack of autonomy and decision making authority, it is unlikely that sick women will take the initiative in obtaining health care for themselves. In particular, there is a tendency to endure obstetric and particularly gynaecological morbidity as a fact of life and a shyness to reveal these conditions to or discuss them with health care providers.

Despite the fact that the large majority of births continue to take place and are attended by untrained personnel, the incorporation of trained traditional dais (TBAs) in the provision of ante-natal and natal services has not been a priority in the health system. Since younger generations are unwilling to become dais, there is the likelihood of a serious shortage of delivery attendants. While there have been programmes to train traditional dais and provide them with materials and safe delivery kits, there has been little rigorous assessment of the impact of this training, and from all accounts, success has been limited. The SEWA (Ahmedabad) experience, however, suggests that dais can be realistically brought into the health service network. Dais are trained for ante- and post-natal care and delivery, as well as primary health care, child health and family planning. At the same time, dais have been trained to provide fee-based services, resulting not only in enhancing the status of the dai, but making her more accountable. Even so, there is a paucity of evidence on the impact of services delivered by trained traditional birth attendants.

The persistence of an unmet need for contraception is further evidence of the poor quality of services and care, since women are inclined to prefer an unwanted birth rather than accept available contraception services. A cafeteria of methods is rarely provided to the potential user; nor is counselling or advice on side effects - despite the fact that study after study has shown that method acceptance and continuation depend largely on the quality of care. Moreover, morbidity arising from contraception is cause for concern. In particular, the camp approach to sterilization and the increasing focus on IUDs have been associated with a variety of side effects. More serious conditions ranging from excess bleeding to pelvic inflammatory disease have also been reported and point to a need for more hygienic service delivery conditions in general and a programme which is sensitive to the needs of constraints facing women, in particular.

At the service delivery level, there are few examples of sensitive, client-oriented family planning and reproductive health services. The government programme remains focussed on fertility reduction, with reproductive health remaining of secondary concern. There are a few examples of client-centred service programmes in the NGO sector; these examples remain undocumented and offer few clearcut strategies for replication for service programmes. There is little attention paid among service providers, policy makers or researchers to quantify standards and measurable indicators of these standards. In short, there is a need for a rigorous quality of care perspective to be incorporated into both interventions for service provision and research.

As far as service delivery is concerned, we need to learn from successful small scale reproductive health programmes on the one hand and expand the programmes of other NGOs to include comprehensive reproductive health programmes based on the needs of women on the other. These include (1) quality outreach services delivered in ways which are sensitive to a cultural milieu which inhibits women from expressing their reproductive health needs or seeking health services; (2) services which go beyond the current exclusive focus on contraceptive method acceptance to a more comprehensive programme which includes safe motherhood, treatment of gynaecological and obstetric infections, abortion and infertility services as well as greater attention to continuity of care, sensitive counselling, screening, follow-up and treatment of complications as well as access to a wide range of services; (3) more attention to women's information needs through culturally acceptable media and messages; and (4) more attention to the quality of service provider-client interaction.

The recent controversy about provider-dependent methods including Norplant and injectables raises concern about the implications of introducing these methods into a programme whose quality raises doubts about adequate counselling and follow-up. Introduction of these new methods has therefore raised fears about their safety, the health consequences for women of poor follow-up or loss to follow-up and of the potential for coercion and abuse.

As far as research is concerned, little is available from the perspective of individual clients and women in particular on the kind of services and care they receive; on the linkages between how women perceive health care services and their utilisation of these services; on how women's perceptions of quality of care affect their lives. Social scientists tend to have a narrow

interpretation of reproductive health, rarely addressing, for example, the user's perspective of health care services. Moreover, it is increasingly clear that in order to document women's perceptions, experiences and needs, what is required is a blend of both in-depth qualitative research as well as the more familiar quantitative survey methodology.

Finally, there is concern about how new economic policies will affect measures to improve quality of care. First, if social sector spending is reduced, resources for the health sector will certainly be curtailed. And second, the trend toward increased privatization of health may also have implications for both access to health care among the poor as well as to accountability in terms of the kind of services and care provided. This is of particular concern for preventive and promotive care activities which are almost entirely provided through the public health system, rather than for curative health care where about 70 percent of all services are already in the private sector.

(f) Women's health seeking behaviour

While poor quality of care can inhibit women from seeking health care, women's lack of autonomy in decision making or movement is also an important constraint on women's health seeking. Women are, by and large, taught self-denial and modesty from an early age and are hence unlikely to acknowledge a health problem, and particularly a gynaecological problem, unless it is very advanced (SEWA-Rural, 1994). For example, large numbers of women experience white discharge but consider it as part of their lives and rarely seek medical care for such a problem. Lack of decision making, freedom of movement and time can restrict visits to health centres, even where a health problem has been recognised. Moreover, pelvic examinations are strongly resisted by women. And even if a problem has been diagnosed, treatment is frequently not followed through because it is seen as an unnecessary expense or too demanding. Often, in addition, the focus on allopathic medicine has tended to alienate women, generally more exposed to traditional medicines; more needs to be known about these traditional treatments, their health benefits and the way they are perceived by women. There is, unfortunately, little rigorous research on women's constraints to health seeking in the area of reproductive health. Moreover, service delivery strategies remain oblivious to the real constraints women face in acquiring good health care.

(g) Health information needs

Communicating new ideas to poor, illiterate and secluded women is no easy task. We have already seen that literacy and school enrolment levels are generally low and school drop-out rates are relatively high in India, especially among women. Given these low literacy levels, it is not surprising to observe that relatively small proportions of rural women are exposed to the media.

Activities promoting communication about population issues have been undertaken as part of the Indian population programme. Once again, however, the aim of the IEC component

of the Family Welfare programme is limited to raising awareness of the small family norm (Ministry of Health & Family Welfare, 1993). Extension education has been given little priority or importance and as a result workers have not maintained regular contacts, domiciliary or otherwise, with the communities they are to serve. Messages have been a regular features of radio (radio programmes on family welfare have appeared some 75,000 times during the year) and more recently on television; their content has traditionally related to contraception and more recently to such issues as immunisation, antenatal care, age at marriage and dowry. Audio-visual materials for telecast on TV and information and quiz programmes in several regional languages for radio broadcast have been sponsored by the family welfare programme. A near complete revamping of communication strategies took place after studies highlighted a high degree of awareness of contraception among the population: new strategies were designed which began to stress other issues such as lactation, immunization, age at marriage, safe motherhood and equal treatment of daughters and sons. The family welfare programme also promotes messages through traditional folk media which are widely accessible to much of rural India. About 27000 programmes of health and family welfare were enacted through plays, songs, skits, folk recitals, puppet and magic shows and so on during the nine month period from April to December 1992, for example.

Poor, rural women are the least likely to be exposed to the electronic or the print media. For them, traditional media continue to be the major source of information and most important among these is interpersonal discussions, at their doorsteps. In recognition of this, not only health workers, but also anganwadi workers (Integrated Child Development Scheme programme) are expected to convey health and family welfare messages to rural women on a regular basis. In addition, women's groups (Mahila Swasthya Sanghs) have been created; these groups are expected to assist ANMs in their activities while at the same time provide a forum for discussion of family welfare issues. In addition, there is the Link Women Scheme aimed at promoting greater participation of village women in the delivery of family welfare messages. There are now almost 30,000 link women, who are chosen from the village community and trained by health workers to communicate family welfare messages in their villages. The success of these schemes, like the singular focus, thus far, on family planning and child survival. Another limitation is the fact that messages and media tend to be uniform throughout the country and are rarely tailored to respond to difference in culture, language and needs at the local level.

(h) **Sex education**

There is a glaring lack of attention to sex education in the official programme. What little education exists is imparted largely through the formal school curriculum and text books. As a result, large segments of out-of-school youth are excluded. Sex education, and knowledge of menstruation or of AIDS for example, is extremely limited and vague, especially among youth and females (Bhende, 1993). If even well educated adolescent girls and boys do not have a comprehensive knowledge of AIDS, its severity and how to prevent it (Chaudhary and Francis, 1994), the levels of ignorance and risk taking among poorly educated slum and rural adolescents

must be much higher, making a focus on innovative sex education programmes all the more urgent.

Although the NGO sector has tried to fill the gap in attention to sex education for some time, their efforts have, by no means, been sufficient. For example, the activities of the Indian Health Organisation, the Family Planning Association of India, the Parivar Seva Sanstha, which have focussed on family life education and sex education for both in- and out-of-school youth, are hardly adequate given the cultural diversity in the country and the generally limited knowledge of the most basic aspects of reduction and reproductive health, especially among women. There is also the problem that few people acknowledge that there is much sexual activity among adolescents and young unmarried people or approve of sex education. Chaudhary and Francis (1994), for example, encountered considerable difficulty in even gaining access to many schools in New Delhi area for their study of sex education and awareness of AIDS at the high school level.

There is therefore a glaring need to (1) convince educators and non-governmental organisations alike about the prevalence of sexual activity and the lack of awareness of the human body, sexual behaviour and the risks of STDs; (2) gain access to school and out-of-school youth to cater to their information needs; and (3) develop culturally sensitive and locally relevant sex education efforts for young men and women. An example of how out-of-touch with reality sex education has been is the fact that in the school system, it has focussed largely on the virtues of abstinence among school students; rather than accepting that students may be sexually active and in need of additional information on STDs, safe sex and the risks associated with unprotected sexual activity. What is therefore urgently required for both adolescent girls and adolescent boys are programmes which help inform adolescents of their own well-being, their health, their bodies and their sexual lives.

In short, there is a need to reorient communication and education activities to incorporate a wider interpretation of reproductive health; to focus attention on the varying information needs of women, men and youth and to the media most suitable to convey information to these diverse groups. More attention needs to be paid, for example, to the appropriateness of content and wording of messages at the local level; to strategies for imparting sex education to out-of-school adolescents; to conveying to women their rights, both in expressing reproductive health concerns and more generally in redressing gender disparities; to informing men of their responsibilities in child-rearing, as well as in contraception and sexual matters; and to channelling research activities in the area of women's reproductive health and disseminating findings. This kind of reorientation of priorities requires not only a fresh look at messages and media but also at training of communicators.

IV. Developing a more Woman-centered Focus on Reproductive Health

The Indian family welfare programme continues to be driven by demographic objectives, notably increasing contraceptive prevalence rates and reducing fertility. Efforts to incorporate

a more holistic approach in addressing women's reproductive health needs must be strengthened. Women remain one of the most underserved segments of the Indian population and a focus on their health and other needs is of special importance. A woman-centered approach is necessarily holistic, looking broadly at women's health needs, as well as their poor economic status, their lack of decision making autonomy and their limited access to new knowledge. These priorities call for a multifaceted set of activities, ranging from innovative programmes for advocacy, service delivery models, training and capacity building, to research, evaluation and documentation. Here, we recapitulate the important areas of concern.

A. Focus missing services

The singular focus of the Indian family welfare programme on female sterilization has meant the neglect of many areas of women's reproductive health. As the earlier sections have shown, there is an urgent need to expand focus of services, referral systems, IEC and research beyond FP to include safe motherhood, abortion services, services for gynaecological and obstetric morbidity; infertility; sexual behaviour and STDs; and even non-terminal contraception. Little is known, for example, of the extent of gynaecological morbidity among women; the little known suggests that the majority of women suffer from one or more RTIs. Similarly, although abortion is widespread, it continues to be performed under illegal and unsafe conditions. With the growing HIV epidemic, while high risk groups such as commercial sex workers (CSWs) and their clients have been studied, little has been accomplished in the larger population, and particularly among women, regarding STD and HIV education.

B. Focus on quality of care

Improvement in the quality of reproductive health care is a critical need. At the service delivery level, there is a need for a rigorous quality of care perspective to be incorporated into both interventions for service provision and research. We need to learn from successful small-scale reproductive health programmes on the one hand and expand the programmes of other NGOs to include comprehensive reproductive health programmes. These include quality outreach services delivered in ways which are sensitive to a cultural milieu which inhibits women from expressing reproductive health needs or seeking health services; services which go beyond the current exclusive focus on contraceptive method acceptance to a more comprehensive programme which includes safe motherhood, treatment of gynaecological and obstetric infections, abortion and infertility services as well as greater attention to continuity of care, sensitive counselling, screening, follow-up and treatment of complications as well as access to a wide range of services; more attention to women's information needs through culturally acceptable media and messages; and more attention to the quality of service provider-client interaction. What is needed then are improvements in the quality of reproductive health care, through both service delivery models and more focussed qualitative research on women's perceptions and needs. Viable service delivery models which can be held up to government need to be supported. Grass-roots level programmes need to be strengthened so that they become

models for provision of services. More needs to be known on how women perceive the service delivery system as it currently exists.

Much neglected today has been the role of traditional medicine, practitioners and local traditions in the health of the rural population. A more in-depth understanding of traditional medical practitioners, the use of traditional medicine and local health traditions in catering to women's health needs to be taken seriously, its advantages incorporated into health service strategies and its limitations widely discussed.

Quality of care concerns extend also to the incorporation of new contraceptive technologies into the programme and to redressal mechanisms for poor contraceptive or reproductive health care. The implications of introducing new technologies, usually highly provider-dependent into a programme whose quality raises doubts about adequate counselling and follow-up need to be better assessed. Fears about their safety, the health consequences for women of poor follow-up, and of the potential for coercion and abuse are all concerns which need to be thrashed out. At the same time, there is a need for greater accountability in the programme and one means of achieving this is to evolve and strengthen redressal mechanisms for complications which arise from poor quality of services and care.

C. Focus on adolescents: an underserved group

While women are generally underserved, among the most neglected women, as shown earlier, are adolescent girls. A focus on the health needs of adolescent girls -- their reproductive health needs, their nutritional status, the risks of early marriage and childbearing -- is urgently required. At the same time, the health information needs of adolescent girls are rarely addressed and adolescent girls remain particularly ignorant about their bodies and about sexual behaviour and pregnancy; filling these gaps is a critical need. More generally, efforts to enhance the status of adolescent girls, through measures to keep them in school, to provide non-formal education to drop-outs and provide skill development and income generating opportunities is an integral part of a really holistic approach.

While boys are more likely to be in school and more likely to receive health and nutritional care than their sisters are, the health and sex education needs of adolescent boys are about as neglected. An appropriate strategy in the area of family life and sex education is to target both girls and boys.

D. Focus on filling the gaps in knowledge

There is surprisingly little social science research which reflects the range of issues included under the rubric of reproductive health. There is, for example, little understanding of the socio-cultural context of reproductive health, of women's actual access to health care and the constraints women face in acquiring good health. Whether we consider the prevalence of RTIs, or abortion, or the prevalence and consequences of infertility, or the needs of adolescents or

constraints to women's health seeking or even the context of demographic change or unmet need for contraception, we are confronted with a glaring paucity of rigorous evidence on either their prevalence or their socio-cultural context. Worthy of support are small scale, intensive studies of women which would highlight these issues, through qualitative and quantitative methods.

Nor is there solid empirical evidence in support of successful NGO projects. NGOs have been particularly lax about maintaining baseline and follow-up data tracking change in the communities which they serve and this can be a major stumbling block when it comes to holding up viable service delivery models to government.

Finally, there is a need for more action research. We need to know, for a start, the current service delivery system and its approach to women's needs. Second, where innovations are introduced in terms of quality of services or care or the incorporation of a woman's perspective, or more integrated services, we should like to know whether they have succeeded in encouraging more clients to avail of services; and above all, whether they have succeeded in improving women's health situation.

E. Conveying messages to rural women

First, recognising that poor, rural women are largely unlikely to be exposed to the electronic and print media, it is important that communication activities directed to them continue to rely on traditional media and interpersonal, door-step contacts. Messages conveyed to them thus far have been limited in content (stressing contraception and the small family norm rather than reproductive health issues more generally) and are rarely tailored to respond to differences in culture, language and needs at the local level. It is important that communications become part of the holistic approach recommended above and that model service delivery projects incorporate locally appropriate communications activities as an integral part of their reproductive health services. Training or re-training of communication is essential. At the same time, however, opportunities to develop a focus on reproductive health issues in the electronic and print media should not be overlooked.

F. A focus on sex education

Finally, there is an urgent need to support programmes of sex and HIV/AIDS education both for adolescent girls and boys and for adults. Sex education for adolescents has, thus far, been vague and incomplete, inadequately addressing their questions concerning their bodies, their physical developments or their curiosity about sexual activity. Boys, no less than girls, are ignorant of sexual matters. And yet we have a growing body of evidence pointing to high risk sexual activity among adolescents and youth. It is time that sex education programmes became more realistic in terms of information needs of adolescents and youth, both in and out of school. Equally challenging are strategies to inform adults, and particularly secluded women, of STDs and HIV/AIDS and more generally to get men involved in such issues as sexual health and safe sex on the one hand and responsibility in sexual matters and contraception on the other. These kinds of education programmes for both youth and adults can best be performed by NGOs which

have developed a closer rapport with rural communities; even so, these kinds of activities require not only a fresh look at messages and media but also at training of communicators.

V. Concluding Observations

A growing recognition that population dynamics, quality of life and women's status are closely interrelated argues strongly for a fresh look at India's population programme, with a broad reproductive health and woman-centred orientation, especially in view of the fact that a national population policy is currently in the process of formulation. In theory, India has a model population programme which aims to provide family planning within a broad framework of maternal and child health care, with emphasis on voluntarism and informed choice. In practice, however, the programme is characterised by a singular focus on sterilisation, by poor quality of services, and an insensitivity to women and their broader reproductive health needs. Strategies to broaden the narrow focus of services, and more important, to put women's reproductive health service and information needs in the forefront are therefore urgently required; at the same time, men's information needs, especially in the area of STDs and AIDS cannot be ignored.

In the long term, however, the pace at which improvements in quality of life in general and women's health in particular occurs is powerfully constrained by low levels of education and control over material resources among Indian women. The importance of programmes to promote universal primary education for girls and non-formal education, skill and employment generation for women cannot be sufficiently emphasised.

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REFERENCES

Acsadi, George T.F., and Gwendolyn Johnson-Acsadi. 1990. "Safe motherhood in South Asia: socio-cultural and demographic aspects of maternal health". Background Paper, Safe Motherhood South Asia Conference, Lahore, 1990.

Agarwal, V., S. Patil and S. Khanijo. 1982. "Study of maternal mortality", *Journal of Obstetrics and Gynaecology* 32, no.5 (October): 688-692.

Bang, R.A. *et al*. 1989. "High prevalence of gynaecological diseases in rural Indian women," *The Lancet*, January 14.

Baroda Citizen's Council. 1994. "Gynaecological morbidity among women in slums of Baroda: Results of a cross-sectional survey by Baroda Citizens Council". (Unpublished).

Bhende, Asha. 1993. "A study of sexuality of adolescent girls and boys in underprivileged groups in Bombay". Paper presented at the Workshop on Sexual Aspects of AIDS/STD Prevention in India, Tata Institute of Social Sciences, Bombay.

Bhasker Rao, K. 1980. "Maternal mortality in India - A cooperative study," *Journal of Obstetrics and Gynaecology* 30, 6 (December): 859-864.

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

Bose, Ashish. 1988. *From Population to People.* New Delhi: B.R. Publishing Corporation.

Centre for Operations Research & Training (CORT), 1994. *Baseline Survey in the State of Madhya Pradesh.* CORT: Baroda.

Centre for Operations Research & Training (CORT), 1994. *Baseline Survey in the State of Rajasthan.* CORT: Baroda.

Centre for Operations Research & Training (CORT), 1994. *Baseline Survey in the State of Bihar*. CORT: Baroda.

Chatterjee, Meera. 1989. "Socio-economic and socio-cultural influences on women's nutritional status and roles," In: C. Gopalan and Suminder Kaur (eds.), *Women and Nutrition in India*. New Delhi: Nutrition Foundation of India.

Chaudhary, Shankar and Paul Francis. 1994. "Pilot study of knowledge of AIDS and sexual activity among Delhi school children." NGO-AIDS Cell, All India Institute of Medical Sciences, New Delhi (Unpublished).

Child in Need Institute. 1994. "Gynaecological morbidities among women in West Bengal." (Unpublished).

Das Gupta, Monica (1987), "Selective discrimination against female children in rural Punjab, India", *Population and Development Review* 13, 1 (March).

Gopalan, C. 1989. "Women and nutrition in India - general consideration," In C. Gopalan and Suminder Kaur (eds.), *Women and Nutrition in India.* New Delhi: Nutrition Foundation of India.

Government of India, Planning Commission. 1992. *Eighth Five Year Plan 1992-1997*. New Delhi: Government of India.

Government of Maharashtra and UNICEF-WIO. 1991. *Women and Children in Dharni: A Case Study after Fifteen Years of ICDS.* Bombay: UNICEF, Western India Office.

Jejeebhoy, Shireen and Saumya RamaRao (1993). "Unsafe motherhood: a review of reproductive health in India. "In M. Das Gupta, L. Chen and T.N. Krishnan, (eds.), *Health and Development in India* (forthcoming).

Kapil, U. 1990. "Promotion of safe motherhood in India, "*Indian Pediatrics* 27, no.3 (March): 232-238.

Khan, M. E. and Richard Anker, S.K. Ghosh Dastidar and Sashi Bairathi. 1988. "Inequalities between men and women in nutrition and family welfare services: an indepth enquiry in an Indian village", *Social Action* 38 (October-December).

Khan, M.E., S.K. Ghosh Dastidar and R. Singh. 1986. "Nutrition and Health practices among rural women - a case study of Uttar Pradesh, India" *Journal of Family Welfare* 33, no.1 (September).

Khan, M. E. and S. K. Ghosh Dastidar (1985), *Women's Perspective in Family Planning Programme*, (Study sponsored by Division of Family Health, WHO, Geneva), Operations Research Group, Baroda.

Mane, Purnima and Maitra, S. 1992. *Socio-cultural Aspects of Sexual Behaviour in India.* Bombay: Tata Institute of Social Sciences.

Mari Bhat, P.N., K. Navaneetham and S. Irudaya Rajan. 1992. "Maternal mortality in India: estimates from an econometric model", *Population Research Centre, Dharwad: Working Paper* 24 (January).

Mathai, Saramma T. 1989. "Women and the health system". In C. Gopalan and Suminder Kaur, (eds.) *Women and Nutrition in India*. New Delhi: Nutrition Foundation of India.

Ministry of Health and Family Welfare (1993), *Family Welfare Programme in India, Annual Report*: 1991-92, Government of India, New Delhi.

Ministry of Health and Family Welfare (1990), *Family Welfare Programme in India, Yearbook: 1988-89*, Government of India, New Delhi.

Ministry of Health and Family Welfare (1990), *India's Population, Demographic Scenario 1990.* New Delhi: Ministry of Health & Family Welfare, Government of India.

Ministry of Welfare, Department of Women and Child Development. 1991. *15 Years of ICDS, an Overview*. New Delhi: Government of India.

Mitra, J. and Khara, B.N., 1983, "Maternal mortality (a review of the current status in a teaching institution)," *Journal of Obstetrics and Gynaecology* 33, No.2 (April : 209-213.

Pant, S.P. and S.S. Mehendale. 1987, "Maternal mortality - review of 6 years," *Journal of Obstetrics and Gynaecology* 37, No.3 (June): 527-529.

Ramasubban, Radhika. 1993. "Patriarchy and the risks of HIV Transmission to women in India." In M.Das Gupta, L. Chen and T.N. Krishnan,(eds.) *Health and Development in India* (forthcoming).

Registrar General. 1987. *Survey of Causes of Death (Rural): Annual Report 1984 and 1986*. A Report, Series 3 No.17 and 19. New Delhi: Office of the Registrar General.

Registrar General, 1985. *Census of India 1981: Social and Cultural Tables Series 1 India.* (New Delhi: Office of the Registrar General).

Registrar General. 1983. *Census of India 1981: Primary Census Abstract: General Population Series* 1 India, Part II B(i). New Delhi: Office of the Registrar General.

Roy Chowdhury, N.N. and K. Sikdar. 1982. "Factors influencing maternal mortality," *Journal of Obstetrics and Gynaecology* 32, 4 (August): 507-510.

Ramachandran, Prema. 1989. "Nutrition in pregnancy" In C. Gopalan and Suminder Kaur (eds.), *Women and Nutrition in India.* New Delhi: Nutrition Foundation of India.

Ramachandran, Prema. 1989a. "Lactation-nutrition-fertility interaction, "In C. Gopalan and Suminder Kaur (eds.), *Women and Nutrition in India*. New Delhi: Nutrition Foundation of India.

Sai, Fred T. and Janet Nassim. 1989. "The need for a reproductive health approach." *International Journal of Gynaecology and Obstetrics,* Supplement 3: 103-113.

SEWA-Rural Research Team. 1994. "Gynaecological aspects of women's health: a cross-sectional study" (unpublished).

Singh, Mehraban and V.K. Paul. 1988. "Strategies to reduce perinatal and neonatal mortality," *Indian Pediatrics* 25, 6 (June): 499-509.

Sinha, Jyoti. 1986. "A 5 year study of maternal mortality: analysis of its causative factors (1976-1980)" *Journal of Obstetrics and Gynaecology* 36,3 (June): 404-406.

Srikantia, S.G. 1989. "Pattern of growth and development of Indian girls and body size of adult Indian women" In C. Gopalan and Sumider Kaur (eds.), *Women and Nutrition in India*. New Delhi: Nutrition Foundation of India.

Starrs, Ann and Diane Measham. 1990. *Challenge for the Nineties: Safe Motherhood in South Asia*. New York and Washington: The World Bank and Family Care International.

Streehitkarini, Bombay. 1994. "Report of Ford Foundation Project `Gynaecological disorders of women in the slums of Bombay adopted by Streehitkarini'." (Unpublished).

UNICEF, India. 1991. *Children and Women in India: A Situation Analysis.* New Delhi: UNICEF.

APPENDIX

Table A-1: Mortality and life expectancy indicators

	Crude death rate 1991	*Infant mortality rate 1991*	*Infant mortality rate 1989*			*Child death rate 0-4 1989*	*Life expectation 1991-96*	
			Total	*Male*	*Female*		*Male*	*Female*
India	9.8	80	91	92	90	29.9	60.6	61.7
1. Andhra Pradesh	9.7	73	81	89	73	21.8	61.4	64.5
2. Arunachal Pradesh	13.5	NA	NA	NA	NA	NA	NA	NA
3. Assam	11.5	61	91	97	85	29.6	58.7	58.5
4. Bihar	9.8	69	91	94	88	32.8	60.8	60.1
5. Goa	7.5	NA	NA	NA	NA	NA	NA	NA
6. Gujarat	8.5	69	86	85	88	29.2	60.9	62.7
7. Haryana	8.2	68	82	75	90	24.1	65.2	64.2
8. Himachal Pradesh	8.9	NA	74	59	92	19.3	NA	NA
9. Jammu & Kashmir	7.9	NA	69	72	60	19.6	NA	NA
10.Karnataka	9.0	77	80	86	74	25.7	64.2	65.3
11.Kerala	6.0	16	22	23	20	6.1	67.2	72.1
12.Madhya Pradesh	13.8	117	117	115	120	43.0	59.2	58.0
13.Maharashtra	8.2	60	59	64	53	18.0	63.9	65.1
14.Manipur	5.4	NA	NA	NA	NA	NA	NA	NA
15.Meghalaya	8.8	NA	NA	NA	NA	NA	NA	NA
16.Nagaland	3.3	NA	NA	NA	NA	NA	NA	NA
17.Orissa	12.8	124	122	123	119	39.7	60.1	58.4
18.Punjab	7.8	53	67	72	56	21.9	66.6	66.5
19.Rajasthan	10.1	79	96	95	99	35.6	60.5	61.3
20.Sikkim	7.5	NA	NA	NA	NA	NA	NA	NA
21.Tamil Nadu	8.8	57	68	67	69	20.6	62.8	63.1
22.Tripura	7.6	NA	NA	NA	NA	NA	NA	NA
23.Uttar Pradesh	11.3	97	118	114	123	41.3	57.1	52.8
24.West Bengal	8.3	71	86	83	71	21.9	61.9	61.9
Four large northern States*	11.2	91	108	107	110	38.7	58.9	56.8
Rest of India	8.8	72	80	82	76	24.0	61.8	65.1

* Bihar,Madhya Pradesh, Rajasthan and Uttar Pradesh

Sources: Registrar General, India. 1993. Sample Registration Bulletin:XXVII-1 (cols 1, 2).

Ministry of Health & Family Welfare. 1991. Family Welfare Programme in India 1990-91. New Delhi: Ministry of Health & Family Welfare, (cols. 3-6).

Registrar General, India. 1988. Report of the Expert Committee on Population Projection. Census of India, Occasional paper No.4 of 1988. New Delhi: Registrar General's Office, (cols. 7,8).

Table A-2: Fertility and selected proximate determinants

	Crude birth rate 1993	*Total fertility rate 1992*	*Mean age at marriage 1981 Female*	*Couple protection rate 1990*	*% users of non terminal methods 1990*
India	28.5	3.6	18.3	43.3	13.2
1. Andhra Pradesh	24.1	2.8	17.3	44.1	8.2
2. Arunachal Pradesh	27.6	NA	NA	9.9	4.4
3. Assam	29.5	3.4	NA	25.2	2.0
4. Bihar	32.1	4.6	16.5	26.3	4.0
5. Goa	14.6	NA	NA	30.9	8.8
6. Gujarat	28.0	3.2	19.5	56.6	17.1
7. Haryana	30.6	3.8	17.9	58.2	26.2
8. Himachal Pradesh	26.7	3.1	NA	50.0	13.3
9. Jammu & Kashmir	30.7§	3.3	NA	22.4	3.4
10.Karnataka	25.5	2.9	19.2	45.4	7.8
11.Kerala	17.3	1.7	21.9	52.5	9.2
12.Madhya Pradesh	33.4	4.4	16.5	40.3	12.5
13.Maharashtra	25.0	2.9	18.8	56.4	12.8
14.Manipur	20.3	NA	NA	26.7	6.8
15.Meghalaya	28.5	NA	NA	5.3	2.1
16.Mizoram	NA	NA	NA	37.7	7.7
17.Nagaland	20.0	NA	NA	4.8	1.2
18.Orissa	27.2	3.1	19.0	40.8	9.3
19.Punjab	26.3	3.1	21.0	74.2	34.9
20.Rajasthan	33.6	4.5	16.1	29.5	8.0
21.Sikkim	23.7	NA	NA	18.0	7.5
22.Tamil Nadu	19.2	2.2	20.2	56.2	12.3
23.Tripura	23.3	NA	NA	17.9	2.4
24.Uttar Pradesh	36.0	5.2	17.8	33.8	14.0
25.West Bengal	25.6	2.9	19.3	34.0	4.6
Four large northern States*	34.3§	5.0#	17.0	32.6	10.3
Rest of India	26.4§	3.2#	19.2	50.3	15.1

* Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh

§ Refers to Year 1991 # Refers to 1989

Sources: Registrar General, India. 1993. Sample Registration Bulletin:XXVII-1 (cols 1).

Ministry of Health & Family Welfare. 1991. Family Welfare Programme in India 1990-91. New Delhi: Ministry of Health & Family Welfare, (cols. 2-5).

Table A-3: Maternal mortality and health indices

	Maternal mortality ratio 1982-86	*% births delivered by trained attendants 1989*	*Population served by doctor 1990*
India	555	42.3	5848
1. Andhra Pradesh	402	51.9	1924
2. Assam	1028	26.8	3536
3. Bihar	813	25.1	8750
4. Goa	NA	NA	3411
5. Gujarat	355	54.2	2523
6. Haryana	435	82.1	13976
7. Himachal Pradesh	NA	45.0	11705
8. Jammu & Kashmir	NA	34.4	5350
9. Karnataka	415	57.1	1884
10.Kerala	234	91.8	1457
11.Madhya Pradesh	535	24.2	7213
12.Maharashtra	393	47.1	6803
13.Manipur	NA	NA	1179
14.Meghalaya	NA	NA	2629
15.Mizoram	NA	NA	5357
16.Nagaland	NA	NA	5123
17.Orissa	778	23.9	5401
18.Punjab	NA	85.0	6985
19.Rajasthan	938	21.1	5642
20.Sikkim	NA	NA	3295
21.Tamil Nadu	319	67.6	4297
22.Tripura	NA	NA	1165
23.Uttar Pradesh	931	27.4	3822
24.West Bengal	551	37.4	15438
Four large northern States*	823	25.4	5997
Rest of India	457	54.0	5750

* Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh

Sources: Mari Bhatt, P.N., K. Navaneetham and S. Irudaya Rajan. 1992. "Maternal mortality in India: estimates from an econometric model". Population Research Centre, Dharwad: Working Paper 24 (January), (col.1).

Ministry of Health and Family Welfare. 1991. Family Welfare Programme in India: Yearbook 1990-91. New Delhi: Ministry of Health and Family Welfare, (cols. 2-3).