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Strengthening Social Science Research on Women's Health

Lessons Learned From a Capacity Building Programme

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New Delhi

STRENGTHENING SOCIAL SCIENCE RESEARCH ON WOMEN'S HEALTH

Lessons Learned From a Capacity Building Programme

M. E. Khan
Bella C. Patel
John W. Townsend

POPULATION COUNCIL
NEW DELHI
September 2001

The Population Council is an international, nonprofit, nongovernmental organisation that seeks to improve the wellbeing and reproductive health of current and future generations around the world and to help achieve a humane, equitable and sustainable balance between people and resources. The Council conducts biomedical, social science, and public health research and helps build research capacities in developing countries. Established in 1952, the Council is governed by an international board of trustees. Its New York headquarters supports a global network of regional and country offices.

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FOREWORD

After the International Conference on Population and Development in 1994, there has been a phenomenal upsurge in interest to implement reproductive health programmes worldwide. The urgency to act has led to the development of disparate activities in several developing countries including India. But while programmes have been growing in numbers, their quality is in question. Several constraints have impeded the design and implementation of comprehensive, integrated reproductive health programmes to effectively address clients' needs. A fundamental problem has been the lack of capacity at all levels of the health service system to respond to the paradigm shift articulated by the advocates of the reproductive health and rights agenda.

There is a clear need to strengthen professional capacity in order to translate the change in paradigm. But for redesigning programmes at such scale, considerable research is needed. Research must be undertaken to understand health needs and the socio-cultural factors that effect the health of women, men, and young people. Operations research is needed to reorient health systems to effectively address clients' needs. A growing concern for women's health, scarcity of reliable data on reproductive health problems, and the lack of trained social scientists to undertake high quality research relevant for policies and programmes were the considerations that led to the development of this project. The project has aimed to strengthen professional capacity for undertaking multidisciplinary research on women's health in India.

I applaud the project team for its foresight in implementing this important project. It was designed to develop the capacity of both researchers in academic institutions, and NGOs working at the grassroots level, to generate quality data that could help shape evidence-based policy and programmatic decisions. A major challenge was to forge meaningful partnerships between academics and programme managers to work jointly on women's health issues. The focus of their research was on adolescent reproductive health, sexuality, domestic violence, health-seeking behaviours, unsafe abortion practices, quality of services, and other reproductive health and gender issues. Through the project, faculty from several different schools at the university, graduate students, and NGOs were trained in research methods. The project enhanced their understanding of reproductive health and the culture-specific nature of the relationships between women's health, sexuality, and gender relations. It resulted in the formation of interdisciplinary teams that jointly undertook research projects on areas of common interest.

An important lesson learnt through the project was that capacity building is highly time-intensive but that such investment is worthwhile as it results in long-term benefits. Modifications in teaching curricula, inclusion of qualitative methods in research initiatives, a focus on interdisciplinary research, and a greater attention to gender issues, and the social context of disease, were important outcomes of the project.

In this volume, the authors discuss how the process of strengthening social science research capacity was initiated and how it evolved through the engagement of multiple partners. A combination of disciplines, skills, expertise, and research methods provided the synergy to develop and implement the agenda. The need to strengthen research capacity in the country is a high priority. Policy planners, service providers, and researchers are all grappling with this challenging problem which must be addressed if the quality of services is to be improved. Considerable work is undoubtedly needed to achieve the goal of capacity development. This volume provides valuable insights and important lessons for future endeavours to strengthen professional capacity in India and other developing countries.

Saroj Pachauri
Regional Director, South and East Asia
Population Council
New Delhi

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We express our thanks to Dr. Michael Koenig who was Programme Officer at the Ford Foundation when the project was initiated. Dr. Koenig spent many days with us in planning the project. We would like to extend our gratitude to Dr. Saroj Pachauri, Regional Director, South and East Asia, Population Council, who valued and encouraged this activity and helped to ensure its smooth completion. We would like to convey our thanks to other Population Council colleagues including Dr. Anrudh Jain, Dr. Jim Foreit, Ms. Carol Hendrick, and Mr. Anil Paul for their sustained support and assistance in implementing the project. We greatly appreciate help provided by Ms. Anjali Nayyar in the publication of the volume. Ms. Jyoti Bahri's assistance in copy editing the document is acknowledged. We received valuable assistance from Ms. Shampa D'Costa in compiling the facts and figures for the document, and from Mr. Tapon K. Bose who provided outstanding secretarial assistance.

Finally, we want to convey our appreciation to our partners, the Society for Operations Research and Training and the Women Studies Research Centre for their collaboration, shared commitment, and collegial involvement throughout the implementation of the project.

M.E. Khan
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INTRODUCTION

Despite a vast health infrastructure, health care services in India are still not adequately reaching or serving the needs of women. The continuous decline in the sex ratio (i.e. number of females per 1000 males) during the last eight decades is one of several indicators pointing to this problem. During the past decade (1991-01) however, due to an increased focus on maternal and child health and legislation against sex selective abortion, the sex ratio has increased slightly from 929 in 1991 to 933 in 2001. This gain is marginal if one considers the trend of sex ratio at the state level. In 12 states, including many advanced states like Gujarat, Maharashtra, Punjab, Haryana, and Tamil Nadu the sex ratio has further declined during this period. Moreover, the sex ratio of the child population in the age 0-6 years has declined substantially from 945 in 1991 to 927 in 2001 (RGI, 2001). At the national level, the maternal mortality rate was estimated at 407 per 100,000 live births in 1998 (RGI, 2000), and these deaths account for almost 65 percent of all maternal deaths in South Asia. Indian women undergo an estimated 6.7 million induced abortions per year, mostly by unauthorised and untrained providers (Chhabra and Nuna, 1994). Several studies also demonstrate that the subordinate status of women in Indian society prevents them from accessing health facilities in the same manner as men. Further, the assumption that barring the reproductive function, men and women have the same health needs is wrong and it has led to the establishment of a health system that grossly neglects the overall health needs of women (Chatterjee, 1991; Pachauri, 1993; and Khan and Patel, 1993).

Other evidence suggests that the specific reproductive morbidity of women is also not being adequately addressed. One pioneering study which brought this point under sharp focus is that of Bang and Bang (1989) conducted in two villages of Maharashtra. The study revealed that 92 percent of the 650 women examined had one or more gynaecological or sexually transmitted disease, and that on average, each woman suffered from 3.6 infections. Bang's study was significant in India as it brought into focus issues of reproductive morbidity and sexuality which were neglected by most programme managers. Several studies, which were subsequently carried out, many of them supported by the Ford Foundation, corroborated these observations (Bhatia *et al*, 1995; Gittlesohn *et al*, 1994; BCC, CINI, SEWA-Rural and Streehitakarini, 1995; Jejeebhoy *et al*, 1995; CORT 1995). The lack of women's access to health services, the weakness of the existing health system in meeting their reproductive health requirements, and the tremendous variability in terms of quality of care available are some of the issues which are now being raised at various forums in India. The recent paradigm shift in the government's programme emphasis, withdrawal of method specific targets from the family planning programme and launching of the Reproductive and Child Health Programme by Ministry of Health and Family Welfare are a positive beginning to address the reproductive health needs of women (Pachauri, 1999; Khan and Townsend, 1999; Pathak, *et al*, 1999).

Lack of Data on Reproductive Health problems

Reproductive health is a broad programmatic area ranging from fertility awareness among adolescents to the needs of post-menopausal women. It also includes participation of men in reproductive health programmes from a broader gender perspective. Topics like postpartum care, unwanted pregnancy and abortion, quality of reproductive health care, sexuality and gender, sexual transmitted diseases, reproductive tract infections (STDs/RTIs), women's health seeking behaviour, the needs of special groups such as youth and men, and safe motherhood, among others are considered as part of reproductive health.

During the last one decade, particularly after ICPD, increasing attention has been paid to these topics. However, the studies which have been conducted are of varying quality and many of them lack programmatic focus. Yet a common finding is that the existing health delivery system needs substantial modifications before it can meet women's health needs, particularly in rural areas. However, planning and introducing significant changes in the system demands reliable data on programmatic aspects as well as contextual issues – why are women unable to avail the services; in what way would they like the services to be delivered; what are the programmatic constraints in meeting women's expectations, and how would these programmatic constraints be addressed for policy and programme strategy development. In the absence of such a database, proper planning and effective interventions in the system to improve access and the quality of reproductive health services are not only difficult but also run a high risk of failure. Thus, the first step towards making the health services responsive to women's health needs is to generate quality data which could help in shaping evidence-based policy and programmatic decisions. While information from other countries in the region on reproductive health is useful for framing the debate, specific information is required for formulating local strategies and sustaining the introduction of new services to improve women's health.

Lack of Trained Professionals

One of the challenges in generating a reliable database on reproductive health issues is the sensitivity of information on reproductive health problems. The task becomes more difficult because of the lack of trained professionals who can conduct sound substantive research on these issues, ethically and efficiently. Such studies are best done by a multi-disciplinary team consisting of both social and medical professionals. Furthermore, the complexity of the interrelationships requires that the team have access to expertise both in qualitative and quantitative approaches. Work with Indian colleagues suggests that while the skills required for undertaking qualitative research are limited, many social science professionals also lack experience in quantitative data management. Operations research, which is an excellent management tool for testing different programmatic alternatives for their effectiveness and economic viability, is rarely practiced by researchers and programme managers.

Thus, in the absence of trained personnel, research on reproductive health has remained neglected or at best, generated data which does not lead to making the health delivery system more responsive to women's reproductive health needs. This also presents a serious problem for the government as well as women's health advocates who seek to foster research on critical issues such as STIs/RTIs, maternal morbidity, and quality of care, among others. Given the serious scenario of

HIV/AIDS in India, training in reproductive health research has gained added importance and needs serious attention.

The problem of trained personnel cannot be resolved unless systematic and sustained efforts are made to train both producers (researchers) and consumers (programme managers) of research with a special focus on reproductive health. Theoretical and class room training is clearly insufficient to produce quality field research. The thrust should be on "learning by doing" and thus programmes to improve skill development should have a proper mix of

- Training
- Small grants for undertaking research, and
- Intensive technical assistance during the implementation of the project.

There are three constituencies which should be included in such an effort. First, the university setting where faculty members and young graduate students could be encouraged to undertake training and work on women's health issues. Attempts could also be made to introduce topics on women and development issues in existing courses or to introduce new courses on women's health, gender issues, research methodology, and the utilisation of data for policy development. Instruction on qualitative research methods and operations research should become an integral part of research methodology courses.

The second constituency is the NGOs, which are taking an active interest in women's health and gender issues. While their main interests are service delivery and advocacy, with some technical assistance, their influence could be made more extensive and their experiences could contribute significantly in improving the services of the public sector. NGOs working in the area of reproductive health and HIV/AIDS desperately need such support.

The third constituency is research organisations which could contribute significantly to programmatic research and provide technical assistance (TA) to NGOs. Further collaboration between research institutions and NGOs could lead to better quality programmatic research.

Institutional Constraints for Social Science Research in the University

There are many institutional constraints to building applied social science research capacity within university settings in India. They include:

- Low priority is given to social sciences. The availability of research grants and scholarships for graduate students is much more limited in the social sciences than in other faculties.
- Partly because of the chronic lack of opportunities and resources, senior staff has only limited interest in and exposure to applied social science research.
- While many of the faculty have excellent theoretical knowledge, they lack practical experience in conducting field studies, managing complex data sets and presenting data in a way to influence policy; skills which are critical for applied research.
- Senior faculty members who have the requisite skill's and could contribute significantly in developing this research capacity and promoting applied social science research in the university are often unable to do so because of lack of time and resources.
- As members of an academic community, researchers often suffer from a lack of contact and an understanding of the needs of users of applied research. The policy arena and service delivery sites are not the common venues for academic discussion, and the products of the research often reflect more a disciplinary

perspective rather than that of the policy maker or programme manager.

These limitations not only discourage programmatic research, but also limit faculty's ability to guide young colleagues or graduate students to take initiatives in applied research.

To strengthen the social science research capacity in a university, it is essential to create an environment in which young professionals can receive mentoring and be encouraged to undertake programmatic research on reproductive health. For this, they need opportunities for training in different research methodologies, data management, use of the computer as well as substantive training on issues related with reproductive health, STIs/RTIs, sexual behaviour, health seeking behaviour, the measurement of quality of services, among others. It is equally important to orient them about reproductive health delivery systems, the programmatic and management issues and how operations research could be useful as a management tool. Indeed, they also need access to small research grants to pursue their interests and apply the techniques they learn from the training. To ensure proper practices and assimilation of the skills learned, they need technical support in the implementation of the projects.

Given the present constraints, a strategy and leadership for strengthening social science research capacity on reproductive health from within the university appears less feasible. To begin with, it was felt that technical support and guidance perhaps could come from an organisation, like the Population Council, which is outside of the university, but nevertheless maintains close collaboration with their staff and enjoys their confidence.

THE FORD FOUNDATION INITIATIVE

The growing concern for women's health issues, the scarcity of reliable data on reproductive health problems for policy decisions and planning programme interventions, and the lack of trained social scientists who could address these complex issues, were the considerations which led the Ford Foundation to support three separate yet complementary projects in Gujarat to strengthen social science research in women's health. The institutions, which were selected to implement these projects were: Women's Studies Research Center (WSRC) of M.S. University, Society for Operations Research and Training (SORT) — a non-government organisation, and the Population Council. While M.S. University and SORT were based in Baroda, to facilitate close interaction with them and the grantees, Population Council decided to maintain an office at Baroda with two key professionals who were responsible for this project. The focus of all three efforts was capacity building in social science research with a special emphasis on women's health. However, the constituency and approach of the three participating organisations varied, depending on their activities and understanding with the funding agency (the Ford Foundation). Briefly, WSRC was mainly responsible for training faculty and research scholars in research methodology with emphasis on qualitative research, networking with various departments to strengthen social science research capabilities at the university level, sensitising them about women's health problems, gender issues, and encouraging them to take on research on women's health and related reproductive health issues. It was also envisaged that, wherever possible, an attempt would be made to incorporate these issues in teaching curricula. Besides, WSRC was also expected to establish a well equipped documentation center on women's issues, including their reproductive health problems.

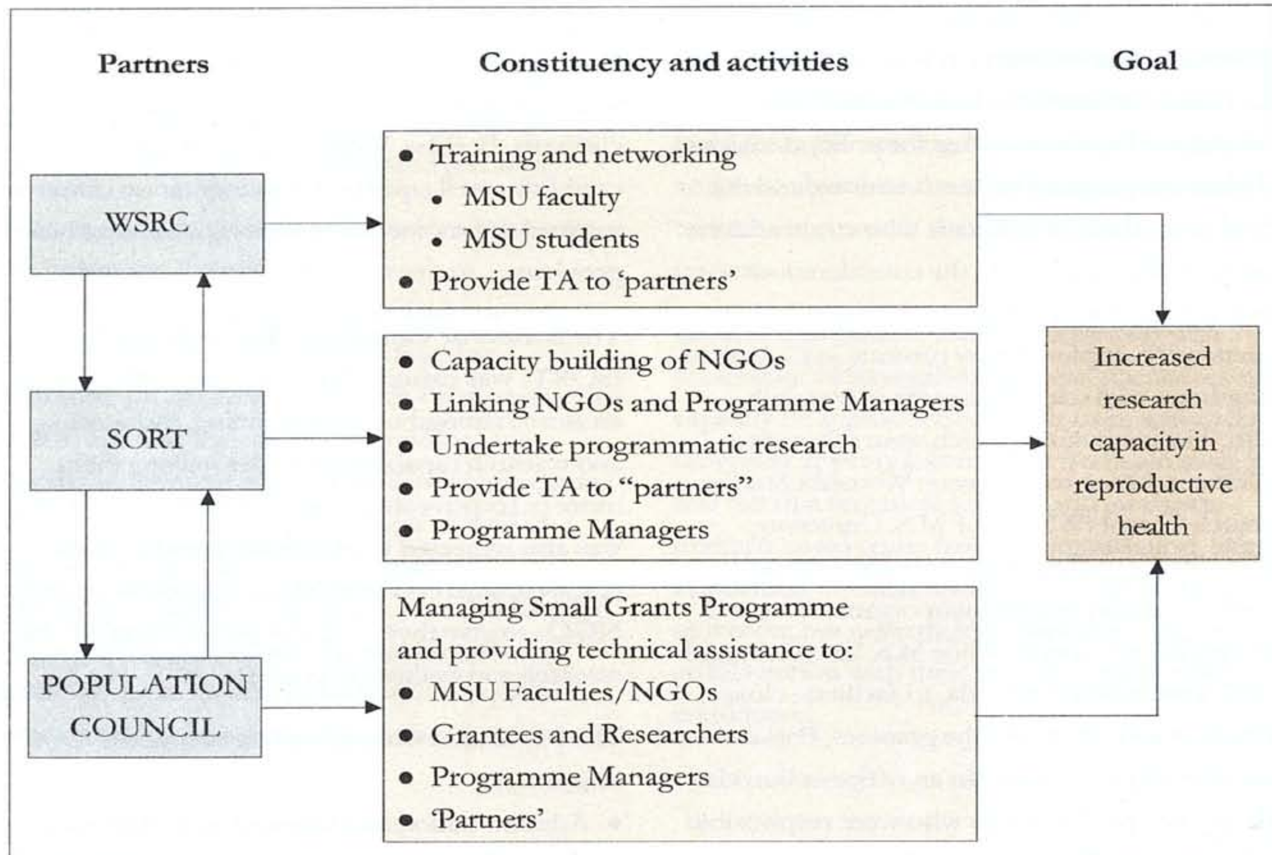
The Society of Operations Research and Training (SORT) was expected to work with NGOs with an aim to strengthen their planning, monitoring, and research capabilities besides making them more perceptive to women's health needs. SORT was also expected to undertake programmatic research, wherever possible, in collaboration with NGOs to give them "on-the-job training" in the research and evaluation process.

The Population Council had three specific objectives:

- Administration and management of a Small Grants Programme to encourage young and mid-career faculty members of M.S. University, as well as other social scientists/researchers in Gujarat to undertake research on women's health, particularly on issues related to their reproductive health problems,
- Provision of regular technical assistance to its grantees to improve their research capabilities and to ensure a high quality research product, and
- Advocacy to increase the utilisation of research findings. Apart from this, the Population Council was also expected to provide technical assistance to WSRC and SORT in their capacity building efforts (Figure 1).

Figure 1

The Three Partners and Their Work Constituencies



While developing terms of reference, no formal linkage or partnership was conceived. However, the fact that all the three organisations (WSRC, SORT, Population Council) were based in Baroda was helpful. It was decided that the three 'partners' would concentrate on new priority topics. It was felt that such a strategy would help in building a body of knowledge on the selected priority topics rather than diffused efforts. This would also help the three partners to collaborate with each other in carrying out research and providing technical assistance. Accordingly, after discussion, the following topics were decided as priority areas of research:

- Adolescent health and sexuality
- Domestic and sexual violence
- Males as partners

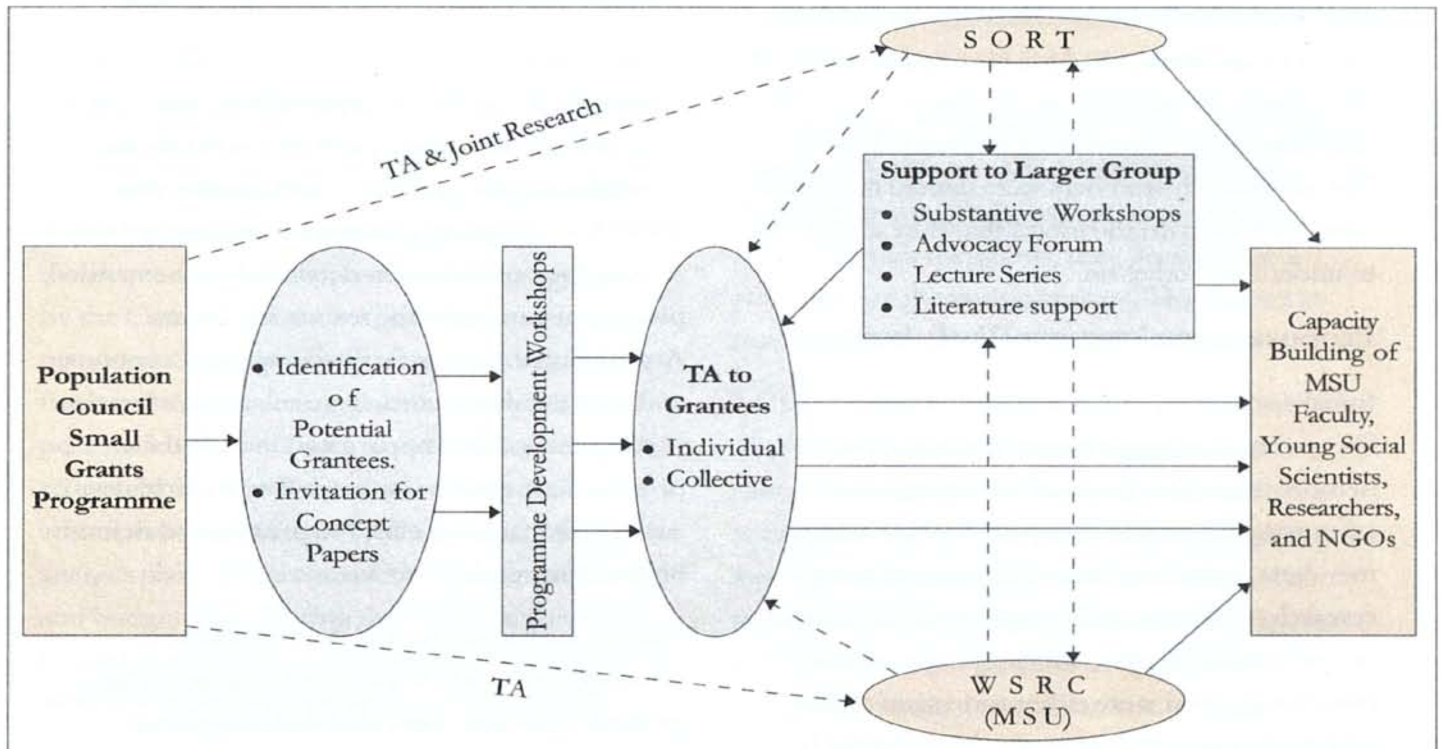
As a result of this decision, many of the activities of the Population Council, SORT, and WSRC clustered around these three broad areas of interest. Occasionally, they interacted and helped each other in organising workshops and providing technical assistance when required. The conceived 'model' or 'partnership' was, however, never fully implemented. This issue will be further discussed in another section at the end of this publication.

SMALL GRANTS PROGRAMME

The Small Grants Programme was conceived as the main vehicle for strengthening the research capacity of young M.S. University faculty and researchers in other organisations. Hence, the process of identification of potential grantees and subsequent technical assistance provided to each grantee became a critical component of this project and consumed a substantial proportion of the Council's professional time. Besides the provision of research grants to a small number of selected professionals, other initiatives aimed at reaching a larger number of researchers were also taken. They included organising substantive workshops to create opportunities for young social scientists to participate in; a lecture series with distinguished scholars to provide opportunities to a larger number of researchers and programme managers for professional exchange; the creation of an advocacy forum to involve different professionals and institutions to undertake evidence-based advocacy for reproductive health problems; and finally, disseminating key publications on reproductive health research to a large number of researchers and institutions within and outside Gujarat state. All these activities complemented each other and helped in capacity building in social science research. Figure 2 presents a diagram of the overall strategy which the Council adopted to implement this project. In the following sections, the process is briefly described to give a clear picture how the project was implemented.

Figure 2

Diagram of Small Grants Programme Activities and Coordination With Partners



Identification of Potential Grantees

The practice generally followed in managing research awards programmes includes the distribution of a project brochure, making the announcement about the grants and inviting proposals for funding. However, in the present project, a proactive approach was adopted for identifying potential researchers for the small grants. The Project Director and Programme Officer visited various departments of M.S. University (MSU) and other institutions located throughout Gujarat, talked with senior faculty members, explained the objectives of the programme and asked for names of possible counterparts who could take advantage of the Small Grants Programme.

This process was repeated several times during the programme. Attempts were made to involve as many academic departments and institutions as possible. Apart from institutions based in Baroda, other cities which were visited several times included Ahmedabad, Surat, Rajkot, Karamsad, and Vallabh Vidhyanagar. However, as the focus of the programme was M.S. University (MSU), in the initial years more attention was given to MSU departments and institutions located in Baroda. The identified researchers were invited to submit concept papers on the topics that they would like to undertake studies on.

Proposal Development Workshops

Initial discussions with potential researchers and the quality of concept papers received clearly demonstrated that most of the young social scientists, and even in some cases senior faculty members, lacked the skills of conceptualising research problems, defining the methodology to be used and writing a coherent proposal. The topics suggested were either too vague or too ambitious. Similarly, the methods suggested for data collection were often inappropriate. In several cases, multiple qualitative approaches (often four or more) were suggested for data collection without any justification as to how the multiple data sets would be analysed or used.

Considering these limitations, it was decided that to generate good proposals as well as to train potential researchers in proposal writing and research methodology, proposal development workshops would be organised. To do this, on the basis of concept papers submitted, potential researchers were selected and invited to proposal development workshops. All selected researchers were provided with guidelines listing different components of a good proposal and were asked to come to the workshop with their draft proposals. The topics covered in the proposal development workshops included: components of a good proposal, conceptualisation of the problem, research questions, hypotheses, research design, research methodology for data collection, data management and analysis, ethical considerations, time schedule, and budgeting.

In each workshop, depending on the topics of the proposals, a number of experts from that area were invited as resource persons. Generally the ratio of resource persons to participants was about 1:4. The participants were encouraged to discuss their proposals in detail and over extended periods of time with the resource persons. Availability of logistic facilities such as computers and secretarial assistance were ensured so that the participants could improve and modify their proposals on day-to-day basis. On the final day, each participant was asked to present and defend his/her proposal.

During the project period, two proposal development workshops were organised. The professionals who extended their support as

resource persons are alphabetically listed in Appendix 1. At the end of the workshop, the participants were given one month to revise their proposals on the basis of the comments given during their presentation. They were also encouraged to consult any of the resource persons including Population Council staff at Baroda, by mail, e-mail, or even personally, if they needed any further guidance in modifying their proposals.

Review Process of Proposals

While considerable technical assistance and guidance was provided in developing the proposals, a very strict standard was maintained in the review of proposals for funding. Following the WHO pattern for such a review process, a Proposal Review Committee was formed. The committee members were selected on the basis of their expertise and recognition of their work internationally. During the project period, 10 professionals worked as members of the Proposal Review Committee at one time or another. The members names and institutional affiliations are listed in Appendix 2.

The Committee met once every year. During the project period it met four times to review the proposals submitted for funding. All proposals were the outcome of the two proposal development workshops which were organised by the Council. All the committee members were provided the proposals at least one week before the committee meeting. For each proposal two peer reviewers were appointed and they were requested to critically review the proposals for appropriateness of the objectives, study design, analysis plan, ethical considerations, time schedule, and budget plan. During the Proposal Review Committee meetings, the two peer reviewers were first asked to present their views on the proposal. On the basis of their presentations and subsequent discussion in which all the members participated, the proposals were voted and put into one of the following four categories:

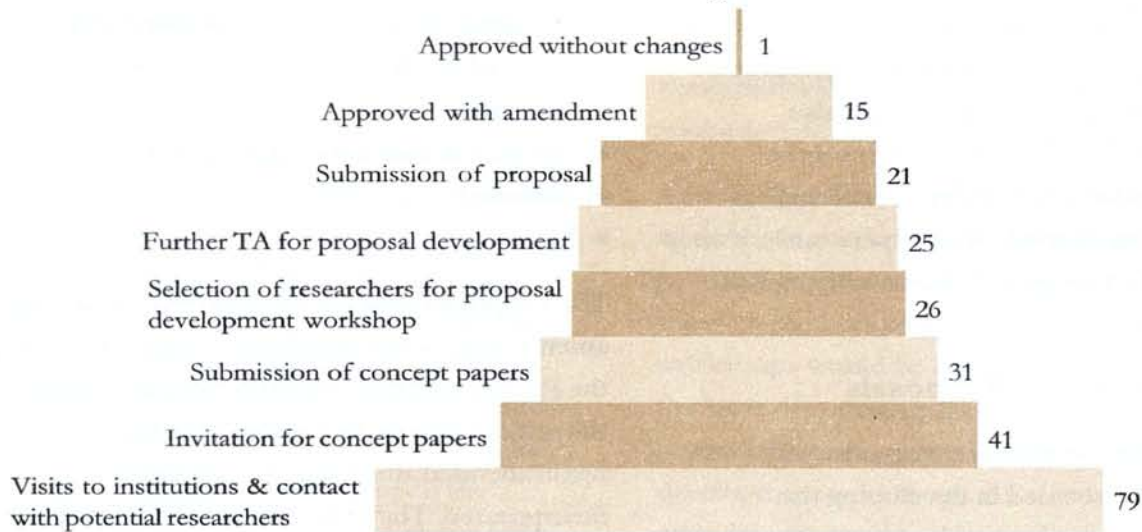
- Approved
- Approved with minor amendments
- Deferred
- Rejected

The proposals which were approved with minor amendments were considered as approved and the Project Director was empowered to sanction the project after being satisfied that the recommended amendments have been incorporated. The Principle Investigators of the deferred proposals were encouraged to submit the proposal again. If required, they were also provided technical assistance in modifying their proposals on the basis of the comments given by the Proposal Review Committee. These proposals were again reviewed by the full committee during the next Review Committee meeting. The investigators of rejected proposals were provided detailed comments on the reasons why their proposals were rejected and they had a choice of resubmitting them after modifications.

As the Project Director and Programme Officer were involved in proposal development and providing technical assistance to the aspiring researchers for the grants, they decided not to participate in the voting process. This helped in maintaining the impartiality in the selection process.

The whole process of identifying potential researchers, the development of proposals, the review process and finally the sanctioning of awards was labour intensive and consumed a significant amount of professional time. Figure 3 presents the whole process of the awards sanctioned under this programme.

Figure 3



Projects Funded

During the Small Grants Programme, a total of 16 small grants were sanctioned and implemented. The list of the projects, methodologies used for data collection, and the duration of the project is given in Table 1. As the table shows, the Small Grants Programme was instrumental in promoting interest in important and critical issues of reproductive health problems. The wide range of issues that the studies addressed included reproductive health morbidities (e.g. post abortion complications, pelvic inflammatory diseases), quality of emergency obstetric care and postpartum services, adolescent health and sexuality, STDs, male involvement and violence against women.

These projects exposed the researchers to a wide range of complex issues related to women's health. Considering the complexity and sensitivity of the research issues, the awardees had to use multiple approaches to collect complementary data to understand the problems in the given socio-cultural and economic contexts. In some cases, up to six different approaches were used for data collection (see Table 1). Analysis of multiple data sets and integration of the findings to draw precise conclusions are difficult and researchers need experience as well as analytical skills. The small research grants provided them an opportunity to *practice* research by doing it. Provision of technical assistance at each stage of the project was a useful component of this programme and helped researchers in sharpening their analytical skills and provided experience in managing and analysing qualitative data and using qualitative-quantitative methods as complementary approaches.

Reports of their studies are interesting, with some significant findings, though of varying quality. A two page summary of each of the funded projects is provided in part II of this report. A copy of the full report of each of the studies can be obtained by writing directly to the authors. Their contact addresses are given in the respective research summaries.

Table 1

Selected Details of the Studies Supported Under Small Grants Programme

Title of projects	Principal Investigator	Methods used for data collection	Duration of the study
Unsafe abortion: socio-behaviour study	Dr. Nandita Maitra	• Analysis of hospital records • Informal discussion • In-depth interviews • Key informant interviews	12 months
Health seeking behaviour of pelvic inflammatory disease patients visiting a tertiary hospital at Vadodara	Dr. P.V. Kotecha	• Analysis of hospital records • In-depth interviews • Semi-structured interviews	12 months
Reproductive health status of middle-aged women	Dr. Parul Dave	• Survey • Informal discussion • In-depth interviews	9 months
Women's reproductive health: Understanding the socio-psychological context	Dr. Shagufa Kapadia	• Social/body mapping • Survey • In-depth interviews • Semi-structured interviews • Key-informant interviews • Focus group discussions	12 months
Quality of reproductive health services at Community Health Centres – An in-depth study in rural Gujarat	Dr. R. A. Ansari	• Situation Analysis • Analysis of hospital records • Exit interviews • Informal discussion • Direct observations	9 months
Quality of care in family planning services available to women in Vadodara city	Dr. Sandhya Joshi	• Exit interviews • Informal discussion • Case studies • Key-informant interviews • Client flow analysis • Direct observations	10 months
User conscious environment in the health sector	Ms. Brintha Lakshmi	• Informal discussion • Direct observations • Social mapping • Case studies	12 months
Mother's perceptions of post partum health care needs and problems in hospitals: A case study from Vadodara	Dr. Rajalakshmi Sriram	• Analysis of hospital records • Informal discussion • In-depth interviews • Key-informant interviews • Focus group discussions	12 months
Reproductive health seeking behaviour of married adolescent girls study in urban slums of Ahmedabad	Dr. Alka Barua	• Survey • In-depth case study • Focus group discussion	9 months
Knowledge, awareness, beliefs and practices on sexuality and reproductive health of adolescents in slums of Ahmedabad	Ms. Pallavi Patel	• Survey • In-depth interview • Focus group discussion	8 months
Sexuality and health seeking behaviour among out-of-school adolescents in Anand slums	Prof. C.N. Daftuar and Dr. Urmi Biswas	• Survey • Social mapping • In-depth interview • Focus group discussion • Observation	9 months
Family life education to secondary school students: An operations research	Dr. Bimal Kumar Sinha	• Social mapping • Key informant interviews • In-depth interview • Survey	9 months
Domestic violence in rural Gujarat	Ms. Usha Nair	• Survey • In-depth interview • Focus group discussion	12 months
Marital violence: Its impact on health – Women's perspectives	Ms. Bhavna Mehta	• Free listing • In-depth interview • Survey	9 months
Treatment seeking behaviour of STD cases attending Skin and VD department and private clinics in Vadodara	Dr. Yogesh Marfatia	• Analysis of hospital records • Semi structured interviews • Case study	9 months
Young men's perceptions of their own reproductive health in a slum of Vadodara	Dr. N. Rajaram	• Social mapping • Survey • Focus group discussion • Case studies	8 months

Note: M. S. U. -- Maharaja Sayajirao University

Technical Assistance to Grantees

As part of research capacity building, the Project Director and the Programme Officer at Baroda made all the efforts to provide grantees with continuous and sustained technical assistance (TA). The technical assistance was provided in two forms:

- Individual technical assistance
- Collective technical assistance

Individual Technical Assistance

In the case of individual TA, generally the Principal Investigators and members of their research teams (often M.Phil./Ph.D. students) visited the Population Council office at a pre-fixed time. Generally these consultations concentrated on reviewing their questionnaire and data collection guidelines, code structure, data analysis and tabulation plan, analysis of case studies and qualitative data, and presentation of findings in the report. Such individual technical assistance was beneficial not only for the Principal Investigators but also for a number of post-graduate students who worked in these projects as research assistants or participated in these studies as part of their M.Phil. dissertation work.

The amount of individual technical assistance provided to the Principal Investigators and their research teams was compiled. The need for such technical assistance on a one-to-one basis varied substantially and ranged between 13 hours to 65 hours. A total of 505 hours of professional time was spent in providing such individual TA. These technical assistance sessions were spread over different stages of their research work. On an average, for each research team at least four TA sessions were held. In some cases it was as high as 11 times.

The time spent by Population Council staff in reviewing their questionnaires, analysis plans and draft reports in their office (but not sitting with the Principal Investigator) or at home was also substantial but has not been included here.

Group Technical Assistance

In this case, instead of one resource person providing technical assistance to a Principal Investigator and his/her team, a formal meeting was organised in which Principal Investigators shared the experience of their fieldwork with the group and sat with a team of two or more resource persons to discuss their activities. During the programme, three collective technical assistance sessions were organised. Some of the topics, which were covered in these collective technical assistance meetings were: ethical issues, study tools, data analysis, and the chapter plan of the report. Research gaps and issues related to adolescent health and sexuality, domestic and sexual violence, and involving men as partners were also discussed in these collective meetings. Conceptual and methodological issues, however, were the main concern of all these discussions. Generally the collective technical assistance was provided just before or at the beginning of a specific activity. For instance, assistance on data analysis was organised for the group of Principal Investigators who were planning to start their data analysis. Technical assistance and interventions at these stages were found to be very productive and helped the grantees to organise themselves more effectively. Such technical assistance, particularly for the analysis of qualitative data, was found very useful and timely. A list of the resource persons who helped in such consultations is provided in Appendix 3.

Review and Approval Process of Project Reports

Each report of the studies funded under the Small Grants Programme was reviewed by two experts before its acceptance. They were chosen on the basis of their expertise and research experience in the areas related to the topics under review.

This review process was less an administrative requirement and more of an effort to provide a last bit of technical assistance to the grantees for improving the quality of their reports.

Accordingly, the reviewers were requested to give detailed comments. They were also requested that while they should review the study reports critically for their scientific rigor and presentation, comments should be *detailed and constructive* so that the grantees could use it for improving the quality of their reports. The art of brief but focused report writing and to an extent English language and scientific writing clearly emerged as major weaknesses of most of the researchers and should be a focus of any future capacity building effort. The list of experts who reviewed the reports is provided in Appendix 4.

SUPPORT ACTIVITIES FOR A LARGER GROUP

Apart from providing small grants to selected social scientists and researchers, certain activities under this programme were carried out with an intention to reach a larger group of social scientists and programme managers. They included national level workshops on substantive issues, lecture series of distinguished scholars, networking with professionals and institutions interested in advocacy, allowing students and researchers to use the Population Council library and literature support to a large number of professionals, programme managers and institutions from all over the country. Brief overviews of these activities are presented below.

Workshops on Substantive Issues

Apart from proposal development workshops and technical assistance, three national workshops on substantive issues were also organised. Generally these workshops were on issues which were critical from a reproductive health perspective and/or were of particular programmatic importance. The purpose of these workshops was to sensitise the researchers on these issues, identify priority areas of research, discuss methodological issues in conceptualising research problems, and stimulate the potential grantees to undertake studies on those topics.

The workshops were instrumental in stimulating many researchers to develop proposals in the priority areas identified by the programme namely, adolescent health and sexuality, male involvement in reproductive health and gender-based violence. As a result, four studies on adolescent reproductive health, and two each on male involvement and gender-based violence were funded under the Small Grants Programme (see list in Table 1). The topics and broad agenda of these national workshops are presented in Boxes 1-3.

BOX 1

Male involvement in reproductive health and contraceptive use: Research priorities and methodological issues
April 30 - May 2, 1997

- Defining male involvement: Putting the issues in context
- Male responsibility in family formation
- Male reproductive health
- Experiences from male involvement projects
- Findings from the field studies
- Research priorities and methodological issues

BOX 2

Status of reproductive health of women in Gujarat
January 8-9, 1999

- Health seeking behaviour of women suffering from reproductive health problems
- Quality of service in Family Welfare Programme: Client's perspective
- Adolescent health and sexuality
- Lessons learned from Operations Research projects in reproductive health
- Experience of capacity building in social science research in reproductive health: What have we learned?

BOX 3

National Workshop on enhancing utilisation of research findings
September 6-9, 1999

- Dissemination and utilisation of research: Concepts and frame work
- Setting dissemination objectives and plans
- Strengthening presentation skills
- Segmenting target audience
- Packaging of research findings
- Interacting with media to increase utilisation of research findings.

Two of these workshops were pioneering in nature. The workshop on male involvement in reproductive health was the first of its kind in India and helped in collecting information on various research initiatives being taken in this area. The information collected was compiled in the form of a volume before the workshop and distributed to the participants. Requests for this volume were received subsequently from different national and international agencies. It was also placed on display at an international workshop organised by AVSC in Mombassa, Kenya on "Men as Partners". This workshop also worked as a starting point for another Population Council project on men's responsibility, funded by the MacArthur Foundation and publication of a book on *"Men in Bangladesh, India and Pakistan: Reproductive Health Issues"*. The book, co-authored by the Project Director, was simultaneously published in India and Bangladesh.

Similarly, the training workshop on Enhancing Utilisation of Research Findings was pioneering in India and was organised at the national level. Apart from the 16 grantees, several senior faculty and the Directors of Population Research Centres such as IIPS Bombay, IIHMR Jaipur, PRC Patna, PRC Pune, PRC Dharwar, and FPAI Bhopal also attended the workshop. A number of top programme managers, such as the Additional Chief Secretary, Gujarat and Additional Secretary, Health and Family Welfare, Government of Bangladesh also attended this workshop. In the four-day workshop, the participants were oriented on the role of researchers in enhancing utilisation of research, segmenting potential users of research findings, communicating with policy makers, techniques of effective presentation, using media for dissemination of research findings, techniques for preparing press releases and writing case studies. Communication Officers from Population Council's office in Cairo, Ms. Sahar Hegazi, and regional office in Delhi, Ms. Anjali Nayyar, acted as resource persons.

The training workshop was highly appreciated for its usefulness and the participants evaluated it very positively. Many of the senior faculty members who participated from other institutions expressed the intention to replicate it in their own organisation. The Additional Secretary of Health and Family Welfare, Mr. D. K. Nath, from Bangladesh attended all the four days and has formally requested Population Council Office, Bangladesh to replicate it in Dhaka. The evaluation of the workshop by the participants is presented in Table 3.

Table 3

Participants' Evaluation of the Workshop

	Percentage
Workshop was very useful	100
Skills learned in the workshop	
• Preparing brief summary for policy makers	50
• How to disseminate research findings to policy makers, media, and donor agencies	35
• Segmentation of target audience	40
• Keeping dissemination and utilisation of research findings as an objective of research	15
Sessions found very useful	
• Dissemination and utilisation of research: Conceptual framework	55
• Packaging of research findings into messages	60
• Preparing research summaries for press release	45
• Strengthening presentation skills	45
• Setting dissemination objectives	30
Reading materials provided were very useful	95
Length of the workshop was appropriate	70
Would strongly recommend other colleagues to attend this workshop	95
Total participants	**25**

Lecture Series for a Larger Audience

Population Council office in Baroda was frequently visited by well known national and international staff. To take advantage of their visits, the Population Council initiated a lecture series for a larger research audience. Accordingly, during the programme five lectures in collaboration with WSRC and SORT were organised. The topics covered in these lectures included:

- Strengthening social science research in reproductive health;
- Post ICPD: Monitoring the Family Welfare Programme in India;
- Advocacy on reproductive health;
- Incidence and cost of treating reproductive health diseases in rural Karnataka; and
- Country specific reproductive health indicators.

The list of those who participated in the lectures is given in Appendix 5. The main aim of the lecture series was to discuss the concept of reproductive health and provide a forum for local professionals to interact with researchers of international repute. Around 45-60 persons including university faculty members and their Ph.D. students, professionals of other research and consultancy organisations, and district level programme managers attended each of these lectures.

Advocacy for Reproductive Health

Another activity, which the Council promoted, was facilitating individual professionals and institutions to work together to advocate for reproductive health and women's empowerment. The purpose of this initiative was to bring various institutions and professionals together at a forum to discuss effective advocacy strategies that were based on research findings.

To encourage this process, the Population Council organised two half-day meetings of a few institutions/NGOs, which are actively involved in advocacy or were interested in collaborating in such activity. The institutions invited were CHETNA and SEWA from Ahmedabad and WSRC, CORT, and BCC from Baroda. Some of the issues which were discussed include: What do we mean by advocacy? What are the different approaches and strategies that could be used for doing effective advocacy work? Who are the audiences? How does the strategy change with type and location of the audiences? The core group also identified some professionals in communications and advocacy to share their experiences with the group. The areas which the group considered for their focused work included women's health, particularly reproductive health, youth and adolescent sexuality, the girl child, male involvement, and the empowerment of women.

To give the advocacy activities more visibility and sustained support in Gujarat, it was decided that the Advocacy project of the Population Council, Delhi, which was also funded by the Ford Foundation, would take over the work initiated under the Small Grants Programme. Accordingly, in January 1998, the core group in collaboration with the Advocacy project organised a two-day workshop on Advocacy for Reproductive Health in Gujarat to share experiences on various issues related to reproductive health and arrive at a common understanding. The workshop also provided a forum to formulate the short and long term strategies necessary for advocating reproductive health in Gujarat.

Literature support

One of the serious limitations in developing research capabilities of young professionals is the inaccessibility of the current literature and research findings on the subject. This is particularly true for the publications from abroad. Most of the Indian libraries, and more so the libraries of small research centres attached with various departments and universities, have extremely low budgets to purchase new publications, e.g. as low

as Rs. 5,000 (US$ 107) per year. During this programme, a serious effort was made to increase their access to the recent literature on population, reproductive health, and women's empowerment and gender issues. The faculty as well as M.Phil. and Ph.D. students from the M.S. University were encouraged to use the Population Council library. In two and half years more than 44 students and researchers from 15 departments of MSU and other institutions extensively used the Council library. Out of these, 21 were M.Phil. or Ph.D. students.

Besides relevant literature including publications from Population Council, PRB Washington, and other institutions were collected and distributed to professionals, Population Research Centres, selected NGOs and departmental libraries. More than 75 institutions in the country benefited from this literature support programme of the Council. Over the period, more than 150 different publications and resource materials were distributed.

ACHIEVEMENTS AND LESSONS LEARNED

An important question to ask is to what extent have the objectives been achieved? What are the lessons learned? Were there missed opportunities? What modifications should be made to make capacity building efforts more effective?

The objective of the Small Grants Programme funded by the Ford Foundation was to *strengthen* the *skills* of researchers, particularly the young faculty members of M.S. University in carrying out social science research on women's health. The approach envisaged in the proposal and actually implemented consisted of: identification of *potential* faculty members and researchers and helping them in improve their analytical skills through a 'hand holding' approach. Such an approach demands extensive technical inputs at *all stages* of research, from the development of proposals to dissemination of research findings. Thus, researchers acquire the requisite skills by actually doing the projects. It is our belief that under the Small Grants Programme all the faculty and researchers who have undergone this orientation process have acquired and sharpened their analytical and research skills. We also expect that their enhanced research capacity will lead to better teaching and guidance to their students - two critical elements for improved human resource development.

Any initiative aimed at strengthening the research skills of faculty in a university setting is presumed to have a long lasting impact and the benefits of such interventions should be observed over several years in the form of better teaching, research and guidance to their students. Given the conducive administrative environment in the university and funding opportunities for research, it may also lead to more applied and programmatic research. As a result, out of the 16 research grants, 12 were awarded to teaching faculty while of the remaining four, two each were awarded to NGOs and research organisations.

Instead of concentrating all efforts on one or two departments, conscious attempts were made to encourage different departments of the University to avail the opportunity offered by the Small Grants Programme. As a result, out of the 12 faculty who received the grants, seven belonged to five different social science departments, four were from different departments of the medical college and one from the department of Architecture of M.S. University (see Table 4).

Table 4

Departments and Institutions Which Received Small Grants

Department/Institution	No. of Grants
Teaching Faculty	12
NGOs	2
Research Organisations	2
Total	**16**
Grants to Teaching Faculty	
Social Science	**7**
- *Human Resource Development and Family Studies (HDFS)*	3
- *Faculty of Social Work*	2
- *Dept. of Psychology*	1
- *Dept. of Sociology*	1
Medicine	**4**
- *Dept. of Obstetrics/Gynaecology*	1
- *Dept. of Preventive and Social Medicine*	1
- *Dept. of VD/STI*	1
- *Dept of Psychiatry*	1
Others	**1**
- *Dept. of Architecture*	1

The award of grants to different departments of the university contributed significantly in creating an environment at the university level, which is today, more sensitive to women's health issues and supports their faculty and students to undertake applied research.

The two other factors which contributed to the achievement of some of these objectives and to the smooth implementation of the Small Grants Programme were: (a) Ford grant to WSRC for training and networking of faculty and students in social science research on women's health, and (b) the presence of a very dynamic and sensitive Vice Chancellor, Mrs. Padma Ramachandran. While WSRC through its trainings and networking efforts tried to sensitise the faculty and students about women's issues and thus created a *'demand'* for small grants, the V.C. of the university, Mrs. Ramachandran, who is dedicated to women's causes and applied research, ensured that administrative bottlenecks did not become a discouraging factor for the faculty to implement the small grants projects.

The activities of WSRC and Population Council were independent of each other. Yet, the synchronisation of the timing of the two programmes contributed positively to each other. This synchronisation was intentional and planned by the Ford Foundation. It is hoped that the joint impacts of the two projects will be reflected in various ways, including:

- Sustained interest of faculty in applied research, particularly on issues related to women's health and their empowerment;
- Inclusion/expansion and strengthening of research methodology courses, particularly qualitative approach, in the curriculum of various departments and its application in programmatic research;
- Encouragement of M.Phil and Ph.D. students to undertake their dissertation on topics related to women's health, gender issues, and women's empowerment;
- Improved quality of research and guidance by the faculty members; and
- Taking a more pro-active role in enhancing the utilisation of research findings.

An assessment of the extent to which the programme objectives are achieved can only be made after several years. But to appraise how far the above listed expectations are correct, ten grantees of the project were interviewed one year after completion of the project. All of them were asked whether the programme had made any difference in their teaching or research activities of their departments. Their response clearly shows some positive results and gives confidence that a beginning has been made in the right direction. These processes and findings of the interviews from the ten grantees have been discussed below.

Training of Young Professionals

To create opportunities for young social scientists to get training, all the Principal Investigators, particularly faculty from the M.S. University, were encouraged to engage their students as research assistants in their projects. To increase student involvement in these studies, the investigators were told that the Population Council would not have any objection if data from these projects were used for their M.Phil./Ph.D. dissertations. They were also told that the students could collect additional data along with the project activities to facilitate their dissertation work. As a result, 41 young social scientists and physicians benefited from the Small Grants Programme.

They had ample opportunities to learn about research methodology, and particularly how quantitative and qualitative approaches taken together could strengthen the study design and provide a more comprehensive understanding of

the issues under study. They also had several opportunities to attend workshops on methodology, data collection techniques, analysis and data management, use of the computer and report writing organised by WSRC and SORT as well as the Population Council. Besides, these young social scientists and students had opportunities to discuss or present their project activities in various meetings and received feedback. All these opportunities significantly contributed to their professional growth as well as enhanced their understanding of women's health problems and broader gender issues. It is hoped that their participation in these learning processes will serve as a foundation in their future professional life.

A list of the students and young professionals who worked on the studies sanctioned under its Small Grants Programme is given in Appendix 6. As the table shows, out of 41 young professionals who participated in the studies, eight used the data from the studies to write their dissertation or at least used a portion of the data to supplement their other data sets for writing their dissertation.

Our recent survey of the grantees shows that of the two research assistants who worked in the male involvement project, one enrolled in a Ph.D course and his thesis is on "reproductive health needs of young men in different segments of population". The second research assistant has become an activist and is working for human rights with special focus on women. Yet another research assistant, after completing her Masters degree in Home Science, joined a leading research organisation and now is actively involved in reproductive health research.

Appreciation of the Importance of Inter-disciplinary Research

It is satisfying to note that during the programme, an appreciation of the needs of inter-disciplinary teams to address women's health issues increased significantly. At the initial stage of the Small Grants Programme, we faced resistance from a few senior social science faculty on the inclusion of medical faculty as possible recipients of the small grants. However, soon these reservations disappeared and the interaction between the faculties of the Medical College, Baroda and WSRC increased significantly. One of the members of WSRC's core team is a senior faculty member of the Medical College. Medical College faculty also expressed keen interest in participating in this programme. As a result, out of the 12 small grants to teaching institutions, four were awarded to various departments of the medical college. All the four studies were conducted by multidisciplinary teams, consisting of medical experts and social scientists. As part of one of the small grants awarded to the Preventive and Social Medicine (PSM) Department, a three-day training course on qualitative methods was organised at the Medical College. A majority of the participants were medical faculty who were interested in using qualitative methods to better understand issues in reproductive health, while most of the resource persons were social scientists from MSU, WSRC, SORT and the Population Council. Dr. Pertti Pelto, Consultant, the Ford Foundation / Johns Hopkins University also participated as a resource person. The medical doctors found the workshop very useful and appreciated the potential and usefulness of social science skills in understanding the health-seeking behaviour of their patients. This workshop led to the foundation of a very healthy relationship between medical college faculty and various social science research organisations in Baroda including WSRC, various social science departments of MSU, Center for Operations Research and Training, SORT and the Population Council. It also led to the development of two more proposals from medical colleges, which were

funded under the Small Grants Programme. During the programme, several inter-disciplinary research projects were initiated in which two or more organisations from different disciplines worked together to achieve the study objectives (see Table 5). It is hoped that with time and proper funding, such professional interactions will further increase and more inter-disciplinary research will be undertaken. The recent survey of grantees indicates that these expectations were not unfounded and in many new initiatives they are collaborating with each other. These include:

- Continued participation of medical faculty in the core team of WSRC
- Participation of Dr. Marfatia (Department of Skin and VD) and Dr. Baxi (Department of Preventive and Social Medicine) in a new initiative by CORT to establish a human laboratory covering 30 villages for testing various community, health and management interventions to strengthen male involvement, adolescent health and livelihood opportunities for youth
- Working with media to sensitise the public on issues like adolescents' need, sexuality, women's health and gender inequality.

Table 5

Inter-disciplinary Projects Developed in Collaboration with Other Organisations/Departments

Name of the Study/ Activity	Collaborative Organisations/ Departments
Treatment seeking behaviour of STD cases attending skin and VD department	• Skin and VD Department, SSG Medical College • Two private VD Clinics • The Centre for Operations Research and Training, Vadodara
Influencing sexual behaviour of truck drivers on a national highway: An action project	• District Collector office Vadodara • VD Department, SSG Medical College • SORT
Introduction of syndromic approach in the health clinics of Baroda Municipal Corporation	• Baroda Municipal Corporation • SORT • NACO* • UNFPA*
Inter departmental expert team constituted by V.C., MSU to develop family life education services for the M.S. University students	• Dean, SSG Medical College • WSRC • SORT • PRC • Various faculties from MSU
Health seeking behaviour and perceptions of pelvic inflammatory disease patients attending SSG Hospital, Vadodara	• Department of PSM • Department of Ob/Gyn SSG Medical College
Women's reproductive health: Understanding explanatory models of illness in a socio-psychological context	• HDFS • PRC, Vadodara
Sexual and reproductive health of adolescents in slums of Ahmedabad	• CHETNA • CORT
Marital violence: Its impact on Health – Women's perspectives	• Faculty of Social Work • CAAAG, Vadodara

Note: List includes only those projects which include more than one organisation/department to make the team interdisciplinary

** Participated by providing their staff as Resource Persons in trainings organised on Syndromic Approach for Baroda Medical Council staff*

Increased Use of Complementary Methods of Data Collection

As discussed in the earlier section, depending on the topic of enquiry, the investigators used complementary methods of data collection (Table 1). In most cases both qualitative and quantitative methods were used to collect required data. Thus, the Small Grants Programme gave the students, faculty, researchers and NGOs an opportunity to *practice* how the qualitative and quantitative approaches could be integrated and used together to gain a better understanding of social realities, a focus of much of the training organised by WSRC and SORT under their Ford Foundation Projects.

Increased Interaction Between Programme Managers, NGOs, and Researchers

One important outcome of the three Ford Foundation projects (WSRC, SORT, and the Population Council) was bridging the gap between programme managers (state as well as district level), the researchers/faculty members and NGOs. In total they organised several trainings, workshops on substantive issues and lectures by scholars, legal experts, advocates of gender equity and collaborated with each other on joint studies. These frequent opportunities for interaction helped them in understanding each other's perspectives and building mutual confidence. The number of NGOs and researchers invited to government meetings and to serve on committees has also increased. For instance, the Reproductive and Child Health (RCH) district project at Baroda, frequently used Population Council/CORT/MSU technical assistance in their activities. Similarly, in drafting and reviewing the State Population Policy, several professionals from these institutions were involved. However, recent interviews with various grantees revealed mixed impressions. For example, Dr. Kapadia, a faculty member said, *"Our interaction within the campus has increased so much with the government."*

On the other hand, Dr. Baxi from the PSM Department of Medical College felt, *"We always work closely with health and family welfare programme. Now we are doing it more frequently. For example, right now we are imparting training to medical officers for the RCH programme at the district level."*

Dr. Sandhya Barge and Dr. Bella Patel from CORT said that they are in close touch with programme managers and are members of the RCH district level advisory committee. Senior professionals of CORT are also regularly invited by the Gujarat State AIDS Control Society as resource persons to train their NGO partners in data collection and use of qualitative methods to idetify and map populations with risk behaviour. Such interactions should lead to better utilisation of research findings and encourage researchers and faculty members to undertake more programmatic and applied research.

Evaluation of the Impact One Year After Completion of the Project

To assess the impact of the capacity building activities of the Small Grants programme, ten grantees were interviewed one year after completion of the programme. Of these, seven were from various teaching departments of M.S. University and one each from the Medical College, a NGO and a research organisation based in Baroda. Apart from them, one grantee who now works with the government in an AIDS control unit was also interviewed. The thrust of the discussion was whether the programme and the technical assistance provided had benefited the department in any way. The gains included helping in strengthening their research methodology course, creating interest among faculty and students in women's health problems and gender

issues, strengthening their research capabilities or helping them use their acquired skills in programmatic work.

The findings of the survey are summarised in Table 6. It is evident that the intensive capacity building efforts carried out under the Small Grants programme are paying dividends and several positive long term impacts can be expected. For example, in three departments, research methodology courses have been formally modified to create more space for qualitative research methods; while in another three departments, the course contents have been modified informally. Two departments have started giving more emphasis to the integration of qualitative and quantitative approaches. At least three teaching departments and three other institutions reported more focus on women studies, while one research organisation and a NGO reported more interest in programmatic and intervention studies. The social contexts of disease and gender issues are getting more prominence both in teaching and research.

Table 6

Evaluation of the Impact of Small Grants Programme

Department	Introduction or expansion of qualitative research methods *	Increased emphasis on integration of qualitative and quantitative methods **	More studies by M.Phil./ Ph.D. students or faculty members on reproductive health and related subjects		Issues like women's health, gender issues, male involvement getting more attention in teaching **	Social context of disease and gender issues **	Attempt to improve quality of service to patients (hospital) ***
			Diagnostic/ Evaluation **	Operations Research (Intervention studies) **			
Teaching faculty							
Human Resource Development	1	1	1	–	1	1	NA
Sociology	2	3	1	–	1	1	NA
Education	2	–	–	–	–	–	–
Social work	1	2	1	–	3	1	NA
Preventive and Social Medicine	1	1	3	3	1	1	2, 4
Obstetrics and Gynaecology	3	3	3	–	2	1	3
Skin/STD/AIDS	Informally	Yes, trying	–	1	1	2	2
Research Organisation							
CORT	Ongoing	1	1	1	1	1	NA
CHETNA	Introduced	1	1	1	1	1	NA
B. J. Medical College	3	1	1	–	1	1	3 ongoing

* 1. Formally: Change in syllabus 2. Informally: No formal change but contents of course modified 3. No change

** 1. Yes 2. No 3. No change

*** Quality of services: 1. Reduce waiting time 2. Giving more attention to client's needs/what she wants to say 3. Improved privacy 4. Encouraging to come with spouse

The following quotes from the interviews of grantees further support these observations:

1. Strengthening of research methodology and training of students

"The Small Grants programme gave us an opportunity to learn by doing research. We have learned sound methodology from social science perspective.... I can say the department as a whole has benefited. Our course curriculum has been modified. Now we have a major unit on qualitative research methods. We can attribute these changes to Small Grants programme.... Apart from the students who were associated with studies funded under SGP, even other students have started using a good combination of qualitative and quantitative research approaches...."

Dr. Kapadia, HRD Home Science

"Informally many changes have been made in course contents. Hopefully, it will be formalised in 2002 when the curriculum will be formally reviewed in the university."

Prof. Rajaram, Department of Sociology

"... Earlier we believed that only hard quantitative data could give good useful results that could be generalised. We did not believe in qualitative methods. Now we realise the use and importance of both approaches...We have introduced qualitative research methods in the under graduate teaching for all medical students ... Besides that we have also expanded teaching on sociological dimensions of society such as social interactions, gender inequality and its linkages with health of the people, particularly women. Earlier this was not there. This is purely due to our exposure to social science research ....."

Dr. Baxi, Department of PSM, Medical College

"Small Grants programme was a useful initiative and it has contributed significantly in institutionalisation of qualitative research in the university settings and enhancing interdepartmental interaction as well as with outside institutions. Now that SGP is over and Council staff is no more available for providing TA; WSRC and CORT are trying to take up this role. We have started regular training in qualitative research methods, Operations Research, and enhancing utilisation of research findings. Demand for these trainings courses are quite high and researchers, NGOs as well as programme implementers are participating in these courses after paying tuition fees."

Dr. Barge, CORT

"The Small Grants programme gave me a good opportunity to learn and sharpen my research capabilities, particularly how to disseminate and utilise research findings .... Now I am using those techniques to build the capacity of our NGO partners in collecting qualitative and quantitative information on sensitive issues like sexual behaviour, mapping of high risk behaviour groups and assessing the magnitude of the problem. So far we have trained 60 partners in qualitative research methods and by March 2002 this number will be increased to 150. CORT is helping us in training by providing resource persons."

Dr. Ansari, Project Support Unit,
Gujarat State AIDS Control Society

2. Enhanced interest in reproductive health, gender, and other related issues

"We are now involved in doing media advocacy and trying to work with adolescents and encourage men's involvement in women's health."

Dr. Kapadia, HRD Home Science

"In sociology departments, health issues have become an important subject. We have incorporated in our teaching not only women's health issues but men's health problems as well. Recently we organised a small workshop in collaboration with the department of economics and political science on the sociological dimensions to health and gender issues."

Prof. Rajaram, Department of Sociology

"This year three students are starting work on their dissertations. All three are working on women's health issues. All of them are planning to use both qualitative and quantitative methods to collect their data."

Dr. Baxi, Department of PSM, Medical College

"One of my students is doing his Ph.D. on "Men's reproductive health needs and treatment seeking behaviour in rural, urban and tribal population."

Prof. Rajaram, Department of Sociology

3. Application in programmatic research and training

"...... We are involved in a gender sensitisation training for Primary Health Centre staff..."

Dr. Kapadia, HRD, Home Science

"...... We are in the process of initiating research on women's health in tribal Baroda......"

Prof. Rajaram, Department of Sociology

"......... We are using these methods extensively for identifying target groups and planning interventions. We have also developed several qualitative process indicators to monitor the programme."

Dr. Ansari, Project Support Unit,
Gujarat State AIDS Control Society

"We are setting up a human laboratory covering 30 villages to test different types of programmatic interventions in the area of reproductive health and adolescent's sexuality."

Dr. Barge, CORT

"In all our ongoing activities now we try to look at it from the client's perspective and quality of services provided. For example, partner's notification for sexually transmitted infection, male involvement in pre and post-natal care and quality of services provided. Now we understand its importance. Earlier it was only a part of our text books."

Dr. Baxi, Department of PSM, Medical College

4. Interaction with programme managers

"Little improvement in the interaction with government programme. Recently I played some role as part of a team for preparing a monograph on health status of women in Gujarat. I was also involved in government's state population policy dialogue."

Prof. Rajaram, Department of Sociology

"We work closely with the government. We are imparting training to medical officers for the RCH programme at district level. We try to teach them the importance of quality of services and understanding it from the client's perspective. Right now we are doing a multi-indicator cluster survey."

Dr. Baxi, Department of PSM, Medical College

"...... We always try to work with the government. I will say during the last year we are working more closely with programme managers at all levels - Municipal Corporation, district, and state. We are collaborating with the State Government in training activities of the State AIDS Control Society, working with district authorities in the implementation of the RCH programme in Baroda district and collaborating with the health unit of the Municipal Corporation of Baroda for intervention studies...."

Dr. Barge, CORT

"Our interaction with medical college and NGOs like CHETNA has also increased significantly for programmatic research."

Dr. Barge, CORT

Missed Opportunities

An initiative that focuses on enhancing research capacity of teaching institutions such as university departments, should focus on the *department* as a whole rather than an *individual* faculty member. While the Small Grants Programme with its sustained and intensive technical assistance, helped in developing the analytical and research skills of selected faculty members, it might not have necessarily succeeded in making the department committed to the women's health problems or the need to change curricula to strengthen social science research. Often the young faculty members who received the grants, functioned as an individual researcher with no or little involvement of other senior faculty members of their department. In changing curricula of the

departments, the support of the senior faculty members is critical. Hence as a strategy, the attempt should be made to involve the department as a whole or at least the Head of the Department as supervisor/co-investigator of the project activity. This will help in making the project *a departmental activity*. To influence the functioning of the departments, at least two or more members of the faculty should be involved or provided with grants. This will help in creating "change agents" within the department.

Nevertheless the *synchronisation of the timing* for implementing the Ford programmes, their *complementary nature* and the *long term prospective* of the initiatives were three powerful factors that contributed significantly to enhancing social science research on women's health in the M.S. University and selected NGOs/research organisations in Gujarat, India. In the future this 'model' could be used more effectively for making applied and programmatic research an integral part of social science research.

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APPENDICES

Appendix 1

List of Resource Persons of Proposal Development Workshops*

- Dr. Sandhya Barge
- Prof. Shalini Bharat
- Dr. Narayan P. Das
- Dr. M. E. Khan
- Dr. Michael Koenig
- Prof. Usha Nayar
- Dr. Saroj Pachauri
- Dr. Bella C. Patel
- Prof. Bert Pelto
- Dr. John Townsend
- Dr. Jayanti Tuladhar
- Prof. Amita Verma
- Dr. Ravi Verma

Appendix 2

Names of Experts who worked as Members of Proposal Review Committee*

- Prof. John Cleland
- Prof. M. M. Gandotra
- Dr. Shireen Jejeebhoy
- Dr. M.E. Khan
- Prof. Sumati Kulkarni
- Dr. Bella C. Patel
- Prof. Bert Pelto
- Dr. Iqbal Shah
- Prof. Amita Verma
- Dr. Leela Visaria

Appendix 3

Resource Persons who assisted in Collective Technical Assistance*

- Dr. Sandhya Barge
- Prof. Shalini Bharat
- Dr. Leila Caleb
- Dr. Narayan P. Das
- Dr. Dale Huntington
- Dr. M. E. Khan
- Prof. Sumati Kulkarni
- Prof. Divya Pandey
- Dr. Bella C. Patel
- Prof. Bert Pelto
- Prof. Vinit Sharma
- Dr. John W. Townsend
- Prof. Amita Verma

Appendix 4

List of Experts who reviewed the Final Study Reports*

- Dr Dinesh Agarwal
- Dr. Shalini Bharat
- Dr. Leila Caleb
- Ms. Indu Capoor
- Dr. Christopher Elias
- Prof. M. M. Gandotra
- Dr. S. D. Gupta
- Dr. M. E Khan
- Prof. Sumati Kulkarni
- Prof. Usha S. Nayar
- Prof. Bert Pelto
- Prof. T. K. Roy
- Prof. A. K. Sharma
- Dr. John W. Townsend
- Prof. Amita Verma
- Dr. Ravi Verma

* *Arranged in alphabetical order*

Appendix 5

Lectures Organised During the Small Grants Programme Period

Date	Topic	Professional	No. of Attendants
February 1995	Strengthening Social Science Research in Reproductive Health	Ms. Margaret Catley Carlson *President, Population Council, New York*	61
January 1997	Post ICPD: Monitoring the Family Welfare Programme in India	Dr. Anrudh Jain *Director, Programs Division Population Council, New York*	49
July 1997	Advocacy on Reproductive Health	Dr. Saroj Pachauri *Regional Director, South and East Asia, Population Council, India*	52
March 1998	Incidence and Cost of Treating Reproductive Health Diseases in Rural Karnataka	Prof. John Cleland *Director, Population Centre London School of Hygiene and Tropical Medicine, London*	45
March 1998	Country Specific Reproductive Health Indicators	Dr. Iqbal Shah *Task Force Manager Social Science Research in Reproductive Health, HRP, WHO, Geneva*	45

Appendix 6

Students and Young Social Scientists Involved in Small Grants Programme

Principal Investigators	Name of young social scientists who worked in the project	
Dr. Nandita Maitra	Ms. Prabha Palasgaonkar, M.A.	Dr. Maya Singh, MD. DGO
Dr. P.V. Kotecha	Dr. Sangita Patel, MBBS Dr. Samir Shah, MD*	Ms. Shailaja K. Trivedi, M.Sc. (FN) Ms. Narmada Patel, PHN
Dr. Parul Dave	Ms. Gayatri Jindal, M.Sc.* Ms. Neerupama Kaul, M.Sc.	Ms. Shipra Nagar, M.Sc.
Dr. Shagufa Kapadia	Ms. Shalini Sikri, M.Sc.* Ms. Neelam Chauhan, .Phil*	Ms. Urvi Shah, M.Sc.
Dr. R.A. Ansari	Ms. Jashoda Sharma, MA	Mr. Yashwant Deshpande, M.A.
Dr. Sandhya Joshi	Ms. Urmila Joshi, M.S.W.	Ms. Lajwanti Mirani, M.A.
Ms. Brintha Lakshmi	Mr. Hitesh Chhadva, B. Arch	Ms. Preeti Shroff, B. Arch
Dr. Rajalakshmi Sriram	Ms. Kasturi Dutta, M.Phil* Ms. Koundinya Prasad, M.Sc.*	Ms. Kashmira Bhojak, M.Sc.
Dr. Alka Barua	Ms. Sumathi Venkiteswaran, B.Sc.	
Ms. Pallavi Patel	Ms. Urmila Joshi, M.S.W.	
Prof. C.N. Daftuar Urmi Biswas	Dr. Urmi Biswas, Ph.D. Mr. Ramsingh Vadhel, M.A. Ms. Pallavi Trivedi, M.A.	Dr. Meena Mehta, Ph.D. Mr. Mukesh Ghadvi, M.A. Ms. Urvashi Raj, M.A.
Dr. Bipul Kumar Sinha Dr. G K Vankar	Dr. Ritambhara Mehta Dr. M.C. Parmar, MBBS	Dr. B. Panchal, MBBS Ms. Tripti Dave, M.A.
Ms. Usha Nair	Mr. Jawahar Vishwakarma, M.A.	Ms. Jashoda Sharma, M.A.
Ms. Bhavna Mehta	Ms. Hina Desai, M.A. Ms. Richa Verma, M.S.W.	Ms. Anandmala Desai, M.S.W. Ms. Dipti Bhatt, M.A.
Dr. Yogesh Marfatia	Dr. Swati Parmar, MBBS*	Dr Nidhi Bansal, MBBS*
Prof. N. Rajaram		Mr. Alok Singh, M.A.

* Students who used a part of the data of the project for their thesis work

1 UNSAFE ABORTION: A SOCIO-BEHAVIOURAL STUDY

Background

Abortion (MTP or medical termination of pregnancy) was legalised in India in 1972, but unfortunately, it did not produce the desired effect on women's health, particularly on those who residing in rural areas. There are various inhibiting factors for the low response towards MTP services which may be identified as poor access to or non-availability of safe abortion services, social taboos, and low motivation, lack of trained doctors, and indifference of Ministry of Health and Family Welfare. According to available statistics, only 10-15 percent of the estimated 6.5 million abortions occurring annually in India receive safe and hygienic abortion services. Septic abortions in unhygienic conditions contribute to about 15 percent of maternal mortality in India.

Objectives of the study

The objectives of the study were to examine: a) the profile of women who developed complications following unsafe abortion, b) their treatment seeking behaviour, and c) the details of the providers of the unsafe termination of pregnancy, the methods they used, and the conditions under which the abortions were performed.

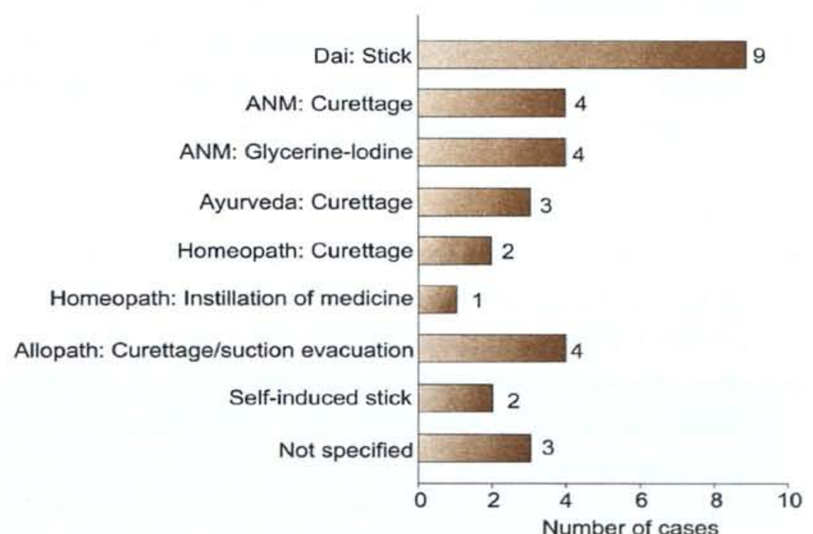
Methodology

Qualitative methods consisting of in-depth case studies of 32 women with complications from unsafe abortions, informal discussions with 23 providers as well as attendants of all the 32 patients were adopted to collect the data. The women were interviewed on several occasions, both in the hospital and at home with their consent.

Findings

- Out of the 32 informants, six were unmarried and one was separated. Eighteen lived in tribal areas. Twenty-two of the women and 16 of their husbands were illiterate.
- To maintain anonymity, out of the 32 women, 11 travelled 16-50 kms. to reach the provider, 16 travelled 20-40 kms. to reach the nearest government, MTP facility, and 11 covered a distance of 100-300 kms. to reach a district or sub-district hospital.

Type of provider and methods used for inducing abortion



- There were three deaths; two were brought to the hospital in a state of septicaemia shock and died within 6 hours of admission.
- Among the married women, desire for fertility regulation was the main reason for seeking abortion. Only four of these women had ever used any contraception. The remaining lacked clear knowledge of spacing methods or did not believe in their use.

> "The dai went to the jungle and brought two sticks each of about 5 inches long. She put the sticks together, tied a cloth on its tip and applied a milky liquid to this cloth. She made me lie down on the floor and inserted the sticks inside me with her bare hands. She turned the stick twice inside and then removed it. There was no pain."
>
> *A tribal woman*

- The main providers of unsafe abortion included *dais* (9 cases), ANMs (8 cases) and doctors following ayurvedic (3 cases), homeopathic (3 cases) and allopathic system of medicines (4 cases). Two women had self-induced abortions by inserting roots.
- The major complications reported during the post abortion period were septic peritonitis, acute pelvic inflammatory disease (PID), and bleeding haematomas.
- To abort, the insertion of a stick was reported by 11 cases (34 percent), while others reported instillation of glycerine-iodine or some medicine; and dilatation and curettage (D&C) as the main procedure of abortion. The rural doctors frequently used D&C method.
- Informal and often substantial referral networks operate to reach the providers. The networks often include the village healer, a female relative, the village *dai*, and *anganwadi* (ICDS centre) worker.

> "She made me lie down on the table and inserted a steel instrument with a rounded tip on which cotton dipped in medicine was applied. She passed it inside and turned it around a few times, ... there was a lot of pain and some bleeding. Four days later she repeated the procedure. Waited for eight days but abortion did not take place. Then I went to a homeopathy doctor. He gave me injections and tablets. On the third day I had a lot of bleeding along with 'chakkar' (giddiness)."
>
> *A woman after help from health worker*

- Auxiliary Nurse Midwives (ANM) are an important part of the abortion network both as providers and as motivators.
- The unmarried girls sought termination at a more advanced stage of gestation (10-16 weeks), thus exposing themselves to the dangers of late terminations. This is perhaps due to sensitivity of the issue and delays in decision-making processes. Among the six unmarried girls, two died.

Recommendations

- Improve infrastructure for abortion services at primary health centres. Dilatation and curettage (D&C) should be replaced with better and simpler Manual Vacuum Aspiration (MVA) for early first trimester abortion. This would greatly reduce the number of post-abortion complications.
- Medical officers should be trained in MTP and provided on-the-job medical education to enhance the quality of services and counselling. These should be given priority in programme planning and implementation.
- Conduct an aggressive IEC campaign to inform people about the legal status of abortion, availability

of services, and dangers of unsafe abortion.

- Sexually active single women and married women who have achieved the desired family size should be considered as a high risk group for abortion. Their contraceptive needs should be addressed, ensuring privacy and confidentiality.
- Introduce newer technologies, such as RU 486 and prostaglandin by paramedical personnel, to reduce the morbidity and mortality due to unsafe abortion procedures.
- Explore possibility of permitting public health nurses to conduct abortion using Manual Vacuum Aspiration (MVA).

Maitra N., Chauhan L. N., Hazra M., Baxi S., Singh M., and Palasgaonkar P. 1999. ***Unsafe abortion – A socio-behavioural study***.
For further information please contact the authors at the Department of Obstetrics and Gynaecology, Medical College, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health**.
The project is funded by Ford Foundation by award no. 940-1148.

2 HEALTH-SEEKING BEHAVIOUR OF PATIENTS WITH PELVIC INFLAMMATORY DISEASE VISITING A TERTIARY HOSPITAL, BARODA

Background

Pelvic inflammatory disease (PID) generally develops as a result of untreated morbidities or delay in treating the morbidities such as infection and trauma. Infection could be caused by infected sexual partners, use of intra-uterine contraceptive devices (IUDs), instrumental or operational interventions with inadequate precautions, and poor hygiene. Delay in treatment may be due to women themselves neglecting morbidity or a lack of health services. The factors which delay treatment have not been properly appreciated and need closer examination.

Objectives of the study

The purpose of the study was to understand: a) health-seeking behaviour of PID patients since the detection of their problem, b) social support available to them during sickness, and c) the perceptions of doctors treating them about the quality of services provided at the hospital from the user's perspective.

Methodology

Qualitative methods were used to collect the data and consisted of 120 in-depth interviews of PID patients who came for treatment at SSG Hospital, a tertiary referral hospital at Vadodara. Trained doctors of the hospital conducted the interviews. At the end of the data collection, the doctors themselves were informally interviewed on the quality of services provided to the patients.

Findings

- Forty percent of the women visited the tertiary care hospital after suffering for three years from the disease and usually after consulting two other clinics. The time gap was much more (61 months) for rural patients than urban patients (31 months).
- At the initial stages of the illness, the common health-seeking pattern was: use of home remedies, visiting a general practitioner or consulting traditional healers. If they failed to get relief or the disease recurred, they came to the SSG Hospital.
- Reasons for selecting the tertiary care centre were: advice of friends, relatives, availability of doctors, and the low cost of the treatment.
- In more than 75 percent of the cases, PID affected women's abilities to conduct routine household chores. During sickness, women generally received help from their husbands, mothers-in-law, and other relatives. However, in about one-third of the cases absence of such support made their life very difficult.
- Often the women sought medical intervention only when they found themselves too weak to work or experienced problems in their sexual relationships leading to conjugal problems.

> "... due to pain I did not allow sex... He had a drink and went to other women."

- Many women linked their morbidity with insertion of an IUD (78 percent), abortion (47 percent), tubectomy (33 percent), lack of good food during pregnancy (10 percent), extramarital relationship (10 percent), or frequent sexual intercourse (5.6 percent).
- Most of the women failed to detect the disease in time, or if detected gave it a low priority as evident from the delay in seeking treatment. Women accepted PID as an inevitable part of womanhood rather than as a treatable problem.
- Interviews of the doctors treating them indicate that they had a busy schedule. Normally a doctor would spend not more than 10 minutes on each patient who visited the outdoor clinic for treatment. This included taking the patient's history, a clinical examination and prescribing treatment. They felt the time spent was insufficient to understand the life situation of women and give proper counselling.
- A patient's sexual behaviour is rarely probed because the set up where counselling takes place does not permit such discussion. Doctors perceived that sensitivity of the subject also discouraged the women. The present study, however, revealed that women were ready to discuss all issues including the extramarital relationships of their husbands, if they believed that the information provided by them would be kept confidential and could help their treatment.
- Doctors felt that preventive advice was essential but admitted that the present set-up did not allow them to counsel. Improving laboratory facilities and providing the nursing staff with a health education component were constructive suggestions that emerged from the discussion.

"There is persistent pain in the lower abdomen for the last 10 years. It becomes unbearable when we are together (having sex)."

•

"During menstruation there is a severe pain in the lower part of my abdomen. When the labour work in the field increases there is more pain. In the last 5 years I have never been all right."

•

"So severe is the pain during the sexual act that I start fearing as the night approaches. As due to pain I do not allow sex, my husband becomes angry and told me to go for treatment the very next day."

Recommendations

- Community level workers should be oriented to educate women about reproductive health problems and how to prevent them. Early treatment also should be advised.
- Hospital authorities should be made aware of the problems in providing good quality services, particularly in the context of privacy and laboratory facilities.
- Doctors as well as staff nurses should be oriented in counselling and the need to obtain a detailed case history, which could help in planning the line of treatment.

Kotecha P. V., Baxi R. K., Shah S., Patel S., Trivedi S. K., Pagi S. L., and Saini H. B. 1999. ***Health-seeking behaviour of patients with pelvic inflammatory disease visiting a tertiary hospital at Vadodara.***

For more information contact the author at Department of Preventive and Social Medicine, Medical College and S. S. G. Hospital, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health.**

The project is funded by Ford Foundation by award no. 940-1148.

3 REPRODUCTIVE HEALTH STATUS OF MIDDLE-AGED WOMEN

Background

During the last five years a number of studies have been conducted on women's reproductive health problems. However, very few studies have addressed the reproductive health problems of aging women, particularly those related to the menopausal health of women. The issues such as types of stress women undergo following menopause, its psychological impact on the overall health of women, and their treatment seeking behaviour have remained neglected. Little is known about the spousal and family support available to women in this transitional period of the life cycle.

Objectives of the study

The purpose of the study was to comprehend: a) reproductive health status of middle-aged women with a focus on menopause, b) spousal communication on reproductive health, c) treatment-seeking behaviour of middle-aged women for their reproductive health problems, and d) available support systems.

Methodology

A combination of quantitative and qualitative methods were used to collect the data. Totally, 150 middle-aged (40-55 years) women and their spouses (n=38) were interviewed from five slums of Vadodara, using a semi-structured questionnaire. Five medical practitioners working in the study area were also interviewed to discuss the reproductive health problems of middle-aged women. A majority (90 percent) of the women interviewed were between 40-55 years of age. Half of them were living in nuclear families; 54 percent of them were illiterate and 32 percent were working for cash or kind. The mean age of their first pregnancy was 19.6 years and on average they had 5.5 live births.

Findings

- One-fourth of the women interviewed complained of problems like vomiting and changes in blood pressure during pregnancy. A few (4 percent) reported post delivery complications. Most of the women experienced some premenstrual symptoms like stomach-ache, backache, and pain in legs, but they did not seek any treatment, considering them normal.
- Very few women reported reproductive health problems of white discharge (13 percent) and infertility (3 percent).
- The mean age at menopause was 43 years. Sixty percent of the women reported vasomotor symptoms including hot flashes and sleeplessness.
- Physiological symptoms were reported by 41-63 percent of the women, while 37-77 percent of women complained of post-menopausal psychological symptoms (see box). Doctors indicated that some of the physiological symptoms such as headache and backache could also be the manifestation of psychological problems such as depression and feelings of loneliness.
- Menopausal problems were more reported by women aged 51 years and above, and by those who were employed.

- Only 17 percent of the women sought treatment from the allopathic system of medicine, while 23 percent took home remedies. Most of the women who went to allopathic doctors used private practitioners. Only 15 percent went to government health facilities. Their husbands provided all the expenses for treatment.
- Three out of four women perceived changes in the husband-wife relationship, while four out of five women observed changes in sexual activity. They said that sex was not desirable after their children had grown up. Aging was also linked with decrease in sexual activity.
- Most of the post-menopausal women reported that they did not like to have sexual relations anymore, while none of the spouses reported the same. Religion, poor health, and absence of spouse for a long duration were the reasons mentioned for decrease in sexual activity.
- Menopause was not mentioned as a factor, which could influence the husband-wife relationship. Women believed that the husband-wife relationship could survive at this age without having sexual relations.
- The postmenopausal period often leads to a more intimate and understanding relationship with their spouses, but there was a decline in recreational activities, such as going to movies together.
- Almost all women said that their family members understood their health problems, and a majority (69 percent) preferred to share their problems with their husbands.

Reported problems among middle-aged women

Physiological symptoms

- Headache
- Backache
- Changes in vision
- Dizziness
- Abdominal disorders

Psychological symptoms

- Feeling of tiredness
- Irritation
- Lack of interest in self
- Memory loss

Recommendations

- Government, NGOs, and researchers should recognise the reproductive health problems of middle-aged women and address their needs.
- More studies are required to understand the physical and psychological stress of middle-aged women and to plan appropriate interventions to address their needs. In the absence of reliable information, their reproductive health needs remain neglected.
- Establishment of recreation and counselling centres, special timings for aging men and women at clinics and organising forums for middle-aged men and women are some possible interventions to reduce their physical and psychological stress. However, the efficacy of these interventions should be tested before scaling up.

Dave P. and Jindal G. 1999. ***Reproductive health status of middle-aged women.***
For more information contact the author at Department of Human Development and Family Studies, Faculty of Home Science, M. S. University, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health**.
The project is funded by Ford Foundation by award no. 940-1148.

4 WOMEN'S REPRODUCTIVE HEALTH: UNDERSTANDING THE SOCIO-PSYCHOLOGICAL CONTEXT

Background

It is now well recognised that viewing women's health within the context of empowerment helps in providing a broader and more holistic understanding of the concept. A holistic approach is one, which recognises not only women's health needs at different stages of their life cycle, but also those reproductive health (RH) problems that evolve in the context of the circumstances of women's lives and women's status. Women's status determines women's access to resources and shapes their ideology, beliefs, values, attitudes, and behaviours related to health and sickness. The socio-psychological context – in terms of what health problems actually mean to women and what they know, believe and feel about these problems- forms an important intervening element in women's perceptions of health problems and their treatment-seeking behaviour.

Objectives of the study

The study examined the linkages between women's treatment-seeking behaviours for reproductive health problems and the socio-psychological factors including social roles, social support, and sense of self-worth.

Methodology

The study used different qualitative methods to collect the data. These included community mapping and body mapping, informal group discussions, key-informant interviews and semi-structured in-depth interviews. A total of 6 key-informants and 50 married women in the age range of 20-44 years from an urban slum community of Vadodara city were interviewed.

Findings

- Most women generally described their reproductive health problems by symptoms rather than by any local name of the illness. Frequently mentioned problems included menstrual problems, white discharge, urinary infection, weakness, aches and pains, feeling of tiredness, and inability to work. Other problems were excessive or scanty menstrual flow, spotting, and a burning sensation.
- Early marriage, frequent deliveries, weakness, and fertility control methods, particularly tubectomy, as well as performing heavy tasks such as fetching water from the hand pump were commonly perceived causes of menstrual problems, white discharge, uterine prolapse and spontaneous abortion. Poor antenatal care, inappropriate food habits and lack of postnatal care were also perceived as causing reproductive health problems. Interestingly, infertility was associated with the 'will of a Goddess.'
- Women generally delay and/or discontinue seeking treatment unless the problem was very severe and likely to hinder their domestic, sexual, and reproductive roles.
- Multiple sources of treatment were used, either sequentially or simultaneously. Allopathic sources, especially government hospitals and private clinics were most commonly used, followed by home remedies and

self-treatment. Homeopathic sources were most frequently sought for problems such as white discharge and urinary tract infections. Faith healers were approached for infertility.

- For seeking treatment, physical discomfort associated with the problem, accessibility and quality of health services, availability of a lady doctor, and the low cost of treatment emerged as important factors. Giving advice and providing company were important forms of social support that facilitated seeking treatment.
- Women's social roles, social support, and perceived self-worth had direct as well as indirect linkages with women's treatment-seeking behaviours.
- Women's sense of self-worth was specifically linked to treatment seeking. It determined their social roles and the social support available to them. Social support (in terms of sharing and seeking help and advice) had a positive effect, while social roles were found to have a negative effect on treatment seeking.

> "My husband tells me not to worry about money and to buy the medicine. But I do not buy it, as I have to take care of everyone, I cannot waste money just like that."

- Women essentially derived their self-worth from their relations with and feedback from significant others as well as efficient performance of social roles. Ironically, the performance of social roles as well as the need to accord priority to others was found to interfere with treatment seeking behaviour.

> "My body part [uterus] comes out, and it causes a lot of discomfort. But I feel very embarrassed in telling anyone, now if I have someone to go with me, I will consult a doctor."

Recommendations

- Interventions should be designed to educate women to acknowledge their self-worth. A positive change in treatment seeking can be effected if women learn to value themselves, and specifically, their own health.
- Health care providers at the community level should design and implement intervention(s) to increase women's awareness of their health problems and the need to address these.
- Health care providers, particularly at the grassroots, should be sensitised to women's health needs beyond maternity and child health care.
- There is a need to reach out to men and other family members to enhance their sensitivity and understanding of women's reproductive health problems.

Kapadia S. and Shah U. 1999. ***Women's reproductive health: Understanding the socio-psychological context.***
For further information contact the authors at Department of Human Development and Family Studies, M. S. University, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health**.
The project is funded by Ford Foundation by award no. 940-1148.

5 QUALITY OF REPRODUCTIVE HEALTH SERVICES AT COMMUNITY HEALTH CENTRES: AN IN-DEPTH STUDY IN RURAL GUJARAT

Background

In the rural areas, Community Health Centres (CHC), functioning as the third tier of health services, are expected to provide essential obstetric care (EOC) services to approximately 120,000 population. CHCs have been recently upgraded for treatment and management of reproductive tract infections, pregnancy complications, and septic abortion cases. Each CHC is expected to have a surgeon, a gynaecologist, a paediatrician, and an ophthalmologist. However, there is lack of information on the functioning of the CHCs, their readiness to provide reproductive health services, and the quality of services provided. To what degree the intended upgrades have actually been implemented is also not known.

Objectives of the study

The study tried to answer questions such as: a) are the CHCs equipped to function as the first referral unit (FRU), b) what services are being provided at CHCs, and c) what is the quality of these services, specifically relates to women's needs?

Methodology

The study used a combination of qualitative and quantitative approaches to elicit the required information. Situation analysis of the facilities at the CHCs in Vadodara district (n=12), analysis of their outpatient department (OPD) records and 206 exit interviews of women patients provided quantitative data. Qualitative information was collected by observation of the functioning of the services provided at the clinics and informal discussion with the providers.

Findings

- Only five out of 12 CHCs in Vadodara district had female doctors out of which two were paediatricians and one each was a surgeon, a general physician, and an ayurvedic practitioner. None of them had specialised in gynaecology. However, four CHCs had male gynaecologists.
- All the CHCs provided emergency services with a

Reproductive Health Services Available at CHCs

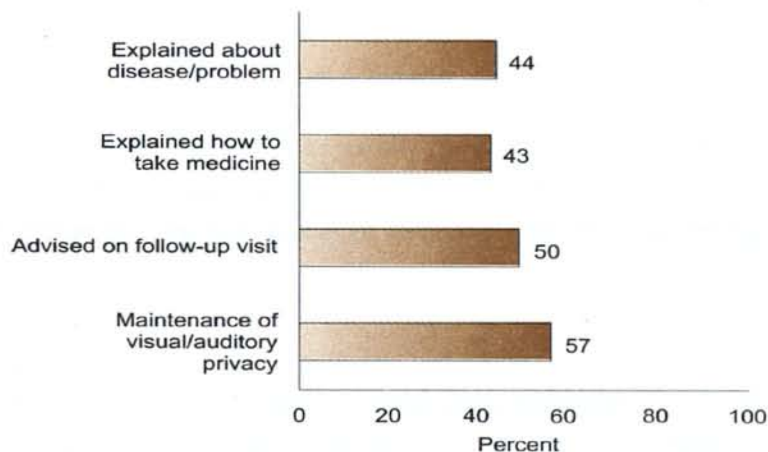
(n=12)

	Services provided		
	Good	Average	None
Emergency Obstetric Care	4	2	6
RTI/STD services	4	3	5
Medical termination of pregnancy (MTP)	9	-	3
Male sterilisation	11	-	1
Female sterilisation			
Laparoscopies	11	-	1
Mini laparotomy	8	-	4
IUD insertion	12	-	-
Infertility consultation	3	6	3

Good services refer to services provided by a specialist, and the availability of required instruments and medicines. ***Average*** quality services refer to services provided by a general practitioner. ***None*** indicates service not provided.

doctor and a nurse available 24 hours a day. However, these emergency services only referred patients to higher-level facilities (see table).

- Lack of an anaesthetist at the CHCs hindered the provision of emergency services in all but one CHC.
- Observations showed cracked floors in the operation theatres and lack of cleanliness in some CHCs. Sources of emergency light were available in only four CHCs. One had a working generator.
- Except at one CHC, the patients had privacy while being internally examined. Awaiting area was available at only five CHCs. Separate male and female wards were available at almost all the CHCs.
- A case study of five CHCs showed that 44 percent of female patients belonged to the same town where the CHC was located, 19 percent came from nearby villages while 37 percent came from distant villages located more than 3 kms. away.
- The main reasons for preferring the CHC for treatment were its reputation for good services (49 percent), free treatment, constellation of services, easy accessibility and cooperative doctors and staff.
- A majority (70-85 percent) reported that providers were co-operative and friendly during consultations and encouraged the women to ask questions. Women were satisfied with the answers given to them by providers.



- Most received services on the day of their visit while others (14 percent) were referred elsewhere.
- Waiting time for services varied considerably, depending on patients' turnover and timing of their arrival at the clinic. In 20 percent of the cases they had to wait for more than 3 hours.
- Services like emergency obstetric care, abortion, and STD/RTIs were offered in a separate room as compared to postnatal care services. In many CHCs, an OPD room with or without curtained area was used for examination.
- Considerable scope exists to improve the quality of services particularly in the area of privacy, explaining to the patient about her problem/disease, how to take medicine, and when to return to the clinic for follow-up services (see figure above).
- Since there were mainly male doctors, few examined the patients internally. Out of 16 women who accepted an IUD, only in 2 cases was the size of the uterus checked. Counselling on family planning methods was generally poor, and only IUD/tubectomy acceptors were informed about side effects.

Recommendations

- To make the CHCs effective as first referral unit (FRU), availability of gynaecologist is important. When an in-service gynaecologist is not available, the services of private gynaecologists or at least a woman doctor should be hired for each CHC, at least on two fixed days a week.
- Doctors and staff nurses should be sensitised about the quality of services and all attempts should be made to improve counselling.
- Immediate improvements in providing privacy to patients should be made.

Ansari, R. A. and Patel B. C. 1999. ***Quality of reproductive health services at Community Health Centres: An in-depth study in rural Gujarat.***
For further information contact the authors at the Centre for Operations Research and Training, 402, Woodland Apartment, Race Course, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health**.
The project is funded by Ford Foundation by award no. 940-1148.

6 QUALITY OF CARE IN FAMILY PLANNING SERVICES AVAILABLE TO WOMEN IN VADODARA CITY

Background

The quality of care in family planning refers to a process of care and treatment given to clients by a service delivery system. Unless quality is improved significantly, the utilisation of services, particularly in the public sector will remain low. Most research on quality of care has focused on service providers and health facilities. Research on quality of services from the user's perspective has remained neglected and needs attention.

Objectives of the study

The objectives of the study were: a) to assess and compare the quality of family planning services from the user's perspective in a public sector unit and a non-governmental clinic run by a charitable private trust hospital; b) to suggest strategies and pathways for improving the quality of care in urban family planning centres.

Methodology

One hundred exit and 40 in-depth interviews from two service facilities provided the information for the study. The data was complemented with client flow analysis, informal discussions with service providers, and direct observations of client-provider interaction.

Findings

- The service delivery approach in the two systems differed substantially. In the case of NGO clinic, services were provided only at the clinic while in government system, both clinic and outreach approaches were used.
- In the NGO clinic services were provided by better skilled doctors than in the government clinics (combination of paramedics and doctors).
- In the NGO clinic, oral contraceptive pills were generally provided as an interim measure during treatment of women for RTI/STD or anaemia before providing them their desired contraceptive (e.g. IUD). Very few clients came to get condoms. In the government clinics, condoms were distributed freely to all women who sought

Good practices followed in the NGO clinic

- Privacy in consultation room
- Availability of two doctors for six hours on six days a week
- Doctors themselves examine each client, note the clients history, check for contra-indications, and counsel.
- Better post operative care and discharge sterilization cases after removal of stitches.
- Efficient system of follow up care for all method acceptors by asking to return to clinic on fixed date
- Cleaner and more comfortable clinic facilities

Good practices followed in the public sector

- Less social distance between providers-clients.
- Positive aspects of community outreach services
- Paramedics trained in IUD insertion and removals.
- Provision of transport to sterilization clients

family planning through an auxiliary nurse midwife (ANM).

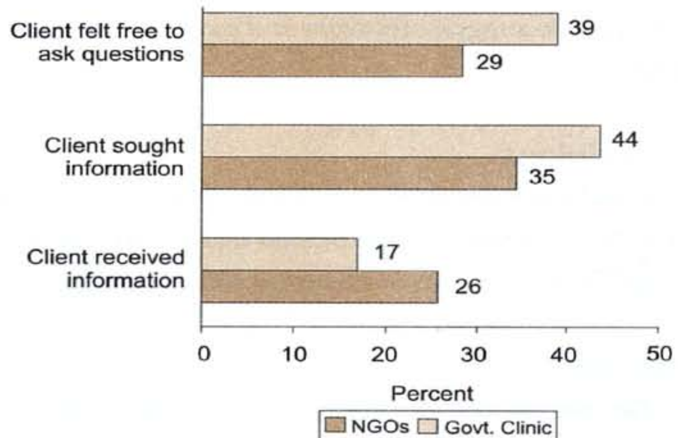
- NGO clinics were better equipped, well maintained, and followed more hygienic practices. All types of family welfare services including female sterilisation and abortion were offered on all six working days a week. In government clinics, MTP and tubectomy were provided only two days a week.

Content of Counselling at NGO and Government Clinics (Percent)

Information given	NGO	Govt.
How the method works	4	7
How to use the method	13	18
Side effects of the method	7	7
Action to be taken for side effects	16	16
Advice on next visit	42	41
Removing client doubts	4	6

- Counselling was equally poor in both types of clinics and no attempt was made by the providers to give detailed information about the methods (see table above). The providers feared that giving information on side effects might reduce the number of clients.
- In government clinics, often paramedics provided services. As the social distance between the providers and the clients was less, women felt more free to ask questions than in NGO clinics. However, few received satisfactory answers to their questions.
- The providers, depending on the reproductive goals of the clients, usually selected a method and motivated the client to adopt the same leading to provider bias.

Characteristics of client provider interaction



Recommendations

- The counselling of clients needs major improvements. All providers should observe clinic protocols while carrying out medical interventions. For example, each provider should use standard procedures for ensuring hygienic insertion of IUD.
- An increased involvement of private and NGO sector in delivery of family planning services is required. This will be lead to a sharing of responsibility with the government sector and enhance quality of services.
- Providers from both public and private sectors need to incorporate client-responsive and bias free counselling to upgrade their efficacy.

Joshi S., Joshi U. and Mirani L. 1999. ***Quality of care in family planning services available to women in Vadodara city.*** For further information please contact the authors at the Faculty of Social Work, M. S. University, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health.**
The project is funded by Ford Foundation by award no. 940-1148.

7 USER CONSCIOUS ENVIRONMENT IN THE HEALTH SECTOR

Background

Researchers interested in the quality of services have paid little or no attention to the structure of buildings and the space available for providing health services. A user-friendly building could provide a better physical and social environment for interaction between providers and users and could improve quality of services in various ways.

Objectives of the study

The broad objectives of the study were: a) to formulate guidelines for designers to plan 'user friendly' buildings, and b) to understand socio-cultural factors and sequence of activities within the buildings that may affect the quality of work environment for providers.

Methodology

The data for the study was collected using direct observation and informal discussions. Direct observations were documented in the form of graphically represented drawings, activity mapping, along with descriptive notes and photographs. Informal discussions were conducted with clients, providers, and those who accompanied the patients.

Findings

- The study revealed that the local functionaries modified the original design prepared by the District Health Department for the utilisation of space in the primary health centre (PHC). The original design was however, more relevant to the requirements of the PHC.
- Observations of the flow of clients through the PHCs were made. For the major sets of activities like outpatient treatment services, the immunisation clinic and the family planning camp, a separate constellation of space in the building was used. The following is the sequence of activities identified for the three major events:
    - *Outpatient treatment services:*
      Entry → collect case papers → waiting before consultation → consulting in doctor's cabin → blood test, if needed → collect medicines → return case paper → exit.
    - *Immunisation clinic:*
      Entry → registration → waiting and vaccination → waiting and examination in the case of antenatal mother → exit.
    - *Family planning camp:*
      Entry→ prepare case paper → blood pressure check-up, urine test and blood test → clean up before operation→ waiting before arrival of surgeon → operation by surgeon → rest for three hours in the ward → exit.
- The analysis of the client's flow through the building in these activities plus the movement of providers shows that activities of the immunisation clinic and the family planning camp require spaces which

offer more privacy and comfort to the clients.

- The waiting area for patients is an important space that requires modification. The present waiting space at the PHC is too small to accommodate the flow of patients at peak hours. The patients prefer to sit and wait very near the doctor's office. The present waiting space, though located near the doctor's office is small, narrow and in some cases a dark passage.
- The waiting space should be within easy visibility of the doctor's office. Otherwise the patients would get impatient and make frequent movements to check the presence of the doctor thereby creating congestion and obstacles in the normal functioning of PHCs.
- The dispensing windows at the PHCs are small and do not facilitate easy interaction between the provider and the clients. This sometimes hampers proper briefing of patients on how to use drugs.
- The immunisation clinics held largely for women require some separation from the main usable area of the PHC, especially if they are conducted during outpatient treatment hours. The sequence of activities needs to be spread over separate areas but linked to one another for easy flow of clients. A semi-covered space such as a veranda is suitable for this activity considering the ease of interaction among clients and between clients and providers. Present arrangements are generally crowded and lack privacy.
- The family planning camp is another event organised mainly for women. Observations revealed poor privacy for activities before and after the operation. Therefore separating the operation theatre and the circulation space from the main outpatient treatment spaces could provide the required segregation.
- The study also identified a serious need to improve storage facilities. The disorganisation and chaos in the PHCs is mainly due to poor storage facilities and storing of scrap and unwanted items for long periods due to administrative requirements. The PHCs also have poor water supply and drainage services.

Recommendations

- The doctors should be discouraged from making alterations in the use of building space from the original plan made by the department.
- The location of the PHC in relation to the settlement is an important aspect that needs to be addressed.
- Providing larger dispensing windows, for easy visibility and communication, at convenient heights will help in better briefing on drug use and reducing crowding in the dispensary.
- Many problems could be resolved through minor changes in the present arrangement of space or rearrangement of furniture within the space.
- It is essential that the buildings are repaired and maintained regularly, and provided with adequate water supply and toilet facilities.

Laxmi B., Chhadva H., and Shroff, P. 1999. ***User conscious environment in the health sector.***
For more information contact the author at Department of Architecture, Faculty of Technology and Engineering, M. S. University, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health**.
The project is funded by Ford Foundation by award no. 940-1148.

8 MOTHER'S PERCEPTIONS OF POST-PARTUM HEALTH CARE NEEDS AND PROBLEMS IN HOSPITALS – A CASE STUDY FROM VADODARA

Background

In-depth studies of the Indian context reveal that health care of the mother peaks during the delivery period but shifts almost completely to the newborn after birth. Even the available services are minimally utilised due to their exclusive focus on family planning and social restrictions placed on women during the postpartum period. The low priority given to postpartum care has also discouraged researchers to study this important aspect of reproductive health care. As a result very limited information is available on postpartum practices and care provided to the mother during this period.

Objectives of the study

The objectives of the study were to: a) document health care practices followed by women who had their deliveries in selected private and government hospitals in Vadodara city, and b) to understand how greater convergence between cultural practices and hospital services.could be achieved to improve postpartum care.

Methodology

Two hundred women who delivered their child in two government and two private hospitals were interviewed three times from the time of delivery to 16 weeks after delivery to understand their care practices and treatment-seeking behaviours. In order to understand the viewpoints of those who influence women's life during this period, 4 doctors, 6 elderly women, 6 paramedical staff and 28 husbands were also interviewed.

Findings

- About 40 percent of women attending hospitals were in the high-risk age group of 16-19 years. Only 44 percent received guidance on diet and 17 percent on breastfeeding. Only 56 percent reported that they had a vaginal or pelvic examination and 35 percent had a breast examination.
- All women irrespective of their parity or social class received some form of special attention during *"sawa maheena"* the traditional postpartum period, which is approximately up to 40 days.
- The percentage of women who were given complete rest after delivery was 60 percent in the case of caesarean section, 55 percent in aided deliveries, and 38 percent who had normal deliveries.
- Only 45 percent reported for post-partum check-ups (mainly the caesarean cases), 30 percent reported that they were not called, and only 15 percent received any form of counselling.
- The women believed that body massage was a health promoting practice to relieve stiffness, breast tension and ensure speedy recovery, but only 43 percent practiced it.
- Around 88 percent reportedly abstained from sexual relations up to 40 days and 71 percent for 2-3 months.

- Eighty percent of the women consumed special food like *sheera/ rab* (porridge), green leafy vegetables, ayurvedic and herbal preparations to increase energy, milk production, and avoid back pain.
- All women practiced some food restrictions like avoiding cold and sour foods and certain legumes and vegetables for fear of digestive and respiratory problems in the mother and the newborn. They believed that legumes not only caused flatulence but also infection in stitches.
- Most women exclusively breastfed their babies for at least 3 months. About 23 percent experienced heaviness and 17 percent experienced other problems like swelling, sore nipples, or pain in the breast, which were treated by home remedies including massage, hot fomentation, manual expression of milk, and rubbing the nipples with breast milk.
- More than 70 percent did not practice or had no clear understanding about family planning measures including LAM (lactational amenorrhoea method).
- About 70 percent women reported other problems in the postpartum period. The most frequent problems were back pain (27 percent), weakness (21 percent) and pain in the stitches. Most of the women did not seek medical consultation for these and resorted to home remedies like fomentation or ayurvedic preparations. Women sought medical consultation for problems that were perceived to be alarming such as fever, headache, infection, and bleeding.

Recommendations

- Quality of antenatal care services needs improvement. Since attendance is good (99 percent came for check-ups), it offers an excellent opportunity for counselling on pre as well as postpartum care.
- Postpartum check-ups need strengthening as many women complained of weakness but considered it inevitable. Since this could be linked to anaemia, blood tests for haemoglobin levels and insistence on continuation of nutrition supplements is required.
- Postpartum counselling needs to be strengthened to relieve women's anxieties in relation to care of their body, sexual intercourse, and family planning.
- Many perceived a strong contradiction between medical advice and traditional practices. Therefore, advice about dietary practices should be such that it can be followed within cultural parameters.
- Mothers, mothers-in-law, and husbands should be involved in the management of antenatal and postpartum conditions of women because they were found to be important decision makers in the family.

Hospitals need to make their programmes women-friendly by

- Regularising postnatal check-ups
- Strengthening and introducing counselling
- Involving family members

Sriram R., Dutta K., and Prasad K. 1999. ***Mother's perceptions of postpartum health care needs and problems in hospitals – A case study from Vadodara.***

For more information contact the authors at Department of Human Development and Family Studies, M. S. University, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health.**
The project is funded by Ford Foundation by award no. 940-1148.

9 REPRODUCTIVE HEALTH SEEKING BEHAVIOUR OF MARRIED ADOLESCENT GIRLS IN URBAN SLUMS OF AHMEDABAD

Background

Married adolescent girls (10–19 years) constitute about 1.8 percent of the total Indian population. In terms of absolute numbers, about 18 million girls are married adolescents. They need special reproductive health services particularly during their first pregnancy. Their reproductive health needs however, cannot be addressed in isolation. Any attempt to address these needs has to ensure involvement of their husbands and has to operate within the overall social and cultural context. Information on husband-wife relationship and decision-making processes related with reproductive health issues is lacking for planning effective interventions.

Objectives of the study

The study attempts to understand: a) the extent of involvement of husbands in the reproductive health of married adolescent girls, b) decision making process in seeking reproductive health services, and c) the factors that affect utilisation of reproductive health services by such adolescents.

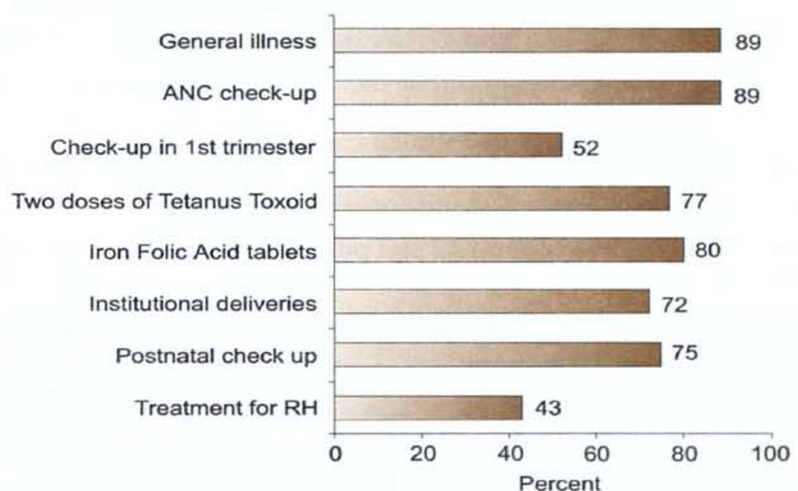
Methodology

A combination of quantitative and qualitative approaches was used to collect the data. This included 30 in-depth interviews each of married adolescent girls, their husbands and mothers-in-law and a detailed sample survey of 472 married adolescent girls. The study was conducted in a ward of Ahmedabad city covering approximately 67,000 population.

Findings

- The study shows that adolescent married girls in general receive health care services when required, irrespective of whether it was due to general illness, pregnancy, postnatal care or reproductive health problem (Figure).
- Husbands in general were found to be caring. They played a significant role in the decision-making process – often in consultation with their mothers. They played a more proactive role in family planning acceptance and in selecting health providers for the treatment of general sickness.
- In the case of antenatal care, most of the husbands (84 percent) played some positive role – 21 percent accompanied their wives to the clinic, 68 percent gave money for ANC checkups while 5 percent also shared routine household

Percent of the adolescent women who received reproductive health care



work; 16 percent of husbands did not do anything to help.

- During delivery and postnatal care, culturally not much was expected from the husbands except providing financial support, if required. A majority of (56 percent) husbands were available at place of delivery, and 54 percent paid money for the services.

Decision Makers for Married Adolescent Health Seeking

(Percent)

	Self	Husband	Mother-in-law	Natal family
General illness	21	34	18	25
ANC	17	29	37	16
Place of delivery	12	22	26	36
RTIs and STDs	23	29	27	22
Use of FP methods	36	36	1	-

In 9 cases provider took the decision

- 63 women (13 percent) reported reproductive health problems. This included backache, white discharge, menstrual problem and lower abdominal pain.
- 42 percent did not inform anyone, as *"it was not causing any discomfort"* and accepted it as an inevitable part of womanhood. The rest informed their husbands (28 percent), mothers-in-law (12 percent), and mothers (17 percent). Most of the women who reported their problems received treatment.
- Husband's role in care of reproductive health was confined to facilitating treatment. This is explained by women saying, "my husband asked his mother and suggested consultation with doctor and provided finance" (56 percent).

"If during day time, I fall sick, I tell my mother-in-law. If at night or early morning I fall sick, I tell my husband. He discusses it with his mother and decides the doctor. As I am newly married, I do not know any doctor in the area."

•

"I do all work of the family ... Here I have fallen sick four times. When I fall sick I inform my husband and he decide, what should be done. He takes me to doctor and gives me all help I need."

•

"My husband does not have time or experience. He asks his mother to take care and that I would not do any household work."

•

"If I fall ill he sends me to my mother's house. Till now he has not spent a single paise on me."

Recommendations

- Very few married adolescents use family planning. Special educational campaigns should be developed to counsel them and their husbands.
- As most married adolescents attend the clinic for ANC check-ups and many come with their husbands, this opportunity should be used to educate them about postpartum care including breast-feeding and use of family planning.
- Husbands of married adolescents should be made special targets for educational efforts, both for pre and postpartum care and contraceptive use.
- Promotion of condoms and pills among sexually active adolescents should be given special attention.

Barua A., Shah M. H., and Venkiteswaran S. 1999. ***Reproductive health seeking behaviour of married adolescent girls in urban slums of Ahmedabad.***

For more information contact the author at Foundation for Research in Health Systems, 6, Gurukrupa, 183 Azad Society, Ahmedabad. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health.**

The project is funded by Ford Foundation by award no. 940-1148.

10 KNOWLEDGE, AWARENESS, BELIEFS AND PRACTICES ON SEXUALITY AND REPRODUCTIVE HEALTH OF ADOLESCENTS IN SLUMS OF AHMEDABAD

Background

According to the 1991 Census of India, there are approximately 183 million adolescents (10 – 19 years), constituting over 22 percent of the country's population. A sizeable proportion of these are illiterate or out-of-school. Their access to information and health care is very limited. There is growing evidence that in slum areas, an increasing numbers of unmarried adolescents are becoming sexually active at a young age without proper information or protection. All this exposes them to a greater risk of contracting sexually transmitted diseases, including HIV/AIDS.

Objectives of the study

The purpose of the study was to assess: a) knowledge of adolescents about reproduction, sexuality, and HIV/AIDS, b) their information needs and sources of information, c) their sexual behaviour, and d) their reproductive health problems, if any.

Methodology

The study used a combination of qualitative and quantitative approaches to collect the required information. Interviews with 151 boys and 93 girls, selected from three slums in Ahmedabad, provided the quantitative data. Qualitative information was collected by observing functioning of clinics and informal discussion with the providers.

Source of information and interest

- 12 percent of adolescents read magazines.
- 48 percent of adolescents read local newspapers with a special interest in sports, murders, accidents and social events.
- Adolescents have tremendous interest in reading about films, heroes, and heroines.
- No girl mentioned reading magazines related to jokes, cricket, or sex issues.
- Most adolescents who listened to the radio enjoyed film songs.
- 95 percent of adolescents watched TV daily. Most girls saw movies, songs, and serials while boys saw sports, BBC news, quiz shows, and educational programmes.
- TV was the most important source of knowledge about health, sex, and body for adolescents. 83 percent of adolescents watched TV as their main hobby.

Findings

- Most of the adolescents were literate; as about two-thirds of both boys and girls had studied beyond middle class. Lack of interest in continuing education, responsibilities of household work, poverty, and distance of higher levels school were the reasons for discontinuing studies.
- About 29 percent of girls and 56 percent of boys were employed. Most of the girls were employed as domestic helpers. Boys were engaged in skilled professions or were self-employed as auto rickshaw drivers, masons, managing bicycle repairing shop, tiffin distribution or selling balloons.
- The minimum age at marriage among boys and girls was 16 years and 13 years respectively. More than half of the adolescents were not aware of the legal age at marriage for boys and girls.
- Films were one of the common topics discussed among peers of both sexes. Boys among themselves

talked about girls, films, sports, jobs, and daily events or family problems, while girls talked to each other about films, family problems, and about other girls and boys.

- One-fourth of the boys but none of the girls admitted to having seen 'blue films'. After watching the 'blue films', the boys reported desire for repeating the act in reality. The other sources of their information were advertisements on public transport facilities, dispensaries, and CHETNA.
- Adolescents (71 percent) accepted and justified wife beating if a woman flirted with other males.
- More boys (55 percent) than girls (25 percent) wanted to have their first child within 2 years of marriage. Similarly, 34 percent of girls and only 15 percent of boys mentioned the need for maintaing a longer interval (3-5 years) between two births.
- Adolescents revealed poor knowledge of physiological changes during puberty among boys and girls, process of menstruation, and conception. 84 percent of boys and only 41 percent of girls knew that pregnancy occurs due to sexual intercourse.
- Girls had poor knowledge of antenatal care, importance of nutrition, iron and folic acid tablets, and tetanus toxoid injection during pregnancy.
- A majority of them did not know that in India, abortion is legal. Surprisingly, two-fifths of adolescents approved of abortion among unmarried girls, one-half approved sex determination tests and one-fifth even approved abortion of a female foetus.
- Generally adolescents were aware of different contraceptive methods. However, they lacked correct and detailed knowledge of method use. Only 5 percent of girls had correct knowledge of the fertile period in women's menstrual cycle.
- Knowledge about safe sex was negligible, particularly among adolescent girls. Similarly, knowledge about STDs, modes of transmission, and curability was also very poor.
- A majority (62 percent of boys and 75 percent of girls) had heard of HIV/AIDS. Though adolescents were aware of AIDS more than other STDs, they revealed many misconceptions about the disease.
- 42 percent of boys and 38 percent of girls had sexually active friends. 24 percent of boys and 12 percent of girls had experienced vaginal intercourse, with a neighbour or relative of the same age. Sexual health concerns were expressed by 6 percent of boys and 19 percent of girls.

Recommendations

- Slums should be declared priority areas for education campaigns on AIDS/STDs and contraception.
- Innovative approaches should be used to provide complete scientific information on puberty changes, menstruation, pregnancy, contraception, safe sex, STDs and HIV/AIDS.
- Adolescents should be empoweed with information and services to reduce gender biases prevailing in the community.
- Lack of knowledge about safe sex and high prevalence of pre-marital sex should be a matter of concern for health authorities.

Patel P., Capoor I., Joshi U., Barge S., and Uttekar V. 2000. ***Knowledge, Awareness, Beliefs and Practices on Sexuality and Reproductive Health of Adolescents in Slums of Ahmedabad.***
For further information contact the authors at CHETNA, Lilavatiben Lalbhai's Bungalow, Shahibaug, Ahmedabad or CORT, 402, Woodland Apartment, Race Course, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health**.
The project is funded by Ford Foundation by award no. 940-1148.

11 SEXUALITY AND HEALTH SEEKING BEHAVIOUR AMONG OUT-OF-SCHOOL ADOLESCENTS IN ANAND SLUMS

Background

Adolescence is a transitional period when a child undergoes the changes from childhood to adulthood. During this period adolescents need information, guidance, and emotional support. Ironically it is also the age when they have very little access to this information. It is very difficult for adolescents to discuss or obtain information about reproduction, sexuality and other related issues from teachers, parents, or any other reliable source. Today adolescent sexuality and sexual health are viewed as a problem rather than as a natural process in the growth towards adulthood.

Objectives of the study

The purpose of this study was to assess knowledge and attitudes of out-of-school adolescent boys and girls in slums towards: (a) family formation, (b) sexuality and sexual behaviour, and (c) STDs/HIV and safe sex.

Methodology

A combination of qualitative and quantitative methods were used to collect the data. First, social mapping and focus group discussions were used to explore the field setting. A sample survey of 300 adolescents in the age group of 12 to 19 years provided the quantitative information. In-depth case studies of 25 adolescents were conducted to collect information on sexual experiences, health problems, and other sensitive issues, such as homosexuality.

Findings

- 69 percent of girls and 39 percent of boys had never been to school. The community had a strong negative attitude towards education, particularly towards education of girls. The girls seemed to have internalised this attitude and expressed their disinterest towards education compared to boys who cited financial constraints as the main reason for not attending school.
- More boys (60 percent) than girls (55 percent) viewed 3 to 4 children as the desirable family size. Knowledge of family planning methods was very limited.
- Only 8 percent of boys and 15 percent of girls knew that it is the sperm of the male partner that is responsible for the sex of the child. Boys were more aware of the reproductive physiology of girls compared to the girls themselves. Many boys correctly knew the process of menstruation, conception, and safe period. In contrast the girls were either completely ignorant or had many myths about the various aspects of reproductive physiology.
- Girls had better knowledge about reproductive health, body hygiene, age at marriage, appropriate age for first childbirth, and duration of pregnancy for safe abortion than the boys. Most girls believed that it was safe to abort a pregnancy until the 10th week, whereas, the boys suggested that it was safe to terminate pregnancy till the 20th to 24th week after conception. Only 15 percent of girls knew that Medical Termination of Pregnancy (MTP) is legally approved. More boys (53 percent) approved of abortion as compared to the girls (30 percent).

- The girls, in general, did not show a positive attitude towards sex. They approved of boys indulging in premarital sex, masturbation, and forcing sex on unwilling wife. An equal proportion of boys and girls thought that the wife had a right to refuse sex with the husband.
- Many late adolescent boys (55 percent) and girls (38 percent) reported having sexual intercourse and an even higher percentage reported having other types of sexual experience. Only 16 of percent girls and 6 of percent boys were ever married. Most of the sexual encounters, thus, were outside marriage.

Kanchan, 17, has just lost her lover to another girl in the same slum. She is quite upset. She says, "Boys out here love the body of the girl. Those girls who are ready to keep physical relationships with boys are the ones who can sustain love affairs."

But, at the same time she admitted,"The boy, with whom I had an affair used to fulfil all my wants, he has given me many things like hairpins, bangles, taking me out to movies. I am unable to fulfil all my wants and desires. I am not even allowed to work."

- The sexual relationships were more or less consistent and regular rather than accidental. In-depth interviews also showed that boys engaged in sex more because of experimentation, sexual excitement, and enjoyment, whereas, girls engaged in sex with individuals with whom they believe that they are in love and have some amount of commitment.
- Adolescent's knowledge about HIV/AIDS was very limited. The male adolescents had better knowledge about the existence and fatality of AIDS as a disease. Boys were also more aware of the modes of transmission of STDs and HIV compared to female adolescents. Only 12 percent of females as opposed to 68 percent of boys were aware that sexual intercourse could cause some health problems. None of the girls knew that sexual intercourse was a possible mode of transmission of STD/HIV.
- Both girls and boys expressed the desire to know more about body hygiene, care during pregnancy, and family planning. However, boys showed more interest in reproductive physiology and care during pregnancy.

Recommendations

- There is a large knowledge gap among girls in terms of knowledge of sex, sexuality, and health. There is a strong need for community counselling to increase the acceptability of women's education and enhance gender equity and women's reproductive rights among slum dwelling adolescents.
- Observing the prevalence of active sexual encounters among slum adolescents, it seems imperative that an awareness programme and information base is created. These should be primarily directed towards the potential consequences of the sexual relationships in terms of health related issues like STDs and AIDS.
- The government and NGOs should carry out education programmes to create awareness about reproductive physiology and safe sex using television and other audio-visual media, as these have a strong influence on adolescents.
- Operations Research is required to test various alternatives to fulfil the information needs of adolescents, particularly those who are out-of-school and living in slum areas.

Daftuar C. N., and Biswas U. N. 2000. ***A study of sexuality and health seeking behaviour among out-of-school adolescents in Anand slums.***
For more information contact the author at Department of Psychology, Faculty of Education and Psychology, M. S. University Vadodara, Gujarat. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health.**
The project is funded by Ford Foundation by award no. 940-1148.

12 FAMILY LIFE EDUCATION TO SECONDARY SCHOOL STUDENTS: AN OPERATIONS RESEARCH

Background

Adolescence is a period of development from puberty to maturity. Both physical and psychological development occurring during adolescence lead to behavioural changes, which are influenced by the socio-cultural milieu. Since adolescents often do not have a proper understanding of these changes and the relevance of the socio-cultural influences, they start distancing themselves from the adult world. Available studies on knowledge, attitudes, and sexuality among adolescents in India are deficient due to flaws in methodology and over reliance on quantitative methods. Intervention studies in this field are very few.

Objectives of the study

An intervention study to reduce the knowledge gaps of students about family formation and sexuality was carried out in four schools of Ahmedabad city. The main purpose of the study was: a) to assess the knowledge and attitudes of secondary school students towards reproductive health, contraception, and sexual risk behaviour and b) determining the effectiveness of peer educators and teachers in providing family life education.

Methodology

A total of 954 students (497 boys and 457 girls) in classes 8th, 9th, and 10th were selected for the intervention. Teachers and peer educators were trained to conduct information sessions among school students (see Box 1). A baseline survey before the intervention and an end-line survey, six weeks after the intervention was conducted to assess the impact of the intervention. In-depth interviews, focus group discussions, and key informant interviews enhanced the understanding of the programme.

BOX 1
Topics covered during training
- Communication skills
- Self-concept and self-esteem
- Anatomy and physiology
- Adolescence
- Conception
- Contraception
- STD, HIV/AIDS
- Myths related to sex

Findings

- The mean age of the students participating in the study was 13.8 years. Students belonged to middle income families. Around 30 percent of the students reported the monthly income of their family as Rs. 7500. Mothers of 50 percent of the students were graduates.
- Students had poor or no knowledge about the country's population size, literacy rate or size of urban population. Only 45 percent knew that pregnancy can be prevented, which was significantly higher among students of class 10th.
- 55 percent supported inter-caste marriages, while 60 percent (more girls) said that arranged marriages are best.

BOX 2
Out of ten students only
- 5 knew pregnancy can be prevented
- 5 knew about oral pills
- 4 knew about condom
- 1 knew how to use condom
- 2 knew meaning of safe sex

- Half of the students believed that sex before marriage is a sin, but 39 percent approved of pre-marital sex, if partners agreed. About 26 percent considered sex before marriage as necessary. One-tenth saw no harm in having multiple sex partners. There was not much difference between the beliefs and attitudes of girls and boys.
- The major sources of information on various aspects of family life reported were TV, newspapers, and magazines. Only few mentioned parents and teachers as sources.
- Just 14 percent were aware that the husband is responsible for the gender of the child.
- Two-thirds of the students favoured family life education (FLE) and one-fourth felt that FLE should be compulsory in schools.
- Students felt the need for information on physical hygiene (75 percent), reproductive anatomy and physiology (60 percent), followed by contraceptive methods, care during menses and during pregnancy, sex education, STDs, HIV/ AIDS (35 percent).
- The adolescents reported increased assertiveness and self-esteem, and better communication skills.
- Adolescents expressed the intention to postpone sexual initiation and to use condoms, if they become involved in sexual activity.

Box 3

Lessons learned

- Despite initial reservations, school authorities cooperated well.
- Both teachers and peer educators as providers of FLE were equally effective.
- Students asked the same questions repeatedly. They require more time for understanding.

The endline survey showed that students gained knowledge after the intervention programme. Qualitative data revealed that both boys and girls developed more positive attitudes toward sexuality.

Recommendations

- Reading materials should be provided along with the training to consolidate learning among adolescents.
- Although the gains in knowledge are positive, they are modest. More innovative methods may increase the effectiveness of the programme.
- Long-term outcomes, especially behavioural change, as a result of FLE programme, should be assessed by a well-designed longitudinal study.

Sinha B. K., Mehta R., Vankar G. K. and Dave T. 1999. ***Family life education to secondary school students: An operations research.***

For more information contact the author at Department of Psychiatry, B. J. Medical College and Civil Hospital, Ahmedabad.

The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health.**

The project is funded by Ford Foundation by award no. 940-1148.

13 DOMESTIC VIOLENCE IN RURAL GUJARAT

Background

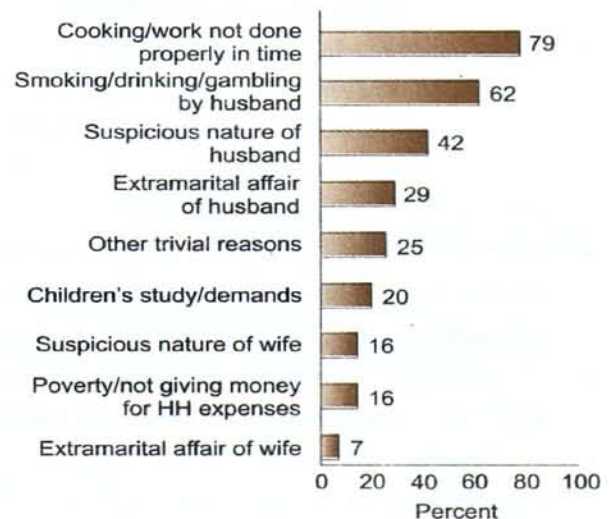
A WHO study shows that violence against women (VAW) causes more death and disability in the 15–44 age group than cancer, malaria, traffic accidents and war combined. For eliminating VAW, it is critical to understand the context of violence and social constructs, which support its perpetuation. Empirical data, estimating prevalence of domestic violence and its determinants, is scant in India and needs urgent attention.

Objectives of the study

The purpose of the study was to assess: a) prevalence and forms of violence against women (VAW) in rural Gujarat, b) community perceptions towards VAW, and c) factors that contribute to the perpetuation of violence.

Methodology

A combination of qualitative and quantitative methods were used to collect the data. The qualitative methods used were free listing, focus group discussions (FGD) four each with men and women and 8 in-depth interviews each of men and women. The quantitative data was obtained from a representative sample survey of 291 community members, 139 men and 152 women, selected from 12 villages of Savli *taluka* (an administrative unit) of Vadodara district in Gujarat.



Findings

- A majority of the females (59 percent) and only 8 percent of males reported frequent VAW in their community. Mostly (78 percent) the victims were wives and the perpetrators were their husbands. 53 percent of female respondents, however, mentioned that at times a wife also acts as a perpetrator.
- The study indicates that frequently trivial issues trigger marital conflicts. Some of the common reasons for triggering violence were "*not preparing food in time*" and "*assigned task not done by wife.*"
- Beating of a wife was justified more by females than males in situations such as "*not cooking food properly*", "*going out frequently without telling him*", "*refusing sex*". More men (68 percent) however, justified a beating than women (35 percent), if the husband suspected her of being unfaithful.
- Frequently reported forms of violence included: abusing (97 percent), scolding (82 percent), taunting (63 percent), slapping (80 percent), kicking/punching/beating with object (74 percent), pulling hair/dragging (27 percent), forced sex (27 percent), not giving money for household expenditure (72 percent), criticising quality of cooked food (70 percent), labelling wife as characterless (68 percent), threatening to divorce (26 percent) or go to other women (34 percent), and abusing her natal family (30 percent).

- Women who are victims, as a defence mechanism, generally keep quiet or at the most retaliate verbally or stop communicating for 2–3 days. In the case of continued physical harassment, women temporally leave the house and go to neighbour's home for a few hours or to the natal family for a few days.
- Very rarely do the victims approach the panchayat (local self government) or file complaints with police. Complaining to them means deciding to leave the husband, family, and children. The main factors, which discourage women to protest or retaliate against the harassment, are concern for family, prestige of parents, lack of economic and social support, and love for the children.

> "It is in our culture that a woman takes beatings (*mar khavo*) as well as all benefits/love (*mal khavo*) from the husband" (*Female FGD*)
>
> •
>
> "We even tolerate severe beating, if it is only once or twice in a month" (*Female FGD*).
>
> •
>
> "The woman would be willing to endure and remain repressed (*daban*) just to uphold her fathers' reputation (*abru*). Affection and concern for her children also gives her strength to bear with her difficult situation" (*Male FGD*).

- Around one-third (32 percent) of the respondents experienced some form of abuse in the last six months. Of these, 24 percent of the respondents experienced verbal abuse and the rest faced a combination of verbal, psychological, and physical harassment.
- In a majority of the cases verbal abuse and minor physical violence started soon after the marriage while major beating and mental-torture started after having the first child. The women reported that there was no change in the status of violence over the period of time; rather there could be an increase due to sex related issues.

> "In the case of non-compliance, husband may ask us to leave the house. Where shall we go? We cannot wander on the roads. How long can a brother and parents keep us? There is no way out (*chutko nathi*), we have to live with it (*ravuj pade*)" (*Female FGD*).
>
> •
>
> "Feeling absolutely consumed, she may go to her father's house just to return after a few days and to once again face the mental agony" (*Male FGD*).

- Frequent physical violence was much less reported than verbal and psychological harassment. However the later reportedly caused greater harm than the former, leading to uneasiness, mental disturbances, self-neglect and often contemplation of suicide.
- A majority (73 percent) of males and almost all who reported violence against their wives confessed that their fathers had mistreated their mothers.
- Community members considered domestic violence as a private issue and do not visualise any role of panchayat (local self government) or other community members in resolving the conflict.

Recommendations

- All community workers, panchayat members and block/district level officials should be sensitised about the gender issues.
- Sustained educational campaigns by NGOs and advocacy groups about the social evils and consequences of violence against women should be launched among community members.

Nair U. and Sadhwani H. 2000. ***A study on domestic violence in rural Gujarat.***
For further information contact the authors at the Society for Operations Research and Training, 27-31, Vardhman Resi-cum-Plaza, Subhanpura, Vadodara. E-mail – sort@satyam.net.in The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health.**
The project is funded by Ford Foundation by award no. 940-1148.

14 MARITAL VIOLENCE: ITS IMPACT ON HEALTH - WOMEN'S PERSPECTIVES

Background

Marital violence takes many forms such as physical, emotional, verbal, sexual coercion, or deprivation of resources. Marital violence is endemic both in developed and in developing countries and its occurrence cuts across all caste, class, ethnic groups and nationalities. Marital violence is detrimental to women's physical and mental health including their very survival. However, it is only recently that this issue has been given some attention.

Objectives of the study

The study aims to explore the nature of violence, frequency of its occurrence and situations leading to violence. The study further examines the impact of marital violence on women's health and the coping mechanisms adapted by women while facing the violence.

Methodology

A combination of qualitative and quantitative methods were used to collect the data. Qualitative methods of free listing and in-depth interviews were used to explore the patterns of violence, its impact on health and coping mechanisms adapted by women. Besides, 140 married women residing in two slum communities of Vadodara were interviewed using a semi-structured interview schedule.

Findings

- Nearly half (44 percent) of the women interviewed reported to have experienced some kind of physical, psychological, or sexual violence sometime in their lives.
- Analysis of the nature of violence by the background characteristics of the women showed that women's education, her husband's education, family income, type of family, her age at marriage and her age difference with husband had some impact in her marital life and the experiences of violence. But, her age, type of marriage, and work status did not seem to have any impact on marital violence.
- Only 20 percent of the educated women as against 44 percent of the illiterate women reported experiencing violence.
- Girls (46 percent) who got married at a very young age (below 18 years) experienced less violence

Nature of Violence Reported by Women

Categories	Number	Percent
Slapped / beaten with hands or object	52	84
Verbally abused	49	79
Taunted / insulted / criticised by husband for their looks, skill	34	55
Given threats and threatening gestures	29	47
Denied treatment / ignored / harassed	23	37
Pushed / dragged / pulled by hair	21	34
Forced sex	18	29
Not allowed to meet parents, relatives	17	27
Burned / strangled attempting to kill	10	16
Restrictions on eating / dressing up	10	16
Driving out of house / scolding	5	8
Others, including suspicion	5	8
Number of women reporting violence	**62**	

than those married after attaining some maturity (20-29 years).

- More women with a larger age difference with their husbands faced violence.

> "I was so young that I was unaware about sexual relations.... When my husband tried to have relations. I got very scared and went to complain to my mother-in-law..." *- Sumitraben, 42 years*
>
> •
>
> "I used to work as a domestic servant earlier. He was suspicious and didn't want me to work. So he had beaten me a lot and broke my leg. I had to go to the doctor." *- Gangaben, 35 years.*

- One-half of the women experiencing violence perceived alcohol consumption by their husbands as one of the main reasons for physical and psychological harassment. Issues over food and other household chores (27 percent), suspicion of infidelity (23 percent), finances (23 percent), or issues related to other family members (22 percent) also triggered violence.

> "He fights with me on every small issue for food, on my dressing up, for sex... He beats me, abuses me and hits me with whatever comes in his hands. This happens 3 to 4 times a week." *- Shantiben, 33 years.*
>
> •
>
> "He does not trust me and keeps blaming me for having an affair with someone else. If I buy or wear something of my choice he tells me that the other man has given me all." *- Jiviben, 27 years.*

- The coping mechanisms adapted by women reporting violence ranged from crying (93 percent) to retaliating verbally (87 percent), or going to neighbours/relatives (68 percent). Very few (6 percent) lodged police complaints and none went to any NGO for help.
- A majority (69 percent) of the women reported physical health problems and 47 percent suffered from psychological disorders like tension and frustration, sense of worthlessness, lack of confidence, and fear of expression (14 percent). 16 percent reported physical health problems and 46 percent reported psychological health problems due to the harassment inflicted by their husbands.
- One-fourth of the women experiencing violence required medical help at least once in their lives due to violence. A few experienced such episodes multiple times.

Recommendations

- There is a need to understand the complexity of marital violence. Reliable data is required for planning interventions and supporting effective advocacy against gender-based violence.
- Interventions against marital violence should be comprehensive and community based. Experimentation and collaboration with NGOs could give leads on how to address this problem.
- A place should be identified in the community where women facing violence can go and share their grief, avail of counselling, or necessary medical help.
- Husbands (perpetrators) need to be counselled. For planning services for addressing the perpetrators and the victims of marital violence, the situations under which the marital violence takes place need to be understood properly.
- Community health workers should be sensitised to the problem of marital violence and attempts should be made to understand how they could contribute in resolving this problem.

Mehta B., Desai A., and Desai H. 1999. ***Marital Violence: Its impact on health - Women's perspectives.***
For more information contact the author at Faculty of Social Work, M.S. University, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health.**
The project is funded by Ford Foundation by award no. 940-1148.

15 TREATMENT SEEKING BEHAVIOUR OF STD CASES ATTENDING SKIN AND VD DEPARTMENT AND PRIVATE CLINICS IN VADODARA

Background

Sexually transmitted diseases (STDs) are a major public health problem in both developed and developing countries. Prevalence of STDs, however, is higher in developing countries. Globally, there are 330 million new cases of STDs every year, mostly affecting young people. In the present arena of HIV/AIDS, STDs assume a greater importance as the transmission of HIV/AIDS is mainly through the sexual route. There are very few studies related to reproductive morbidities among men, about their treatment seeking behaviour, partner notification and decision-making process.

Objectives of the study

The study aimed to explore the treatment seeking behaviour of patients attending public and private STD clinics. More specifically, the study focused on the awareness of patients towards STDs, HIV and AIDS, delay in seeking treatment, sexual behaviour and the use of condoms, attitudes towards partner notification, and the economic cost of the disease.

Methodology

A combination of qualitative and quantitative approaches were used to collect the information. Data was collected from 141 semi-structured interviews of STD patients who came for treatment at STD clinics. Out of these 141 cases, 111 patients had come to SSG Hospital, a tertiary referral hospital at Vadodara, while the other 30 cases were interviewed at two private STD clinics. Trained doctors of the hospital conducted the interviews. Qualitative information was collected by conducting 30 in-depth case studies of STD patients.

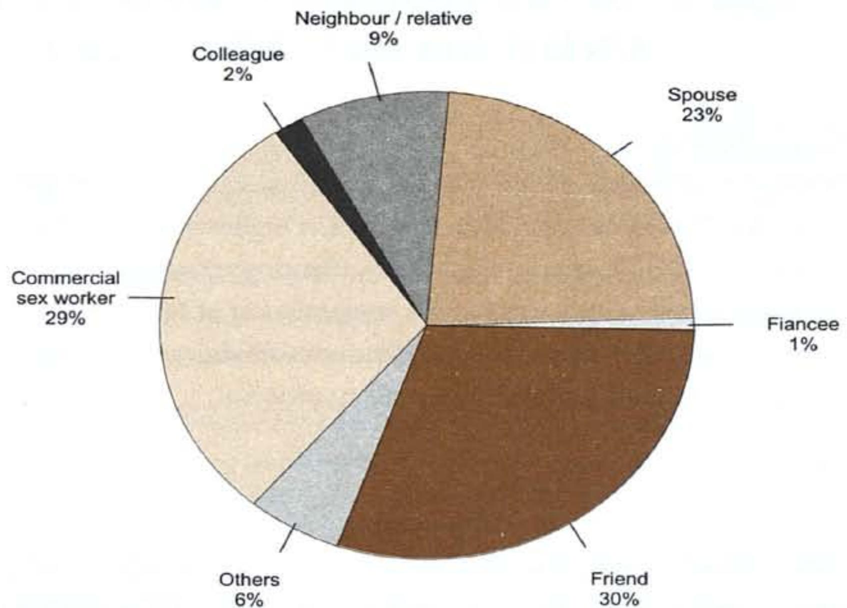
Findings

- Out of 141 STD cases (8 females and 133 males), half were below the age of 25 years. One-fourth were illiterate, while 32 percent had schooling upto higher secondary or above. About half of the patients were unmarried.
- There was a wide gap between knowledge and use of the condom. Both, awareness and use of the condom as a method of safe sex was low. Condoms were used only to avoid pregnancy.
- Most youth (81 percent of cases) had heard about STDs and 73 percent about HIV/AIDS. The main sources of information were friends, TV or print media.
- Two-thirds of the patients reported that they had become sexually active before 20 years of age. Peer pressure was the most important reason for initiating sexual life.

> *"My friends used to go to commercial sex workers. I did not want to go but still they took me along."*

- Nearly half (44 percent) of the cases reported a sexual relationship with sex workers. The rest reported sex with friends, colleagues or girl friends. This indicates that designing HIV/AIDS programme targeting

sex workers only will not go a long way in controlling the spread of the disease.



- 57 percent of STD patients knew that STDs are preventable. Only 30 percent of patients perceived their symptoms as a serious health problem. Reported methods for preventing STDs included avoiding sex with strangers (28 percent), having sex with only one partner (16 percent), and using condoms during sex (8 percent). Patients attending private clinics were more aware of ways of prevention against STDs.
- 37 percent of STD cases knew that their partners should also be treated. But, only a few (7 percent) brought their partners for treatment.
- 30 percent did not communicate their problems with anyone. The level of spousal communication on the subject was very low (18 percent) and only symptoms were mentioned to their wives.
- In 50 percent of the cases, the gap between noticing the problem and visiting a health provider was less than a week. Other cases waited for self-healing, used a home remedy, or went elsewhere for treatment.
- In 57 percent of cases, the first action taken was getting advice from a health worker/clinic/ hospital or bringing medicine from a clinic. Around 18 percent of the cases used medicine available in home or brought medicine from a pharmacist.
- Only 16 percent of the cases in the private clinics and 45 percent in the government STD clinic came directly. The other cases visited one or more services before coming to this clinic. The cases coming to government STD clinics after visiting other doctors spent more time and money as compared to their counter parts visiting private clinics. The average amount of money spent by the patients was rupees 237 (US$ = 5).

> "When I told my wife that I am having pus discharge through urethra, she did not ask me anything she just advised me to visit a good doctor."
>
> "I did not communicate with my wife because if I had told her there would have been a quarrel in my house and it could lead to divorce."

- Only 10 percent of the cases were advised to use condoms and only one case was given advise on partner management.

Recommendations

- The spread of STDs goes well beyond the high risk populations like commercial sex workers. Hence educational campaigns of STDs/AIDS should address all.
- Few people know about safe sex. Dual protection with condom prophylaxis should be emphasised in all family planning and AIDS educational messages.
- Experimental studies should be undertaken on how to increase treatment of partners of STD patients.

Marfatia Y. S., Barge S., Parmar S., Bansal N., and Khan W. U. 2000. ***Treatment seeking behaviour of STD cases attending Skin and VD Department and private clinics in Vadodara.***

For more information contact the authors at Department of Skin and VD, Medical College and S. S. G. Hospital, Vadodara and Centre for Operations Research and Training, 402, Woodland Apartment, Race Course, Vadodara. The study was supported by the Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health**.

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16 YOUNG MEN'S PERCEPTIONS OF THEIR OWN REPRODUCTIVE HEALTH IN A SLUM OF VADODARA

Background

Since ICPD, the involvement of men in reproductive health has come under sharp focus. The three aspects which are important are: a) men as supportive partners for reproductive health concerns of women, b) understanding men's own sexuality and reproductive health needs, and c) expanding reproductive health services for men. While the first aspect has received considerable attention, the remaining two aspects have been neglected.

Objectives of the study

The specific objectives of the study were to understand: a) information needs of young men about reproductive health and their present sources of information, b) their perception about masculinity and sexuality, and c) their sexual behaviour and sexual health.

Methodology

The data was collected by using a combination of qualitative and quantitative approaches. They included social mapping and census of households in the study slums, three focus group discussions and detailed interviews of 100 married and 100 unmarried men using a semi-structured questionnaire and eight case studies to illustrate the findings.

Findings

- Perceived traits of masculinity, which often guide youth's social and sexual behaviour, were probed in the study. The study showed that only 50 to 60 percent of the youth linked masculinity with early fatherhood or having frequent sex. Other characteristics, which were identified as traits of masculinity included physical appearance, showing strength or projecting normative values about honour (see Table).
- A majority of the youth did not consider having many sexual partners (77 percent), committing rape (89 percent), sex with sex workers (82 percent), forced sex with unwilling wife (80 percent) or having a large sexual organ (82 percent) as traits of masculinity.
- A majority of youth (87 percent) were

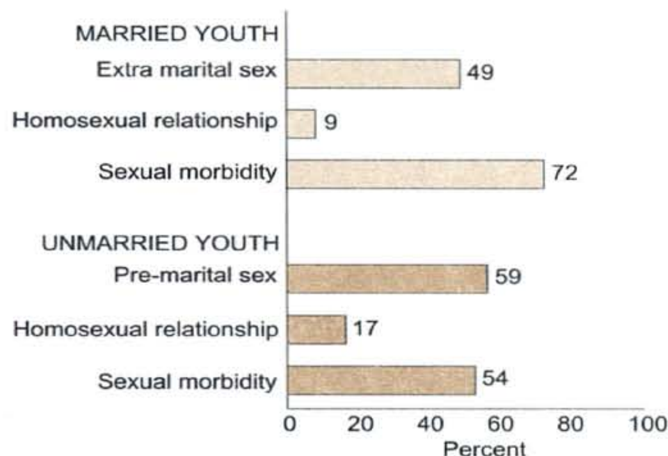
Perceived Traits of Masculinity

Traits of masculinity	Percent
Sexuality	
Having frequent sex	48
Becoming father soon after marriage	59
Physical built and appearance	
Being muscular	52
Having moustache	63
Showing strength	
Sticking to own decisions	51
Being aggressive	58
Holding normative values related to honour	
Ready to fight to protect:	
Self honour	71
Sister/wife's honour	67
Any women's honour	54
Being kind to women	74
Number of men interviewed	**200**

aware of STDs and AIDS and knew that both men and women (71 percent) could get these diseases. About one-fourth (24 percent) believed that only men could get these diseases.

- Very few had knowledge of women's physiology. Only about 20 percent were aware of the fertile period of the menstrual cycle when women could conceive, if they had unprotected sex.
- Almost all knew about family planning methods and about 66 percent had actually seen a condom.
- Unprotected heterosexual contact was mentioned as the principal mode of transmission for STD (50 percent) and AIDS (94 percent). Less than half and only one-fourth of the youth were aware that AIDS could also be transmitted by infected blood and needles respectively.
- For about three-fourths of the youth, friends. and peer group were their main sources of information on sexuality and reproductive health. About one-third depended on TV or cinema. Very few felt that they would ever seek this information from teachers (5 percent) or relatives/parents (6 percent).
- Premarital and extramarital sex was common. Half (49 percent) of married youth had sex with some women other than their wife. Similarly, 59 percent of unmarried youth were sexually active. Sexual relationships were generally reported with neighbours (36 percent), girl friends (32 percent), and sex workers (15 percent). Sex with girlfriends was more common among unmarried youth (42 percent) while married youth (27 percent) preferred sex workers. About half of them (47 percent) had unsafe sex with their partners.
- Homosexual relationships were also reported, particularly among unmarried youth (17 percent).
- Prevalence of sexual health problems is high in the urban slum. About two-thirds (63 percent) of the youth interviewed reported at least one sexual morbidity during the last six months. These were reported more by married youth (72 percent) than by unmarried (54 percent) youth.
- A fairly large proportion of youth had sexual health worries. These were related to wet dreams (35 percent), masturbation (34 percent), early ejaculation (30 percent), incomplete erection (25 percent) and size of their penis.

Sexual Behaviour and Sexual Health of Youth in Slums of Baroda



Recommendations

- Specially designed educational campaigns in slum areas could help in reducing risk-taking behaviour among the youth.
- User-friendly health services need to be developed to reach youth suffering from sexual health problems.

Rajaram, N. 2000. ***Young men's perceptions of their own reproductive health in a slum of Vadodara.***
For further information contact the authors at Department of Sociology, M. S. University, Vadodara. The study was supported by Population Council's Small Grants Programme under its project entitled **Strengthening Social Science Research on Women's Health.**
The project is funded by Ford Foundation by award no. 940-1148.

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