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ATTITUDE TOWARDS BIRTH-SPACING: A CROSS-SECTIONAL STUDY AMONG WOMEN LIVING IN J.J. CLUSTERS IN DELHI

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ABSTRACT

The study was undertaken to find out the awareness of mothers regarding birth-spacing and the influence of socb-demographic factors affecting such awareness. Of the total 477 women interviewed, 393 (82.4%) were in favour of birth-spacing. This favourable attitude towards birth-spacing was almost same in all the age groups of women studied. Among the study population, only 13 percent women were illiterate. As the literacy level of women increased, the trend was more in favour of birth-spacing. It was also favoured in equal proportions both by Hindu and Sikh women (87.1% and 90.0% respectively) but significantly less by Muslim women (39.6%). The findings revealed a high interest level and desire to space birth intervals indicating the need to increase advocacy and availability of contraceptive choices for women. The study concludes that women living in J.J. clusters of Delhi do have a positive attitude towards spaced birth-intervals and two-child norm.

Keywords: Birth-spacing, women, J.J. Cluster, Religion and Family size.

The Family Welfare Programme in India seeks to promote responsible parenthood with two-child norm through voluntary choice of family planning[1]. Recent studies[25] have shown that knowledge regarding different spacing methods varies from 10 to 60 per cent among masses. Even in Kerala, which has almost 100 per cent literacy level, approximately 70 per cent of people know about different types of spacing methods[2].

Research studies have shown a positive association between the widely spaced birth interval and the child survival, and an increased

mortality risk at close interval. The child survival becomes more difficult or both the children may become vulnerable, if the first child is not more than a year old[6]. It has been established that a gap of three to five years between two children increases the chances of survival not only for children but also for mothers[7]. The study of contraceptive prevalence in Bangladesh has also revealed that the survival status index among children was high while following birth-spacing[8].

The factors that modulate contraceptive acceptance leading to birth-spacing are age at marriage, status of women, education level, employment opportunities, old age securities etc and these are well documented in earlier studies[2-6-7].

OBJECTIVES

The present study was undertaken with the following objectives:

(i) To evaluate the attitude and awareness regarding birth-spacing among mothers living in J.J. clusters of Delhi and
(ii) To analyse the effects of socio-demographic factors on awareness and compliance to birth-spacing.

MATERIALS AND METHOD

The study was conducted in three Jhuggi Jhonpri (slum) clusters surrounding the Vardhaman Mahavir Medical College and Hospital in New Delhi. The study subjects were the currently married women in their reproductive age group of 15 to 45 years. A total of 477 currently married women were included in the study. A pre-tested, pre-designed proforma consisting of mainly close-ended questions was used. A team of interns under the supervision of the investigators interviewed the subjects individually. The faculty verified the collected information and recorded the same for further investigation and analysis. The data were analysed using the SPSS software.

FINDINGS AND DISCUSSION

Of the total 477 women interviewed, 393 (82.4%) were in favour of wider birth-spacing between two deliveries. The attitude of favouring

birth-spacing was almost the same in all the age groups, which is contrary to the findings, reported earlier[8]. The difference may be explained on the basis of differences in age group and religion of the study population and other factors specific to each study. Demography and health survey comparisons of 17 countries revealed that short period of birth-spacing increases the health risk among children[10]. In the present study, majority of the subjects were in favour of birth spacing while 17.6 per cent of the subjects were not in favour of birth-spacing who need more attention by the health and family welfare staff and policy managers (Table 1).

Literacy of women has a direct bearing on the attitude regarding different aspects of family welfare. Several authors have already highlighted that women's education, as a variable, accounts for four times more in controlling fertility in couples as compared to other variables[7-8]. In the current study, it was observed that as the literacy level of women increased, more and more women were in favour of birth-spacing.

Table 1 shows that almost equal proportion of Hindu and Sikh women (87.1% and 90.0% respectively) were in favour of birth-spacing. In contrast, only 39.6 per cent of the total Muslim women favoured the same. Similar trends have also been reported by other researchers[9-10] indicating a low acceptance of family planning methods by Muslim couples; though Islam, as a religion, does not necessarily discourage contraception[9]. The notion that child spacing is forbidden in Islam, was countered by many Muslim religious leaders who were later included for successful implementation of family planning programmes that helped to deflect people's concern and inhibition about birth-spacing[10].

Those who were in favour of spacing, they also favoured small family norm and practice of various methods of contraception. As per data on birth-intervals for the country, 60 per cent of children are born under 36 months and over 25 per cent under 24 months[10].

TABLE 1

DEMOGRAPHIC CHARACTERISTICS VERSUS ATTTUDE OF RESPONDING TOWARDS BIRTH-SPACNG

Demographic Characteristics	**Attitude towards birth-spacing**		**Total**
	Yes	**No**	
Age in years*			
<25	165 (47.1)	38 (45.2)	223(46.7)
	(83.0)	(17.0)	
26-30	113(28.7)	21 (25.0)	134(28.1)
	(84.3)	(15.7)	
31-35	69 (17.6)	17(20.2)	86 (18.0)
	(80.2)	(19.8)	
>35	26 (6.6)	8 (9.5)	34(7.))
	(76.5)	(23.5)	
Literacy level**			
Illiterate	48 (12.2)	14 (16.6)	62 (13.0)
	(77.4)	(22.6)	
Primary	99 (25.2)	20 (23.8)	119(24.9)
	(83.7)	(16.3)	
Middle	175 (44.5)	45 (53.6)	220(46.1)
	(79.5)	(20.5)	
Above	71 (18.1)	5 (5.9J	76 (15.9)
	(93.4)	(6.6)	
Religion			
Hindu	365 (92.9)	54 (64.3)	419 (87.8)
	(87.1)	(12.9)	
Muslim	19 (4.8)	29 (34.5)	48 (10.1)
	(39.6)	(60.4)	
Sikh	9 (2.3)	1 (1-2)	10 (2.1)
	(90.0)	(10.0)	
Total	**393**	**84**	**477**
	(82.4)	**(17.6)**	

'Significant P< "Insignificant P <

Figures in parentheses indicate percentage

In the present study, 59.3 per cent of the women expressed to have birth-intervals of minimum of three or more than three years between two deliveries. But a significant proportion (23.9%) of the respondents left this matter to God and they were actually not in favour of birth-spacing. Since women desire to have wider birth intervals, programme initiatives should be undertaken by the health and family welfare personnel and other associated authorities, institutions and individuals to increase the awareness among women about various available methods of birth-spacing

TABLE 2

DISTRIBUTION OF RESPONDENTS ON THE BASIS OF VARIOUS ISSUES RELATED TO BIRTH-SPACING AND FAMILY WELFARE

	Attitude towards birth-spacing		**Total**
	Yes	**No**	
Use of family planning method*			
Temporary	160(40.7)	29 (34.5)	189 (39.6)
Permanent	68(17.3)	8(9.5)	76(15.9)
None	165 (42.0)	47(56.0)	212 (44.4)
Preference for small	**family**		
Yes	380(96.7)	23 (27.4)	403 (84.5)
No	13(3.3)	61 (72.6)	74(15.5)
Desired birth-interva			
< Three years	242 (61.6)	41 (48.8)	283 (59.3)
> Three years	69 (17.6)	11(13.1)	80(16.8)
Depends on God	82 (20.8)	32(38.1)	114(23.9)
Desired No. of children*			
Two	273 (69.5)	35 (41.7)	308 (64.6)
Three	88 (22.4)	19(22.6)	107 (22.4)
Four or more	20 (5.1)	18(21.4)	38 (7.9)
Depends on God	12(3.0)	12(14.3)	24 (5.0)
Existing No. of children**			
One or two	144 (36.6)	25 (29.8)	169 (35.4)
Three	165 (41.9)	31 (36.9)	196 (41.1)
More than three	84(21.5)	28(33.3)	112(23.5)
Total	393	**84**	**477**

* Significant ** Insignificant
(Figures in parentheses indicate percentage)

64.6 per cent of women were in favour of a two-child family norm, but a wide gap was found between the current and desired family size because only 35.4 per cent of the respondents had only two children in their families. Thus, it is evident that respondents who favoured birth-spacing were unable to avoid a large family size to a great extent (Table 2).

To conclude, the present study revealed that majority of the subjects were in favour of birth spacing and two-child norm. Intensive EC activities aimed at potential mothers and unmarried boys and girls should be effectively planned and initiated at the peripheral level to spread the importance of birth spacing; and at the same time, steps should also be taken to various spacing methods for better compliance.

Lkkjka'k

प्रस्तुत अध्ययन नई दिल्ली की मलिन बस्तियों में रहने वाली माताओं द्वारा बच्चों को जन्म में अन्तराल रखने के बारे में उनकी जागरूकता के आंकलन करने के उद्वेश्य से तथा उनकी जागरूकता पर पड़ने वाले सामाजिक–जनांकिकीय घटकों के प्रभाव का पता लगाने के लिए किया गया था। साक्षात्कार की गई कुल 477 महिलाओं में 393 (82.4%) महिलाएं बच्चों को जन्म देने में अन्तर रखने के हक में थीं। अध्ययन के लिए चुनी गई सभी आयु–वर्गों की महिलाओं का जन्म–अन्तराल के बारे में लगभग एक जैसा ही रूख था। अध्ययन में शामिल महिलाओं में केवल 13% महिलाएं ही निरक्षर थीं। महिलाओं के साक्षरता स्तर में वृद्धि होने के साथ–साथ जन्म अन्तराल के प्रति उनका रूझान भी बढ़ता गया था। हिन्दु और सिख जाति की महिलाओं (क्रमशः 87.1%) और (90.0%) के रूझान का अनुपात भी लगभग एक जैसा ही था, लेकिन मुस्लिम महिलाओं (36.6%) की इस ओर कम रूचि पाई गई थी। अध्ययन से प्राप्त निष्कर्षों से जन्म अन्तराल के पक्ष में रूचि का स्तर महत्वपूर्ण रूप से उच्च पाया गया था तथा यह संकेत भी मिले हैं कि इसके पक्षपोशण की और अधिक आवश्यकता है और महिलाओं को उनकी पसन्द के अनुसार गर्भनिरोधक विकल्प उपलब्ध कराये जाने की आवश्यकता है। अध्ययन से यह निष्कर्ष निकलता है कि दिल्ली की मलिन बस्तियों में रहने वाली महिलाओं का बच्चों के बच्चों के जन्म में अन्तराल रखने के बारे में दो बच्चों के पारिवारिक आकार के बारे में सकारात्मक रूझान है।

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A STUDY OF OBSERVING FAST AMONG WOMEN IN CHANDIGARH

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ABSTRACT

The custom of observing fast was studied among 161 women, aged 18 years and above, residing in the field practice area of the Department of Community Medicine, Government Medical College, Chandigarh. Among the 89 fasting women, 39.3 per cent used to fast for a day in a year, 19.1 per cent for more than 40 days and the remaining in between. Majority (51.7%) of women began observing fasts starting from 18 years of age. Further, 58.4 and 62.9 per cent of women continued fasting even during pregnancy and sickness respectively. Women (70.7 %) who fast, consumed lesser than 1,000 Kcal on the day of fasting in comparison to non-fasting women (22.2 %) but consumed more fruits, vegetables and other preparations rich in micronutrients. Pallor was present more in non-fasting (50%) than in fasting women (39.3%). Systolic blood pressure was 113.8mm Hg in fasting compared to 116.06mm Hg in non-fasting women. More women were overweight (22.2%) in non-fasting than in the fasting (15.7%) group. Nearly half of the fasting women were free from depression related symptoms in comparison to one-third of women not observing fasts (P<0.05). The above findings indicate a strong association between fasting and health benefits such as reduction in weight, blood pressure and depression related symptoms.

Keywords: Women, Fasting, Customs, Medical benefits, Nutrition and Health.

Fasting is an important criterion used during various diagnostic, therapeutic and preventive applications such as assessing blood glucose, cholesterol etc. in the blood. Fasting, to some extent, controls obesity and reduces calorie consumption in ailments like cardio-vascular disorders, diabetes and osteoarthritis. In addition, dieting to look slim has been common among adolescents and young persons in order to follow role

models in modem day life. In India, a large number of women observe fast as a social cause pertaining to customs and religious beliefs. Studies have proved that religion and beliefs make an important impact on health. Older adults particularly women observing religious practices at least once a week have a survival advantage over others who do not[1]. Attendance in religious services has been associated with higher well-being[2], less depression[3] and lowering of blood pressure among participants[4]. Women who used to fast are considered more religious. However, such benefits may be neutralized since fasting may lead to further complications in cases where there is a continuing medical problem or during vulnerable stages of life such as pregnancy, lactation or adolescence.

OBJECTIVE

The present study was conducted with the objective to find out the prevalence of fasting and its associated health consequences among the rural women in the Union Territory of Chandigarh.

MATERIALS AND METHOD

The study was conducted in the Union Territory of Chandigarh, a modern city located at about 250 Km from the National Capital, New Delhi. Nearly 90 percent of the population (0.8 million) resides in urban and remaining in rural areas. The Union territory has 27 villages but most of them are in close proximity to the urban area as the city is spread over 114 sq. km. The Union Territory has the highest literacy rate in the country.

The study sample was drawn from the rural population in the field practice area of the Department of Community Medicine, Government Medical College, Chandigarh. The women above the age of 18 years were enrolled. Information was collected by medical social workers and doctors through a semi-structured interview schedule consisting of socio-demographic profile, type of fasting, eating practices, medical problems associated with fasting etc. Out of 161 women enrolled, 18 were unmarried and the rest 143 married. The women observing some kind of restrictions on either eating or missing regular diet over a period of 24 hours (1 day) for the sake of fasting other than for medical

diagnosis/ailment/management were enrolled in the fasting group. Body mass index (BMI) was calculated on the basis of WHO classification. Pallor was assessed by experienced doctors and uniformity in the observation was maintained for all the subjects. Morbidity was assessed by confirming any type of sickness that occurred during the last one year preceding the study. The information collected was analyzed with various correlates in fasting as well as in non-fasting groups.

FINDINGS

The study covered 161 rural women of Chandigarh. 143 (88.8%) were married and 140 (86.9%) subjects lived in nuclear families. With regard to educational status, 42 (26.1%) were illiterate and 53 (32.9%) studied beyond high school. Husbands of one-fifth of the subjects were also found to be illiterates. There were more vegetarians (79.8%) in the fasting group than in the non-fasting group (55.6%). Similarly, women observing fasts were visiting religious places more frequently (93.2%) than those not fasting (77.8%) (Table 1).

While comparing the fasting pattern between married and unmarried women, it was noticed that 54.8 per cent (40) of the married women observed *Karvachoth* in the month of October/November, a fast observed by women for the well-being of their husbands and during which nothing was consumed between sunrise and moonrise. Similarly, "Monday fast" was observed by 26 per cent of the married women. The commonest fast among unmarried girls again was the "Monday fast" (81.2%) followed by Thursday fast' (18.7%). The purpose of keeping fast for married women was mostly for the sake of husbands' well-being (47.9%) and for satisfaction (24.7%). Unmarried girls practiced it for personal reasons (50%) or for the purpose of satisfaction (50%) (Table 2). The main source of information and inspiration for observing fasts by both married and unmarried women was mothers (51.7%) followed by friends (20.2%), grandparents (19.1%) and relatives (15.7%). It was noticed that 51.7 per cent (46) of the subjects kept fast alone whereas friends (18%), mother-in-law (13.5%), sisters (5.6%) and sister-in-law (5.6%) were the common companions while fasting (Table 2).

TABLE 1
SOCIO-DEMOGRAPHIC PROFILE OF SUBJECT

Profile	**Fasting (n=89)**	**Non-fasting (n=72)**	**Total (n=161)**
Marital Status			
Unmarried	16(18.2)	02 (2.8)	18(11.2)
Married	73(81.8)	70 (97.2)	143 (88.8)
Type of Family			
Nuclear	72 (80.9)	68(94.4)	140 (86.9)
Joint	17(19.1)	4(5.6)	21 (12.1)
Food Pattern			
Vegetarian	71 (79.8)	40 (55.6)	111(68.9)
Non-vegetarian	18(20.2)	32(44.4)	50(31.1)
Visits to Religious places			
Nil	6(6.8)	16(22.2)	22 (13.7)
1-10	64(71.9)	44(61.1)	108 (67.1)
>10	19(21.3)	12(16.7)	31 (19.2)
Literacy Status			
Illiterate	26(29.2)	16(22.2)	42 (26.1)
Upto Middle	25 (28.1)	16(22.2)	41 (25.4)
9-10	13(14.6)	12(16.7)	25 (15.5)
>10	25(28.1)	28(38.9)	53 (32.9)

Table 3 reveals that 23.6 per cent of the respondents started the practice of fasting just at the age of 14 years while another 28.1 per cent did so between 15 and 18 years (i.e.51.7% by 18 years). Though 39.3 per cent (35) used to fast for one day only in a year, while 28.1 per cent observed fasting between 2 and 20 days, 13.4 per cent between 21 and 40 days and 19.1 per cent for more than 40 days in a year. The daily routine on the day of fasting was different among 78.6 per cent of the women as most of them left bed early in the morning (100%) and perform various religious activities (68.6%) or both (10%).

TABLE 2

OCCASION AND PURPOSE FOR OBSERVING FAST BY WOMEN

Type of Fasts	**Married (n=73)**	**Unmarried (n=16)**	**Total (n=89)**
Type of Fasting			
Monday	19(26.0)	13(81.2)	32(35.9)
Thursday	3(4.1)	3(18.7)	6 (6.7)
Friday	6(8.2)	1 (6.2)	7(7.9)
Karvachoth	40 (54.8)	2(12.5)	42 (47.2)
Shivratri	2 (2.7)	2(12.5)	4 (4.5)
Janamasthmi	6 (8.2)	2(12.5)	8 (9.0)
Purnima	3(4.1)	2 (12.5)	5 (5.6)
Navratras	5 (6.8)	1 (8.2)	6 (6.7)
Roja	3(4.1)	-	3 (3.4)
Teej	1 (1-4)	-	1(1.1)
Purpose of Fasting			
Husband's well-being	35(47.9)	1 (6.2)	36 (40.4)
Gives Satisfaction	18(24.7)	8 (50.0)	26 (29.2)
Personal Reasons	15(20.5)	8 (50.0)	23 (25.8)
Traditional	4 (5.5)	3(18.7)	7 (7.9)
Children's well-being	15(20.5)	-	15(16.9)

(Figure in parentheses indicate percentage)

TABLE 3

AGE, DAILY ROUTINE AND NUMBER OF DAYS DURING

Age at Fasting (in years)	**n=89**	**% age**
<14	21	23.6
15-18	25	28.1
19-21	16	18.0
>21	23	25.8
Do not remember	4	04.5
Total fasting days		
One	35	39.3
02-20	25	28.1
2140	12	13.4
>40	17	19.1
Routine on fasting day		
Same	19	21.4
Different	70	78.6

Table 4 reveals that the average calorie intake by the fasting women on a fasting day was lower than the calorie consumed by them on a non-fasting day. It was also far less as compared to calorie intake by women who do not fast. On the day of fasting, while 40.4 per cent consumed below 750 Kcal/day, 30.3 per cent between 751 and 1,000 Kcal/day. The rest of the women consumed between 1,000 and 1,500 Kcal/day or more. Calorie consumption was reduced as a result of fasting. The common food items restricted on fasting days were salt (37.1%), water (44.9%), cereals (wheat flour, rice, pulses etc. 97.7%), sour food items (9.0%) and onion/garlic (6.7%). The food items which were consumed more on the days of fasting were fruits (68.5%), milk (33.7%) and sweets (29.2%).

TABLE 4

CORRELATION BETWEEN CALORIE CONSUMPTION AND FASTING

Calorie consumption	**Fasting group (n=89)**		**Non-fasting group (n=72)**
	Diet on non-fasting days	**Diet on fasting days**	
<750	05 (5.6)	36(40.4)	04 (5.5)
751-1000	12(13.5)	27(30.3)	12(16.7)
1001-1250	32 (35.9)	18(20.2)	16(22.2)
1251-1500	21 (23.6)	04 (4.5)	20(27.8)
>1500	19(21.3)	04 (4.5)	21 (29.2)

(Figures in parentheses indicate percentage)

Physical and mental efficiency was affected on the days of fasting among 43.8 and 30.3 percent of the subjects respectively. As a result, 57.3 percent of the study samples suffered from some kind of illness like headache (42.7%), dizziness (31.5%), hunger (27.0%), clouding of vision (13.5%) or sweating (9.0%) (Table 5). Even in special situations like pregnancy and sickness, 58.4 and 62.9 per cent of subjects respectively continued the practice of fasting. The morbidity was significantly higher (55.6%) in the fasting ($P<0.05$) than in the non-fasting group (38.9%). It was further noticed that pallor was more prevalent (50%) in the non-fasting than in the fasting women (39.3%). Mean systolic blood pressure was 113.8 mm Hg in the fasting and 116.06 mm Hg in the non-fasting group (Table 6). A higher prevalence of women was over-weight (22.2%) in the non-fasting group than in the fasting group (15.7%). It was also noticed that 49.4 percent (44) of women observeing fasts were free from any symptoms of major depression compared to 33.3 percent (24) in the non-fasting group (PO.05) as shown in Table 6.

TABLE 5

MEDICAL PROBLEMS AND PREVALENCE OF FAST

Medical Conditions	**n=89**	**% age**
Pregnancy Condition		
Continues as usual	52	58.4
Continues with relaxation	08	09.0
Discontinues Fasting	08	09.0
No response	21	02.3
Sickness		
Continues as usual	56	62.9
Continues with some relaxation	08	09.0
Discontinues	12	13.5
No response	13	14.6
Medical Problems		
Dizziness	28	31.5
Headache	38	42.7
Clouding of Vision	12	13.5
Hunger pains	24	27.0
Sweating	08	09.0
Confusion	05	05.6
Anxiety	07	07.9
Palpitation	03	03.4
None	38	42.7
Medical Attention Sought	10	11.2

TABLE 6
FASTING: ASSOCIATED HEALTH RISK AND BENEFITS

Diseases / Ailment	Fasting (n=89)	Non-fasting {n=72)j
Pallor Present Absent	35 (39.3) 54 (60.7)	36 (50.0) 36 (50.0)
Mean Blood Pressure	113.8/75.6	116.06/76.66
Body Mass Index Under Nutrition <18.5 Normal 18.5-24.99 Overweight >25	22 (24.7) 53 (59.6) 14(15.7)	16(22.2) 40 (55.5) 16(22.2)
Morbidity None Present*	40 (44.4) 49 (55.6)	44(61.1) 28 (38.9)
Major Depression No Symptoms** Depressed or irritable mood Diminished interest or pleasure Weight loss or weight gain Insomnia or hypersomnia Psychomotor agitation or retardation Decreased concentration or indecisiveness Thoughts of death, suicidal idea or suicide attempt	44 (49.4) 13(14.6) 10(11.2) 12(13.5) 6 (6.7) 1(1.1) 2 (2.2) 4 (4.4)	24 (33.3) 8(11.1) 16(22.2) 12(16.7) 8(11.1) 4 (5.6)

*x_1^2 = 4.16 d.f = 1; p <0.05
**x_2^3 = 4.23, d.f = 1; p <0.05

DISCUSSION

The current study among the rural women in Chandigarh revealed that a large number observed fast (83.2%) not on medical grounds but for social beliefs, customs and religion pertaining to well being of husband/children or for some personal satisfaction and peace. Women visiting religious places more frequently observed fast. Fasting, religious attendance and health have strong inter-connections. A study of 3,968 adults in Maryland, USA, showed that frequent attendance by women in

religious services decreased the mortality to 29.7 per cent as compared to others (37.4%). Thus, adults frequently visiting religious centres appeared to have a more life expectancy rate[1]. The present study revealed that there are important family related, religious and social factors associated with fasting even in cases where a person is vegetarian either for certain days or for specific occasions. It also showed that mothers are the major source of inspiration for fasting. About half of women fast along with a companion though 83.2 per cent were residing in a nuclear family set-up.

Another interesting observation in the study was that about one-fourth of the women began observing fasts when they were 14 though the majority (51.7%) started after 18 years of age. The number days of fasting varied from 1 to 40 per year. Fasting during adolescent years sometimes leads to adverse effect on nutrition and personal development. But this awareness was lacking among subjects. Dieting, skipping meals, snacking, eating away from home, consuming fast foods, and attempts to gain or lose weight are some of the other characteristics of eating behaviour among adolescents which affect their physical, emotional and social development[5].

Even during vulnerable phases of pregnancy, lactation and sickness, majority of women continued fasting. The energy requirement in women is increased by 300 Kcal daily through out pregnancy and 550 Kcal during first 6 months of lactation[6]. Adolescent growth spurts during 10-12 years in girls and 2 years later in boys. The recommended calorie consumption per day for Indians is 2,190 to 2,640 Kcal/day for boys and 1,970 to 2,060 Kcal/day for girls in the age group of 10-18 years[7]. Thus, restricting the diet on socio-religious grounds especially by the vulnerable groups such as adolescents, pregnant and lactating women is not desirable as it might lead to health problems.

The calorie consumption per day for the fasting group on non-fasting days was almost similar with the non-fasting group. 40.4 per cent of women consumed lesser than 750 Kcal/day and 70.7 per cent up to 1,000 kcal/day on the day of fasting. As per standards of National Institute of Nutrition, Hyderabad, India, the average calorie consumed by the sample subjects was only about one-third to half of the recommended calorie consumption.

Majority (57.3%) of women faced different symptoms or medical problems due to fasting viz. headache, dizziness, hunger pains, clouding of vision etc. and 11.2 percent sought medical help for the same. It is documented that any imbalance between the actual intake and the recommended calorie consumption would result in wasting of muscle, negating nitrogen balance and multi-system dysfunction that ultimately may lead to clinical complications such as infection, poor wound healing and increased mortality. In the present study, the morbidity was statistically higher ($p<0.05$) among women observing fasts than non-fasting women.

Anaemia was less prevalent in fasting group despite lower calorie consumption. It is probably because of more consumption of fruits and sweets including jaggery. Similarly, systolic blood pressure was slightly lower (by about 3mm Hg) which may be due to restriction of salt observed by fasting women, reduction in weight and depression related symptoms. Diet therapy recommends adequate calorie consumption and sodium restriction to 1,000-2,000mg/day in people suffering from hypertension[8]. Even lower hypertension values have been reported among persons attending more religious places[9].

Though under-nutrition (BMI <18.5) was nearly similar in fasting and non-fasting groups, women with normal weight (59.6%) were more artlong the fasting group. Similarly, fasting group included less number of overweight women (15.7%) than the non-fasting group (22.2%). The most prescribed diet for weight reduction is approximately 1,000 Kcal/day for an adult. To prevent obesity, the basic consideration being the food energy intake, which need not be more than the energy consumed[6].

Half of the women in the fasting group were free from depression related symptoms in comparison to one-third of non-fasting group. It could be because of observing fasts, visiting more religious places or preying for peace and satisfaction. A strong religious faith reinforces active religious participation which in turn may help people to cope up with stress in a better way[10]. This may also help to reduce direct[11] and indirect self-destructive behaviours[12] and depression[13].

CONCLUSION

Fasting is a good practice to control overweight and also depression related symptoms. There is a need to encourage and educate the community to adopt and continue useful fasting practices. Fasting will be a beneficial tool for regulating psycho-medical disorders, if practiced in an appropriate manner.

Lkkjk'k

यह अध्ययन गवर्नमेंट मेडिकल कालेज, चण्डीगढ़ के कम्युनिटी मेडिसिन विभाग के फील्ड प्रैक्टिस एरिया में रहने वाली 18 वर्ष से अधिक आयु की व्रत रखने वाली 161 महिलाओं पर किया गया था। व्रत रखने वाली 89 महिलाओं में 39.3% महिलाएं साल में एक दिन व्रत दिन के बीच व्रत रखती थीं। आधिकांश महिलाओं (51.7%) द्वारा 18 वर्ष की आयु से ही व्रत रखना प्रारम्भ किया गया था। इसके अतिरिक्त 54.4% और 62.9% महिलाओं ने क्रमशः गर्भावस्था तांम रूग्णावस्था में भी व्रत रखना जारी रखा था। व्रत न रखने वाली महिलाओं (22.2%) की तुलना में व्रत रखने वाली 70.7% महिलाओं ने व्रत वाले दिन 1000 कैलोरी से कम आहार लिया था। किन्तु अधिकतर फल, सब्जियां और अधिक पौष्टिक तत्वों वाला आहार ही लिया था। लेकिन व्रत रखने वाली महिलाओं (39.3%) की अपेक्षा व्रत न रखने वाली महिलाओं (50%) में पांडुता (पालोर) अधिक पाया गया था। व्रत रखने वाली महिलाओं में अंकुचन रक्त चाप (113.8 एम एम एचजी) की मात्रा व्रत न रखने वाली महिलाओं (116.06 एम एम एचजी) की तुलना में कम पाया गया था। व्रत न रखने वाली महिलाओं (22.2%) की संख्या व्रत रखने महिलाएं (15.7%) की अपेक्षा अधिक संख्या में मोटी पाई गई थीं। व्रत न रखने वाली एक तिहाई महिलाओं की अपेक्षा व्रत रखने वाली लगभग आधी संख्या में महिलाएं तनाव संबंधी लक्षणों से मुक्त पाई गई थीं जबकि व्रत न रखने वाली एक तिहाई महिलाओं में यह लक्षण मौजूद पाया गया था ($P<0.05$)। अध्ययन से प्राप्त उपरोक्त निश्कर्शों से पता चलता है कि व्रत रखने की आदत में तथा स्वास्थ्य लाभों (जैसे वनज में कमी, रक्तचाप तथा तनाव संबंधी लक्षणों में कमी में दृढ़ संबंध पाया गया था।

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DOMESTIC VIOLENCE AGAINST WOMEN IN INDIA: AN OVERVIEW

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ABSTRACT

The article attempts to identify the causative factors leading to domestic violence and discusses various consequences and experiences in relation to it. Abusive language, threat and intimidation, cases of dowry related bride burning, wife beating and violence on pregnant women are the most common forms of domestic violence in India. 20 to 30 per cent of the male respondents in India admit to beat or hit their partners at least once. The health consequences of domestic violence may be non-fatal and fatal as well. These lead to significant economic consequences like non-productivity and increase in expenditure to meet the subsequent health care problems. According to the World Bank report, one work day out of every five lost by women is due to health problems arising out of domestic violence. The National Family Health Surveys (NFHS) conducted by the International Institute for Population Sciences (HPS), Mumbai, indicate that women who are less educated and belonging to the low socio-economic status, justify wife beating on certain situations. There are various reasons for which a woman is bound with her partner for life. These include, fear of being left alone and homeless, security concerns, lack of economic independence, religious, social, personal and emotional beliefs linked to marriage. It is, therefore, imperative that the community and other agencies should try to sensitize people against such evils in order to bring a perceptible change in the society mindset.

Keywords: Violence against women (VAW), Physical and psycho-social abuse, Economic consequences and Literacy.

Literacy and employment rate among women in India have improved considerably over the last decade but the status and role of women at home remain as dismal as before since domestic violence against women still continues unabated. Studies from all over the world have revealed that the greatest source of danger to women lie within

their homes, *from* spouses, *parents or brothers. The* acts of hurting, harming, harassing and killing anyone within the four walls of a home by whatever ways is considered as domestic violence. It is the pattern of coercive behaviour that involves physical abuse or threat of physical abuse, repeated psycho-social abuse, assault, progressive social isolation, intimidation or economic coercion and deprivation of essential requirements such as food, money, transportation or access to health care facilities. The prevalence, patterns and consequences of domestic violence are primarily highlighted in this article.

OBJECTIVES

(a) To describe the prevalence of domestic violence among Indian women,
(b) To examine the common situations in which violence occurs and the reasons that evoke such violent behaviour,
(c) To anlyse the health, psychological and economic consequences of such violence, and
(d) To suggest remedial measures to minimize the occurrence of domestic violence in the community.

REVIEW OF LITERATURE

Reported data on domestic violence against women in India are scanty. The middle or higher middle class families consider that conjugal strife and wife-battering are the problems which should not be discussed outside the family. It is also treated as a matter beyond the reach of the law. In most cases, the incidents of violence against women (VAW) are reported as suicide, attempted suicide or accidental deaths. Thus, there are many cases that go unreported and the incidence of domestic violence against women in India might be much more than the actual reported cases.

During the period 1987-1989, 120 cases of dowry deaths and 20 cases of intentional injury related to dowry were recorded in 50 district courts in Maharashtra. These included physical violence (59%), mental torture (28%), molestation by family members and perversity (10%) and starving (3%). Causes of death of women were mostly by burning (46%) and drowning (34%). Significantly, it is observed that 58 per cent of the

victims were childless and 22 per cent had only female children[1] which indicate that infertile women and mothers of only female children are more vulnerable to domestic violence.

It is revealed that 76 per cent of the 115 women in lower caste households of Punjab were beaten by their husbands and two-thirds of them had reported regular beating[2].

Seventyone point five per cent (71.5%) increase in cases of torture and dowry deaths in women in India during the period from 1991 to 1995 has been reported by the National Crimes Record Bureau, Ministry of Home Affairs, Government of India, 1995. According to Women's Feature Service 2002, New Delhi, in every six hours in India, a young married woman is burnt alive or beaten to death or forced to commit suicide. At least 20 per cent of the married women aged between 15 and 49 years have experienced domestic violence at some point or other in their lifetime and many may have suffered almost continuously[3].

According to a study by the International Center for Research for Women (ICRW, 2000), 45 per cent of the women reported to have experienced at least one incident of physical or psychological violence in their lifetime. More than 50 per cent of the pregnant women experienced severe violent physical injuries. At least 50 per cent of the domestic violence victims admitted that their husbands were alcoholic. 82 per cent reported that their husbands' infidelity was a major reason for spousal quarrels and 70 per cent reported that their husbands hit them because they suspected wife's infidelity[1].

The National Family Health Survey-ll reported that almost three out of five women (56%) justified wife beating for at least one out of four specific reasons such as (i) neglecting the house or children (40%), (ii) wife going out of home without informing the husband (37%), (iii) wife showing disrespect to in-laws (34%), and (iv) the husband suspecting his wife as unfaithful (33%). The results also show that at least one out of five women has been beaten or physically mistreated since the age of 15 and most commonly by their husbands[2].

Causes of Domestic Violence

Various studies have revealed the following common reasons for the occurrence of domestic violence:

a. Men's habit of consuming liquor is a common cause for quarrel between the husband and the wife. A drunken husband at home is seldom a pleasant sight for the wife.
b. Infidelity/suspected infidelity by the husband or by the wife becomes a cause for spousal conflict.
c. Economic inequality between men and women is another reason that creates rifts in families. It is mostly the men who are the bread earners in the family for which they feel that they should enjoy a superior position. This many a times translates into a coercive behaviour to suppress their partners.
d. Hierarchical gender relations and established traditions in the family is one of the reasons of VAW. Acts of violence against female members of the household, whether wife or child, are perceived as acts of discipline considered essential for maintaining the rule of male-authority within the family.
e. Tendency of polygamy (due to the woman's infertility, family pressures etc.) sometimes gives rise to spousal fighting, which is the most demeaning experience for women.
f. In-laws dissatisfied with the dowry, torture the daughter-in-law to give in to their greed.
g. Sometimes, the rising awareness among women about their rights is another cause of VAW. When literate and educated women raise their voices at some point of time against such violence, this, in retaliation, provokes and adds fuel to further violence from the male partners.
h. Reports of incidents such as preparing a meal late/improper cooking or not disciplining/caring a child may seem trivial but in cases of failure to fulfill such 'duties' becomes an excuse for VAW.

Various Forms of Domestic Violence

Abusive Language: Several studies on domestic violence revealed that husbands use abusive language even in the presence of their children.

Use of abusive language increasing with the length of marriage has also been reported. 53 per cent of the newly weds reported verbal abuse compared to 85 per cent of women married for more than 15 years[1].

Threat and Intimidation: The abuser uses threatening looks, voice, gestures and actions to keep her in constant fear. He may damage valued objects, hurt pets or punch holes in the wall in the form of warning to show that he can further in order to discipline her. There is a constant threat that violence can happen at any time. The abuser may threaten to commit suicide, take children, hurt a pet, hurt or lie to her family and friends, or seriously injure her.

Dowry Burning and Murder: Women whose families pay less dowry suffer from increased risk of marital violence. The phrase "dowry violence" refers not to the dowry paid at the time of the wedding, but to the additional payments demanded by the groom's family after the marriage. When the dowry amount is not considered sufficient or is not forthcoming in the post-marriage period, the bride is often harassed and abused. This abuse can escalate to the point where the husband or his family bums the bride, often by pouring kerosene/petrol on her or opening the cooking gas hearth and lighting it. The official records of these incidents are low because the family often reports them as accidents or suicides. Annually, as many as 15,000 women are killed by their husbands in disputes related to dowry[3].

Sati (widow-burning): Sati is the practice through which widows are voluntarily or forcibly burnt alive on their husband's funeral pyre. It was banned in 1829 but had to be banned again in 1956 after resurgence. There was another revival of the practice in 1981 with another prevention ordinance duly passed in the Parliament in 1987[5].

Wife-beating: Violence inside the home which includes beating with a stick (or any other object used as a weapon), slapping, kicking, punching and biting. Rape is also widespread in states like Uttar Pradesh, Haryana and Rajasthan. It affects women throughout from wealthy urban households to poorest rural households irrespective of religion, class and caste. Studies from India show that 20 to 30 per cent of the male respondents admitted to have beaten and hit their wives/female members in the family at least once. According to the NFHS (1995)[3] conducted by the International Institute for Population Sciences (HPS), Mumbai, out of

90,000 Indian women studied across the country, more than half of them justified wife-beating under certain circumstances such as neglecting house and children, going out without telling their husbands, showing disrespect to in-laws and suspicion of infidelity.

Violence on Pregnant Women: Jejeebhoy (1998) while studying the association between wife-beating and foetal and infant death in rural India, reported that the health consequences of domestic violence in terms of pregnancy loss and infant mortality are considerable[1]. It ranges from miscarriage to low birth-weight infants to maternal morbidity and mortality. The report further reveals that battered pregnant women are twice likely to have miscarriage and four times likely to have a low-birth-weight baby than non-battered pregnant women[6]. The children bom to battered women are 40 times more likely to die before the age of five than children of non-battered mothers[6]-[7].

Thrown out of House: The most common form of domestic violence is driving the victim out of her home or forcing her to go to her parents' place. Women ejected from their homes in such circumstances often have nowhere to go. It is because of this threat of being thrown out without any viable options of living, millions of women today continue to silently tolerate and suffer extreme violence at the hands of their relatives, sometimes, even to the point of death. According to a study, 35 per cent of high caste women in abusive relationships mentioned that their husbands threatened to expel them from the house compared to 62 per cent of lower caste women. Such reported violence declined with the increasing education of both men and women[8].

Health Consequences

Domestic violence has long-lasting adverse effect on women's reproductive health; including unwanted pregnancy, complications during pregnancy including miscarriage, unsafe abortion, sexually transmitted infections (STIs) including HIV, and maternal death. According to the World Bank, in developing countries, rape and domestic violence together account for 5 per cent of the healthy years of life lost in a woman's reproductive age.

The health consequences of domestic violence are considered as a burden on health care systems and a drain of resources. VAW is also an obstacle on the socio-economic development of a nation. This lowers educational attainment, affects maternal health, and produces adjustment problems in children. An increasing amount of research also indicates that the acceptance and experience of domestic violence has adverse consequences on women's health and subsequently on the health of their children.

The non-fatal outcomes of domestic violence are disturbances in both physical and mental health. The physical health problems stemming out of VAW include injury from lacerations to fractures and internal organ injuries, unwanted pregnancy, gynaecological problems, miscarriage, headaches, permanent disabilities, asthma, and self-injurious behaviours like smoking and unprotected sex. Similarly, in the mental health front, victims suffer from depression, fear, anxiety, low self-esteem, sexual dysfunction, eating problems, obsessive-compulsive disorder and posttraumatic stress disorder. The fatal outcomes of domestic violence may be suicide, homicide, maternal death and HIV/AIDS[3].

Economic Consequences

Domestic violence has also significant economic consequences like reduction in family income, increasing health care costs, job absenteeism, non-productivity and costs related attending to the rule of the law. Gender-based violence also compounds other effects of economic exploitation. In India, domestic violence is used as a bargaining instrument to extract huge amounts in the form of dowry from in-laws, once the marriage has taken place.

According to a World Bank report, one workday in every five lost by women in India is a result of health problems arising from domestic violence. The costs that a woman may have to incur as a victim of domestic violence are medical services related to physical, psychiatric, or psychological care; physical and occupational therapy or rehabilitation; necessary transportation, temporary housing, child care expenses, loss of income (if she is employed), attorney's fee in addition to the costs incurred in obtaining a civil protection order; and any other losses suffered by the victim as a proximate result of the offense[5].

Awareness Generation against VAW

During the last two decades, there has been a growing public awareness against VAW. Women activists have mobilized and pressed for significant changes in the criminal code and police procedures in order to address various acts of domestic violence. Throughout the eighties, protests were organized by women's organizations against dowry deaths, custodial rapes, abductions of women, *sati,* amniocentesis used for sex determination of children, sexual harassment of young girls and women in public places, trafficking and prostitution.

On 11 December 2001, Ministry of Human Resource Development, Government of India, published and circulated "The Protection against Domestic Violence Bill, 2001". This bill was introduced in Parliament on 18 February 2002. It seeks to redefine the meaning of domestic violence to include mental and emotional torture, thus, correcting the fallacy that domestic violence is mere wife-beating. Besides, the bill permits prosecution of all those in the family who victimize women, be they related to her by blood, marriage or adoption.

Also states response in the form of passing the amendment 498A to the Dowry Act of 1983 establishing All Women Police Stations or setting up family counselling cells, marked the beginning of attempts to provide some options to women staying outside the family but facing domestic violence.

Following the recommendation of the Fourth UN World Conference on Women in Beijing in 1995, the Government of India promised several measures for the advancement of women's rights in India. The Department of Women and Child Development of the Ministry of Human Resource Development began working on a National Policy on Women, which was meant to bridge the gap between the equal de-jure status and unequal de-facto position of women in the country. In January 2000, while hearing India's first periodic report, the Committee on the Elimination of Discrimination Against Women (CEDAW) recommended to develop a national plan of action to address the issue of gender-based violence in a holistic manner. It was the first international human rights instrument exclusively and explicitly meant to address the issue of violence against women.

The National Commission for Women was established in January 1992 under the 1990 National Commission for Women Act. As a statutory body, its aim is to check incidents of violence against women and to promote social, legal and economic equality for women[4].

DISCUSSION

Domestic violence exists in the Indian society in the form of severe oppression against women. This expression of violence is the most disgraceful component of oppression practiced against women since time immemorial. However, it is difficult to measure the extent of incidents of violence and also the degree of domestic violence due to the absence of proper studies at various levels. This is more so, since many such incidents largely go unreported or underreported due to various reasons. Thus, the statistics on VAW might be significantly much higher than the figures reported from time to time.

The World Bank report states that such a situation often drives women to take extreme decisions. For example, victims of domestic violence are 12 times more likely to attempt suicide than women who have not suffered such abuses[4].

Most of our social structures and institutions are based on a patriarchal system that provides men an advantage to shape the society, which may be biased against women in some spheres of life. The cause of domestic violence is the 'crave for supremacy'. They use violence because they believe it works. The batterer begins and continues his behaviour because violence is an effective method for gaining and keeping control over the opposite partner. It also hardly affects the former against any adverse consequences as a result.

At the same time, there are many complexities signifying why a woman is unable to leave her partner under such circumstances[5]. Many abusive partners apologize after the abusive incident, or promise to change style to which most wortien believe and expect a change in the behaviour to occur. A majority of them apprehend that no body would believe them that their partners are abusive because of various reasons pertaining; to social status, community trivializing the abuse and doctors not addressing the results of visible abuse.

It has been observed that the abusive partner tends to isolate the battered woman receiving any outside support from family, friends and coworkers. He may also go to the extent of threatening her for seeking custody of her own children, to hurt/kill her or other family members, to commit suicide, or to expose her as a liar. Hence, she develops an intense fear of becoming homeless and helpless in the absence of any support coming from family, friends and close relatives. The situation is worse when women are not employed and don't have any property in their names and lack access to cash or bank accounts. Thus, in the absence of any economic support, they are left with a feeling that they have no other way to support themselves or their children once they leave their homes.

She also suspects that the batterer would become more violent and it might be fatal if she attempts to leave. It is seen that many battered women are killed after they live separately (especially when the abuser has a high socio-economic status) because the abuser cannot cope with the thought of her letting her out of his control.

It is often observed that women who grew up in a violent or abusive home, for instance, where a mother is beaten and tortured before their growing children, generally perceive the abuse as a 'normal' part of the family life and they are less likely to escape from their present situation.

An important reason that inhibits women from leaving home or getting a divorce is their personal beliefs about marriage connected to religious, ethnic or social customs. They feel themselves responsible to make their marriage work.

Most victims go through the stages of leaving and returning to their partners many times before fihally deciding to leave their husbands permanently. But the overall fear they experienced in the past still persists in their minds. The nature of support and assistance the battered women receive from their respective families, friends, police, NGOs, courts, medical personnel, educators, therapists and other community agencies, determine how safely they can stand on their own after leaving their partners' home.

The underlying fact is that people use violence to exercise their power and control over others and this behaviour is reinforced each time the person gets away with the use of violence. Domestic violence is a choice the abuser makes to systematically and deliberately gain power and control over the opposite partners. Abusers come from all groups and backgrounds and from all personality profiles. The degree of abusive behaviour may emerge from the batterer's deep sense of low esteem, for which he feels powerless and inadequate from within. He rationalizes his actions by blaming his partner, the world or some circumstance or something else. He may show extreme jealousy and possessiveness and even cruelty to animals. His own children may also face the brunt of his 'violent temper'.

Witnessing violence against mothers can be a mental trauma for the children. They often try to intervene to protect the mother and in the process, get themselves physically abused or hurt. Children often learn the violent behaviour they witness, both as children and as adults. As a result, they may lose self-confidence, be afraid/angry, blame themselves for what is happening or feel guilty and may imitate such behaviour as adults in similar situations.

Many theories have been formulated to explain why some men use violence against their partners. The reasons are economic inequality/hardships, women's rising independence and alcoholic behaviour etc. However, though these factors may be present, they may not always be the actual causes of violence. Removing these associated factors will probably end men's violence against women[7].

The results of National Family Health Survey (NFHS, 1995)[3] conducted by the Department of Family Welfare, Ministry of Health and Family Welfare, Govt, of India) at the International Institute for Population Sciences (HPS, Mumbai) did not show a marked difference of opinions on domestic violence between women of different ages. But views of the respondents differed between educated and uneducated women, and between urban and countryside women. The results further indicated that those who were less educated justified wife-beating in certain situations like cooking a bad meal or neglecting home and children etc[3].

Health consequences of domestic violence are severe. It may have long-lasting damaging affects on women's reproductive health and lead to other serious health problems causing permanent physical disability[1]. VAW has severe economic consequences such as reduced family income, increased medical costs and loss of working days and so on[3].

Historically on a global level, domestic violence against women has not been treated as a 'punishable' crime. Moreover, it is either not reported or under-reported. Such violence has been on the rise due to lack of punitive measures such as economic penalties for men guilty of battering their partners or for other punishments. Rarely batterers are put to trial in spite of being accused of physically assaulting their partners.

Remedial Measures for VAW

Ending physical and sexual violence requires a long-term commitments and strategies involving all sections of the society. Incorporating this holistic approach, several valuable recommendations have emerged from various studies.

Firstly, safe mother-hood programmes should be organized which are sensitive and responsive to the conditions and needs of battered women during pregnancy and the post-partum period. There should be provisions for medical and psychological services including provision of counselling for severely injured women. Health workers need to play an important role in identifying and providing care to the battered women because they may be the first and the only contacts for the inflicted women victims. The victim's immediate need for shelter and economic support should be organized at local government levels. They can be encouraged to seek help from voluntary organizations, specifically those concerned with domestic violence in the community. For the children of victims of domestic violence, shelter homes must be made available with the provisions of child care facilities.

Existing preventive and supportive services and programme interventions also need to be expanded for the victims of domestic violence especially in the rural areas. Since the women officials posted at Police Stations are primarily located in urban areas there is a non

availability and non-accessibility of immediate help to victims in rural areas.

Attempts should be made to strengthen women's economic capacities by improving women's access and control over income and assets, recognize her shared right in the family home and matrimonial property.

It is important to address domestic violence through educational and sensitisation programmes such as community education, education in schools and colleges, educating health/ medical practitioners, organizing programmes for the batterer and spreading public awareness on VAW through media.

Last but not the least, there should be a comprehensive law that should address domestic violence against women of all ages and irrespective of the marital status so that victims could seek immediate legal assistance.

CONCLUSION

Social attitudes play a big role in abetting abuse against women by excusing the abuser from taking any responsibility. A common attitude is that 'she provoked it', which implies that it is her fault or there is something wrong with her behaviour. A difficult task lies ahead in terms of changing the attitudes of the society and making them more responsible and sensitive towards the needs of the women. Only fundamental social change that eliminates women's subordinate status will bring an end to such violence. The changes needed include eliminating laws that discriminate against women and children, promoting women in leadership and decision-making processes, improving access and sense of entitlement to education, and increasing women's access to economic resources, health information and other rights of women. Moreover, there are some shocking statements from.women who justify wife-beating as an expression of affection on the husband's part.

The affects of violence can be devastating to a woman's reproductive health as well as to other aspects of her physical and mental well being. In addition to inflicting injury, violence increases women's long

term risks against a host of other health problems including physical disability, drug and alcohol abuse and depression. Women with a history of physical or sexual abuse are also at increased risk of unintended pregnancy, sexually transmitted infections (STIs), and adverse pregnancy outcomes. Victims of violence who seek counselling and care from health professionals and other kinds of health providers often have needs that providers do not recognize, do not ask about, and do not know how to assess from such victims of violence.

Strategies to combat VAW are urgently needed. In addition to taking care of the immediate needs of the battered women, concrete steps should also be taken to increase women's empowerment through education, employment and economic independence, etc.

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महिलाओं के विरूद्ध घरेलू हिंसा को पूरे विश्व में महिलाओं के मानवीय अधिकारों का उल्लंघन माना जाता है। वर्तमान भारतीय समाज में, विवाहित महिलाओं को घरों में अनेक प्रकार से प्रताड़ित किया जाता है। इस लेख में घरों में महिलाओं को दी जाने वाली प्रताड़ना से संबंधित घटकों की पहचान करने का प्रयास किया गया है और इससे संबंधित विभिन्न दुष्परिणामों एवं अनुभवों के बारे में चर्चा की गई है। भारतीय घरों में महिलाओं के उत्पीड़न के सबसे आम तरीकें हैंः गाली–गलौच, डराना, धमकाना, दहेज को लेकर बहुओं को जलाना, पत्नियों को मारना–पीटना और गर्भवती महिलाओं को प्रताड़ित करना आदि। भारत में 20 से 30 पुरूष उत्तरदाताओं ने अपनी औरतों को कम से कम एक बार मारने–पीटने की बात को स्वीकारा है। घरों में उत्पीड़न के कारण स्वास्थ्य पर पड़ने वाले प्रभाव गैर–प्राणघातक तथा प्राणघातक भी कहे जा सकते हैं। इनके आर्थिक दुष्परिणाम हो सकते हैं जैसे गैर–उत्पादकता और स्वास्थ्य लाभ के लिए प्रताड़ना के परिणामवस्वरूप होने वाला व्यय। विश्व बैंक की एक रिर्पोट के अनुसार घरों में महिलाओं को प्रताड़ित करने के कारण प्रत्येक पांच दिन में उनकी एक दिन की दिहाड़ी का नुकसान होता है। अर्न्तराष्ट्रीय जनसंख्या संस्थान, मुम्बई तथा राष्ट्रीय परिवार स्वास्थ्य सर्वेक्षण के लिए किए गए आर्थिक स्तर वाले घरों की महिलाएं कुछ खास स्थितियों में उन्हें प्रताड़ित किया जाना सही मानती हैं। ऐसे अनेक कारण हैं जिनमें एक महिला के लिए अपने पति के साथ बंधा रहना उसकी मजबूर है। इनमें अकेलेपन का डर और बेघर हो जाना, सुरक्षा संबंधी चिंताएं आर्थिक स्वतन्त्रता का अभाव, और विवाह से जुड़ी धार्मिक, सामाजिक, व्यक्तिगत एवं भावनात्मक अस्थायें। अतः यह आवश्यक हो जाता है कि समुदाय और अन्य संस्थाओं को चाहिए कि वे लोगों की इस सामाजिक बुराई के बारे में सचेत करें और समाज की विचारधारा में परिवर्तन लायें।

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NEED IDENTIFICATION FOR CAPACITY BUILDING AMONG NURSING PERSONNEL IN TWO HOSPITALS OF DELHI

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ABSTRACT

Training is an important tool for enhancing competencies provided the gaps in desired and actual performance are identified. In order to assess the status and desired needs for training of the nursing personnel, 30 Nursing Sisters and 96 Staff Nurses engaged in the major specialities in the two Employees State Insurance Corporation hospitals were interviewed. In the field of basic nursing, more than 75 per cent of the respondents in both the groups, identified training in the areas of barrier nursing, oro-pharyngeal airway insertion and maintenance, guiding and helping patients with special feeding problems and protection of pressure points etc. In advanced nursing, an equal percentage desired training in the area of cardiopulmonary resuscitation, blood transfusions and monitoring. Crisis management, legal aspects and consequences of negligence, setting up a ward routine and handing over and taking over charges during shift changes etc. falling under 'ward management' are identified for inclusion in the in-service training programme by 73 per cent of the respondents. A formal induction training was favoured by most of the respondents. For 'Continuing Nursing Education' specialized training in ICCU, PICU, critical care (ICU), paediatrics, oncology, psychiatry, neurosurgery and nursing for AIDS patients was identified. Senbr Nursing Administrators felt that training for Staff Nurses and Nursing Sisters should include identified areas of reorientation/changes in Hospital's Nursing Policy, Disaster Management and Infection Control Policy and Protocol in addition to training under 'Continuing Nursing Education'. It is concluded that for improving the quality of care, the areas as mentioned above must be included in the regular training programmes for the nursing personnel.

Keywords: Nursing personnel, Training needs, Capacity building and Nursing policy.

Human Resource Development (HRD) has gained importance not only to achieve the goals and targets set for any organization but also as a process to improve the overall competency in the designated areas. As a goal, it is valued as the development of human capacity and upliftment of human aspirations. In terms of process, HRD involves activities related to education, training, empowerment, awareness raising, skills enhancement, team building, community mobilization, organization and entrepreneurship development, sensitization and human resources planning and policies[1].

Training is an important tool for attaining the HRD goals. It can be defined as 'a planned programme designed to improve the performance and bring about measurable changes in knowledge, skills, attitude and social behaviour for doing a particular job'. Additionally, management training is aimed at equipping managers with such knowledge, skills and techniques as are relevant to their managerial tasks and functions from time to time. Prominent on the training agenda of an organization should be re-training, which involves unlearning of old concepts and learning new skills[2].

Training, however, is 'only a means and not an end in itself' as a capability building tool. Learning is essentially self-directed and any amount of training may result in no development if the individual trainee is not interested in learning from the training programmes and does not see the relevance of training to his job needs and requirements or his professional and personal development. In view of the self-directedness of learning, it is important to involve the individual employee in all training decisions so that he sees the relevance and importance of training to his job performance and set the training agenda. Formal training is only one of the methods for development. Other development methods should also not be neglected[3].

In almost every healthcare facility, the department of nursing is the largest department in terms of number of personnel, size of the budget, types of health services offered and types of personnel involved. The profession of nursing has undergone a sea change in terms of education and practice as well[4]. These changing orientations necessitate the nursing personnel to learn new competencies and re-orient some of the old ones to be in tune with the changing times. The amalgamation of

their role as manager, nursing care provider, administrator, and counsellor in addition to the overall nursing role has created a situation where Human Resource (HR) needs on-going up-gradation of skills in the above mentioned roles to provide high quality of service to the clients.

Training of these personnel by providing them the required knowledge and skills can achieve this purpose to a significant extent. A study at the All India Institute of Medical Sciences (AIIMS) to assess the level and knowledge of staff nurses on infection control measures and to find out the relationship between knowledge and practice revealed a positive relationship between knowledge and practice and both were directly proportional to each other. It was suggested to have in-service education, refresher courses and training programmes regularly and in a systematic manner in order to keep the staff nurses up to date[5].

In-service training is an important mechanism for up-gradation of skills to achieve the ultimate organizational goal of better quality of patient care. Williamson (2002) has observed that speciality-nursing programmes would ensure development of existing competencies and learning of new ones. Short-term in-service education programmes in the form of formal training were right steps in this direction[6].

Before a training programme is conceived and conducted, it is necessary that the training needs must be identified. This means that the training inputs required for specified groups of employees are characterized. Various processes are available to carry out this exercise. Training needs identification can be done through focus group discussions (FGDs), problem analysis, interviews, survey through questionnaires, job analysis, performance appraisal, and records and reports etc[2]. Ravindran (1995) at the Safdarjung Hospital successfully used the interview method and observation checklists to validate the interview findings for identifying the training needs among the nursing personnel[7].

A training needs analysis is basically a data gathering process used to identify and compare an organization's actual performance to the projected (desired) level of performance. The difference will identify the immediate and/or long-term training needs. The perforfnance can be interpreted keeping in mind the new managerial (behavioural) or technical (professional) skill requirements[8]. The present study was an endeavour in

this direction to identify the training needs of nursing personnel in the selected areas of basic nursing, advanced nursing and ward management.

MEHTODOLOGY

The study was conducted in the hospitals of Employees State Insurance Corporation (ESIC) in Delhi. These were selected by random sampling method and the final tally included two out of four ESIC hospitals (50%). Nursing personnel (Nursing Sisters and Staff Nurses) working in major specialties like Medicine, Surgery, Paediatrics, Obstetrics and Gynaecology, Ophthalmology, Otorhinolarygology (ENT), and Orthopaedics were selected to make the sample representative of the population under study. In addition, Senior Nursing administrators were interviewed.

Each ward and personnel were visited a minimum of three times due to the 'shift' nature of duties of these personnel. The final sample consisted of 30 Nursing Sisters of a possible of 37 and 96 staff nurses from a possible of 104 along with 3 Senior Nursing Administrators.

Primary data were collected by an interview technique using a semi-structured interview schedule. This schedule was pre-tested and appropriately modified before administering to different categories of respondents. Information was collected on various aspects like background information of the respondents, expressed opinion on training needs based on their job requirements and responsibilities, training received in the form of induction and promotional training, trainings received over the last five years in the form of orientation/reorientation trainings, expressed opinion of the respondents on various aspects of induction, promotional and orientation training etc. The expressed training needs for staff nurses and nursing sisters in technical areas were limited to selected activities in basic and advanced nursing. The selection was done in consultation with senior nursing staff and administrators. Opinion of the senior nursing administrators was also taken on the issue of strengthening the orientation training for the nursing personnel.

FINDINGS

Data related to training received, desired training needs in basic and. advanced nursing, opinion of both the categories of the nursing personnel regarding different types of training and opinion of the nursing sisters on the perceived needs of their subordinates are described.

The mean age of the respondents was 33.3 years for staff nurses and around 46 years for nursing sisters (Table 1). The mean duration of service for staff nurses was 6 years (maximum percentage 5-10 years) and nearly 19 years for nursing sisters (maximum percentage 15-20 years). Only 7 per cent of the staff nurses had received induction training. No induction training was provided to nursing sisters. The nursing sisters had a higher percentage of orientation trainings in comparison to the staff nurses. Table 2 shows the distribution, qualification and place of posting of the nursing personnel. 83.3 per cent of the staff nurses and 90 per cent for nursing sisters were from Basaidarapur hospital. All staff nurses at the Rohini hospital were posted in combined wards.

Table 3 reflects the training needs of the personnel in the areas of basic and advanced nursing. Over 75 per cent of the respondents in both the groups, expressed their desire for training in the areas of barrier nursing, oropharyngeal airway insertion and maintenance, oxygen administration, guiding and helping patients with special feeding problems, and change of posture and protection of pressure points in 'basic nursing'. Over 60 per cent of the staff nurses and around 50 per cent of the nursing sisters wanted the sub-area of administering intra-muscular and intravenous injections to be covered as a part of the in-service training. For the sub-area of catheterization of the urinary bladder (UB), only 22 to 23 per cent wanted inclusion of 'catheterization for male UB' as against around 47 to 60 per cent for female UB. 75 per cent of the respondents in both the groups expressed the need for training in the areas of cardio pulmonary resuscitation and giving and monitoring of blood transfusion as a part of 'advanced nursing'. The expressed need for 'helping the doctor in diagnostic procedures' was around 50 per cent.

TABLE 1
GENERAL PROFILE
THE STAFF NURSES AVD NURSING SISTER

Profile	**Staff Nurses (N=96)**	**Nursing Sisters (N-30)**
	n(%)	*n(%)*
Age in years		
<25	3(3.1)	Nil
25-30	34 (35.4)	Nil
31-35	30(31.3)	1 (3.3)
3640	11(11.5)	3(10)
41-45	11(11.5)	7(23.3)
46-50	1(1)	9(30)
51-55	1(1)	8 (26.7)
56-60	5(5.2)	2(6.7)
Mean	33.28	46.03
Standard	7.83	6.08
Sex		
Male	6 (6.3)	Nil
Female	90 (93.8)	30(100)
Total years in service		
< 1	22 (22.9)	Nil
1-5	15(15.6)	Nil
6-10	37 (38.5)	Nil
11-15	22 (22.9)	5(16)
16-20	Nil	12(40)
21-25	Nil	10(33.3)
26-30	Nil	3(10)
Mean	6	18.68
Standard deviation	4.18	4.17
Received training		
Induction	7(7.3)	Nil
Orientation (last 5 years)	17(17.7)	12(40)

(Figures in parentheses indicate percentage)

TABLE 2

GENERAL PROFILE OF STAFF NURSES AND NURSING SISTER

Profile	**Staff Nurses (N=96)**	**Nursing Sisters (N=30)**
Qualification	*n(%)*	*n(%)*
Diploma in nursing	92 (95.8)	28 (93.3)
B.Sc Nursing	2(2.1)	2(6.7)
Diploma in nursing + Any other	2(2.1)	Nil
Place of posting (Hospital)		
Basaidarapur	80 (83.3)	27(90)
Rohini Sector-15	16(16.7)	3(10)
Place of posting (ward)		
Medicine	**16(16.7)**	**6(20)**
Male	8 (8.3)	3(10)
Female	8 (8.3)	3(10)
Surgery	**10 (10.4)**	**5(16.7)**
Male	**4(4**.2)	2(6.7)
Female	6 (6.3)	3(10)
Paediatrics	**11 (11.5)**	**4(13.3)**
Ophthalmology and Otorhinolaryngology	**4(4.2)**	**2(6.7)**
Obstetrics and Gynaecology	**26 (27.7)**	**7 (23.3)**
Antenatal ward	7(7.3)	2 (6.7)
Postnatal ward	10(10**.4)**	2(6.7)
Gynaecology ward	9 (9**.4)**	3(10)
Orthopaedics	**6(6.3)**	**2(6.7)**
Male	6 (6.3)	2(6.7)
Surgical-male and Orthopaedics	**7(7.3)**	**1 (3.3)**
Combined wards	**16 (16.7)**	**3(10)**
Male-all specialties	6 (6.3)	**1** (3.3)
Female-all specialties	5(5.2)	1 (3.3)
Paediatrics (with emergency ward)	5(5.2)	1 (3.3)

(Figures in parentheses indicate percentage)

Areas in Basic Nursing	**Staff Nurses (N=96)**	**Nursing Sisters (N=30)**
	n(%)	**n(%)**
Cjroph^ryngeal Airway insertion, maintenance and suctioning	81 (84.4)	25 (83.3)
Postural drainage	48(50)	21 (70)
Oxygen therapy	77 (80.2)	24 (80)
Guiding and helping patients with special feeding	78(81.3)	23(76.7)
Care of the skin	57 (59.4)	21 (70)
Helping maintain comfort for the patient	68 (70.8)	23 (76.7)
Change of posture and protection of pressure points	76 (79.2)	27 (90)
Providing safe and clear environment to the patient	68 (70.8)	21 (70)
Avoiding dangers in the environment-Barrier Nursinq	88 (91.7)	26 (86.7)
Encourage patient to express own needs	55 (57.3)	24 (80)
Areas in Advanced Nursing		
Taking and recording Temperature/Pulse and Respiration	63 (65.6)	17(56.6)
Administering injections		
Intravenous	61 (63.5)	14 (46.7)
Intramuscular	61 (63.5)	15(50)
Subcutaneous	58 (60.4)	15(50)
Giving Extra oral feeds	46 (47.9)	12(40)
Administering different kinds of Enemas	29 (30.2)	10(33.3)
Irrigation of Bowel / Bladder / Vagina	45 (46.9)	17(56.6)

'Table 3 continues in the following page)

Catheterization of the Urinary Bladder		
Male urinary bladder	21 (21.9)	7 (23.3)
Female urinary bladder	58 (60.4)	14 (46.7)
Care of the Breast and assisting in breast-feeding	68 (70.8)	19(63.3)
Care of a patient with POP cast	65 (67.7)	21 (70)
Cardio Pulmonary Resuscitation	84(87.5)	26 (86.7)
Care of the Dying	61 (63.5)	20 (66.7)
Giving and Monitoring Blood transfusion	77 (80.2)	23 (76.7)
Testing urine	38 (39.6)	12(40)
Helping Doctor in diagnostic procedures		
Lumbar puncture	54 (56.3)	15(50)
Pleural tap	51 (53.3)	15(50)
Ascitic tap	51 (53.3)	15(50)
Bone marrow puncture	52 (54.2)	17(56.6)
Liver biopsy	51 (53.3)	17(56.6)

Over 73 per cent of the staff nurses expressed the need for training in the areas of legal aspects and consequences of negligence, handing over and taking over duties and setting a Ward-routine which are integral parts of 'Ward management.' A higher percentage (83 %) wanted training in crisis management, 70 per cent in record and report writing and nearly 67 per cent in the sub-areas of patient discharge, death and after service, and 'absconding patients'. For nursing sisters, the expressed needs were in the areas of crisis management (90%), setting a ward routine, indenting and storage of pharmacy supplies (>80%), system for ensuring staff for 24 hours and legal aspects and consequences of negligence (73% and above). Charting of duties to all categories of staff nurses was another favourite area of training for 70 per cent of the respondents (Table 4).

Opinions differed on the aspect of duration for different categories of training. Over 70 per cent (cumulative) respondents in both the groups considered a duration of 3 to 7 days optimal for induction training. Again Over 75 per cent of the respondents in both the groups wanted this training programme to be given within one week of joining the post. One nursing sister, however, did not feel the need for a training programme prior to induction.

Areas in Ward management	**Staff Nurses (N=96)**	**Nursing Sisters (N=30)**
	n(%)	**n(%)**
Charting of duties of all categories of staff nurses	45 (46.9)	21 (70)
System for ensuring staff for 24 hours	39 (70.6)	22 (73.3)
Setting a Ward routine	72(75)	26 (86.7)
Requisition of Material and Equipment and it's Care and Storage		
Sending and receiving linen from the Laundry	30(30.3)	14 (46.7)
Sending and receiving supplies and equipment from the C.S.S.D	37 (38.5)	17 (56.6)
Pharmacy supplies - Indenting and Storage	33 (34.4)	24 (80)
Crisis management	80 (83.3)	27 (90)
Handing over / Taking over duties	73 (76)	19(63.3)
Nursing Records and Reports		
Writing Admissions / Discharge register	68 (70.8)	17(56.7)
Writing Doctors' orders in treatment book	68 (70.8)	20 (66.7)
Writing Night orders in Report Book	65 (67.7)	19(63.3)
Writing daily Shift report of the serious patients	66 (68.8)	19 (63.3)
Writing complaints to relevant maintenance depts. for Civil, Mechanical and Electrical maintenance	31 (32.3)	16 (53.3)
Admission procedures and transfer of patients to other wards	62 (64.6)	16(53.3)
Patient Discharge, Patient Death and after service	64(66.7)	17(56.7)
Absconding patients and Control on visitors	64 (66.7)	18(60)
Release of information to relatives	45 (46.9)	15(50)
Legal aspects, consent forms, and consequences of negligence	71 (76)	22 (73.3)
Blood Bank requests and Laboratory requests	39(41.6)	10(33.3)
Distribution of prescribed diet to patients	48(50)	18 (60)
Monitoring of Housekeeping services	41 (42.7)	18 (60)
Supervision of orderlies and Safai karamcharis	56 (58.3)	16(53.3)

Maximum number of respondents in both the groups expressed that a duration of 4 to 5 days was optimal for promotional training. Further, 37 per cent staff nurses and 57 per cent nursing sisters opined that promotional training must be given within one week of promotion.

The staff nurses and nursing sisters wanted continuing nursing education programmes to be a part of their orientation trainings on a regular basis. The primary specialty subjects favoured by staff nurses were nursing in ICCU (50%), neonatology (32%), critical care/ICU (22%) and paediatrics (16%). Other mentioned areas were transplant nursing, neurosurgical nursing, nursing for real failure patients, bums nursing and psychiatry nursing. Continuing nursing education programmes for the nursing sisters included coronary care (ICCU), management in nursing, oncology, paediatrics, critical care (ICU), peadiatric critical care (PICU), nursing for AIDS patients, psychiatry, nursing aspects of disaster management, bums nursing and infection control.

Table 5 shows the expressed needs of the respondents for duration, venue and methodology for Orientation trainings. Most preferred the duration of training (nearly 40%) for the staff nurses upto 4 weeks. Nearly 37 per cent of nursing sisters wanted the course to extend upto 2 weeks. More than 90 per cent of the respondents in both the groups preferred a separate venue for orientation training other than their own organization where they are posted. About 60 per cent (cumulative) of the staff nurses favoured the frequency for orientation training once in every one to two years. A similar percentage of nursing sisters wanted the training once in every six months to one-year. Around 79 and 66 per cent of staff nurses wanted hands on training and workshops as training methodology. This figure was 80 and 70 per cent respectively for nursing sisters.

Tables 6 and 7 show the expressed opinion of the nursing sisters regarding training needs for their subordinate staff nurses in the areas of basic and advanced nursing. Over 80 per cent of the respondents opined the need for training in the areas of barrier nursing, oropharyngeal airway insertion and maintenance, oxygen administration, guiding and helping patients with special feeding problems, care of the skin and change of posture and protection of pressure points for their subordinate nurses (Table 6).

Training Parameters	Staff Nurses **(N=96)**	Nursing Sisters **(N=30)**
Average duration	**n(%)**	**n(%)**
1 week	15(15.6)	4(13.3)
2 weeks	17(17.7)	11(36.7)
3 weeks	8(8.3)	2(6.7)
4 weeks	38(39.6)	7 (23.3)
6 weeks	7(7.3)	2(6.7)
8 weeks	Nil	1 (3.3)
3 months	8 (8.3)	2(6.7)
More than 3 months	3(3.1)	1(1)
Venue		
Organizational	4(4.2)	1 (3-3)
Extra Organizational (specialty institute)	1(1)	2(6.7)
Both Organizational & Extra-organizational	91 (94.8)	27 (90)
Methodology		
Classroom Lecture discussions	96(100)	30(100)
Accompanying printed material handouts + AVaids	93 (96.9)	30(100)
Demonstrations	43 (44.8)	16 53.3)
Field Visits	9 (9.4)	4(13.3)
Workshops	63 (65.6)	21 (70)
Seminars	34 (35.4)	11(36.7)
Hands on training	76 (79.2)	24 (80)
Observational trainings	17(17.7)	5(16.7)
Group work	17(17.7)	8 (26.7)
Frequency		
Once in 6 months	22 (22.9)	11(36.7)
Once in 1 year	31 (32.3)	10(33.3)
Once in 2 years	37 (38.5)	5(16.7)
Once in 3 years	6(6.3)	3(10)
Once in 4 years	Nil	1 (3-3)

TABLE 6

VIEWS BY NURSING SISTERS TRAINING NEEDS OF STAFF NURSES IN BASIC NURSING

Areas in Basic Nursing	**Nursing Sisters n(%)**
Oropharyngeal Airway insertion, maintenance and suctioning	27 (90)
Postural drainage	23 (76.7)
Oxygen therapy	28 (93.3)
Guiding and helping patients with special feeding problems	27(90)
Care of the skin	26 (86.7)
Helping maintain comfort for the patient	20 (66.7)
Change of posture and protection of pressure points	24 (80)
Providing safe and clear environment to the patient	19(63.3)
Avoiding dangers in the environment - Barrier Nursing	27 (90)
Encourage patient to express own needs	19(63.3)

In advanced nursing, the expressed opinion by nursing sisters for training their subordinate nurses was significantly more (97%) in the areas of 'CPR' and 'care of the dying[1] followed by 'care of a patient with POP', 'giving and monitoring blood transfusions' and 'catheterization of the urinary bladder' (80 - 87%) (Table 7).

The opinion of the senior nursing administrators regarding orientation training areas for the subordinate staff nurses and nursing sisters are reflected in Table 8. All the respondents expressed the need for inclusion of all the listed sub-areas as contents in orientation training programme. The respondents wanted the inclusion of sub-areas of 'reorientation to changes in hospital's policy for nursing' and 'reorientation to changes in hospital's infection control and disaster management policy and protocols' specifically, under the area of 'Reorientation to changes in Policy Guidelines for health programmes and related activities'. In the 'others' category for the staff nurses/nursing sisters, the chosen areas were Continuing Nursing Education programmes, especially in the field of coronary care, critical care, trauma nursing and neurosurgical nursing, and nursing audit. For nursing administrators (ANS, DNS, NS) this category had training in management in nursing and nursing audit as expressed choices (Table 8).

TABLE 7
VIEWS OF NURSING SISTERS ON THE TRAINING NEEDS FOR STAFF NURSES IN ADVANCED NURSING

Areas in Advanced Nursing	**Nursing Sisters n (%)**
Taking and recording Temperature/Pulse and Respiration	13(43.3)
Administering Injections	
Intravenous	19(63.3)
Intramuscular	15(50)
Subcutaneous	16(53.3)
Giving Extra oral feeds	17(56.7)
Administering different kinds of Enemas	21 (70)
Catheterization of the urinary Bladder	24 (80)
Care of the Breast and assisting in breast-feeding	23 (76.7)
Care of a patient with POP cast	26 (86.7)
Cardio Pulmonary Resuscitation (CPR)	29 (96.7)
Care of the Dying	29 (96.7)
Giving and Monitoring Blood transfusion	24 (80)
Testing urine	15(50)
Helping Doctor in Diagnostic Procedures	
Lumbar puncture	15(50)
Pleural tap	16(53.3)
Ascitic tap	18(60)
Bone marrow puncture	20 (66.7)
Liver biopsy	20 (66.7)

(Figures in parentheses indicate percentage)

TABLE 8
VIEWS OF SENIOR NURSING ADMINISTRATORS ON THE AREAS FOR ORIENTATION TRAINING FOR NURSING PERSONNEL

Content areas	**Total (N=3)**
Reorientation to / Changes in General Administration / Service and Conduct Rules	3(100)
Reorientation to / Changes in in Policy guidelines for Health Programmes and Related Activities	3 (100)
Reorientation to / Changes in Hospital Policy for Nursing Services	3(100)
Reorientation to / Changes in Hospital (i) Infection Control Policy and Protocols (ii) Disaster Management Policy and protocols	3(100)
New Programmes / Activities initiated by ESIC for Patient Care / Welfare	3 (100)
Reorientation / Orientation to Relevant Contemporary / New Areas and Programmes including Continuing Education	3(100)
Others (for NS, staff nurses)	2 (66.7)
Others (for Nursing administrators)	2 (66.7)

(Figures in parentheses indicate percentage)

DISCUSSION

All the categories of nursing personnel observed that induction training for a duration of around 7 days need to be given to all just one week after joining the post. All categories of nursing personnel except one nursing sister felt the need for formal induction training. This is in concurrence with the recommendation of policy for induction training to all nursing personnel as reported by Talwar et al.(1990)[9].

With regard to Promotional Training, the respondents had the view that training for a duration of four to five days should be given within one week of promotion. Interestingly, it was observed that no formal promotional training programme was being conducted for any category of personnel during the time of the study. According to the respondents, promotional training was detrimental in carrying out their added roles and responsibilities more actively and efficiently following posting in their promoted positions. Often, individuals learrit by working with their supervisors, picking up instructions, and thus, 'getting trained'. This is akin to Rod Weston and Mike Grimshaw's (1990) description of traditional

method of traning the laboratory staff, a "Sitting next to Nellie" approach where the individual was placed along with a more experienced staff member and suffered from the usual disadvantages[10]. The respondents felt that unlike the induction training programme where a reasonably accurate figure was not available regarding the training load; for promotional training, the load could be calculated on an yearly basis and an appropriate calendar for formal training could be drawn up. There was consensus on the necessity of a formal promotional training programme for the smooth transition into the new role by the nursing personnel.

Most of the respondents wanted orientation training for a duration of two to four weeks with a frequency of once in every one to two years. Pro-active methodologies (hands-on, observational, workshops) in addition to lecture discussions for training were found mostly preferred. This is similar to the findings of an earlier report by Guiscafre et al (1995) where 'observational' and 'hands-on' methods offered excellent opportunity to train the primary care physicians in recognition and management of acute diarrhoeas and respiratory infections[11]. They also felt that pro-active methodologies for orientation trainings provided better learning and practice while interacting with patients. This finding is synchronous with the findings of Evans and Flagg (2000) where a Simulated Medical Unit was used for "hands-on" experience and training that resulted in soaring of the GN's confidence to confidently perform as nurses on return from training in a busy inpatient unit[12].

All nursing personnel expressed the necessity of training in specialty areas in addition to the needs in basic and advanced nursing. Some of these needs in basic and advanced nursing for nurses have similarities with those expressed in the Training Needs Assessment of Nursing Personnel" conducted by Ravindran (1995) at Safdarjung hospital[7]. 18 per cent of the staff nurses and 40 per cent of the nursing sisters who had received some form of orientation training over the past five years prior to the study period, felt it was a case of too few, too infrequent with less then optimal utilization of the trained manpower. They wanted these refresher trainings to be more systematic and on a more regular scale. This is in tune with the suggestions made by Vij et al (19^9) who suggested regular, planned refresher/orientation training programmes for the staff nurses[5]. In a similar study, Williamson (2002) advocated opportunities for in-Service education programmes for all

nurses through formal training programmes using the technological advancements in the field to improve the quality of nursing services[6]. They also felt that the trained manpower, though small, was not appropriately used in the right clinical settings.

The respondents expressed needs in ward and other management areas, related directly or indirectly to actual managerial roles performed by them in their day-to-day activities. This is akin to the observations made in the WHO technical series that states that at all levels of the Health Care System, nurses have demonstrated their effectiveness as managers, sometimes having no educational preparation for the role[13].

The findings in the present study reveal that there was an agreement between the expressed opinion of the nursing sisters regarding training requirements of their subordinate staff nurses and the expressed needs of the staff nurses in several areas of basic (barrier nursing, oropharyngeal airway insertion and maintenance, oxygen administration, guiding and helping patients with special feeding problems, and change of posture and protection of pressure points) and advanced nursing (cardio-pulmonary resuscitation and giving and monitoring blood transfusions).

The Nursing administrators also opined favourably with regard to the necessity of training in specialty areas for the staff nurses and nursing sisters. This was in tune with the expressed needs of the respondent subordinate nursing personnel. The advocacy of the nursing administrators was similar to the advocacy as earlier reported[5] and the need for specialty nursing education for nurses to develop existing competencies and imbibe new ones in them[6]. In the opinion of the nursing administrators, orientation-training programmes should be conducted on an annual basis for a duration of one to two weeks. The suggested content areas for such trainings were coronary care, critical care, trauma nursing, reorientation to change in hospital policy for nursing services, reorientation to/change in hospital's infection control and disaster management policy and protocols and nursing audit.

CONCLUSION

Since the delivery arm of any programme or organization are people, their method of functioning determines the shape of the delivery of the services. The clients' demand for quality services is getting stronger with each passing day. This is especially true in situations where the client is a partner in contributing towards the cost of the services. Additionally, keeping pace with the rapid technological advancements, nursing too demands new challenges in every sphere of providing quality health care. Additional inputs and improvement in the process form two important dimensions for improvement in the quality of services. The role of additional inputs into an organization is important but has limitations. Improvement and optimization of the process part is, therefore, an aspect that assumes greater importance for realization of organizational goal of providing quality service. It makes the organizational efforts to consistently and continuously improve the competencies (both clinical and applied managerial) of its personnel. The personnel are empowered through in-service training programmes, a critical component, for the improvement of the process part in provision of these quality services. Hence, ongoing in-service training programmes should be provided consistently and continuously to cater to the needs of the individuals in an organization for the overall professional satisfaction of the human resource that would excel the performance and otlt-put of the organization in return.

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यदि अपेक्षित और वास्तविक निष्पादन के बीच के अन्तराल की पहचान कर ली जाती है तो सामर्थ्य बढ़ाने के लिए प्रशिक्षण एक महत्वपूर्ण साधन है। प्रशिक्षण हेतु वर्तमान स्तर तथा अपेक्षित एच्छिक आवश्यकताओं का आंकलन करने के लिए राजकीय कर्मचारी बीमा निगम के प्रमुख विशेषता वाले दो अस्पतालों में कार्यरत 30 नर्सिग सिस्टरों और 96 स्टाफ नर्सों से साक्षात्कार किया गया था। नर्सिंग के आधारभूत क्षेत्र में दोनों वर्गों में से 75% उत्तरदाताओं द्वारा अवरोधक नर्सिंग, औरो–फिनाजियल एयर–वे इनसरशन तथा रख–रखाव, आहार संबंधी समस्याओं के विशेष संदर्भ में रोगियों के मार्गदर्शन तथा सहायता और दबाव बिन्दुओं आदि के संरक्षण संबंधी क्षेत्रों में प्रशिक्षण की आवश्यकता की पहचान की गई थी। उन्नत नर्सिंग के क्षेत्र में समान अनुपात में कार्मिकों द्वारा कार्डियो प्लमनरी रस्सीसाइटेशन, ब्लड ट्रांस्फूजन और प्रबोधन आदि क्षेत्रों में प्रशिक्षण प्राप्त करने की मंशा व्यक्त की गई थी। 73% उत्तरदाताओं द्वारा वार्ड प्रबन्धन के अर्न्तगत संकटावस्था प्रबन्धन, लापरवाही संबंधी कानूनी पहलुओं और परिणामों, दैनिक वार्ड

व्यवस्था और ड्यूटी बदलने के समय चार्ज लेने और देने संबंधी पक्षों को भी सेवा–कालीन प्रशिक्षण में शामिल करने की मंशा व्यक्त की गई थी। अधिकांश उत्तरदाताओं द्वारा प्रवेश के समय प्रशिक्षण प्रदान करने का समर्थन किया गया था। सतत् नर्सिंग शिक्षा हेतु आईसीसीयू, पीआईसीयू, आईसीयू, शिशु चिकित्सा, मानसिक चिकित्सा, न्यूरो सर्जरी और एड्स रोगी परिचर्या संबंधी क्षेत्रों में प्रशिक्षण देने की बात भी कही गई है। वरिष्ठ नर्सिंग नीति में आये परिवर्तनों, आपदा प्रबंधन तथा संक्रमण नियंत्रण नीति और आचार संहिता आदि क्षेत्रों में भी प्रशिक्षित किया जाना चाहिए। अध्ययन से प्राप्त निष्कर्षों से पता चलता है कि स्वास्थ्य परिचर्या की गुणवत्ता में सुधार लाने के लिए नर्सिंग कार्मिकों हेतु नियमित एवं सामयिक प्रशिक्षण कार्यक्रमों में उपरोक्त कार्य–क्षेत्रों को शामिल किया जाना आवश्यक है।

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NGO-GOVERNMENT PARTNERSHIP FOR PROMOTING PRIMARY HEALTH SERVICES: A FEASIBILITY ANALYSIS IN ARUNACHAL PRADESH

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ABSTRACT

With the objective of improving the primary health care services in the community, a feasibility study of NGO- government collaboration was carried out in Arunachal Pradesh. Views from policy-makers, planners, professionals, community leaders and members were collected with respect to the existing health care system and the needs in rural areas for justifying such a partnership. A large number of non-profit organizations in the state were found involved in promoting health education and income generating scheme. However, in spite of the felt need of the community, there was hardly any health and family welfare services jointly carried out by NGOs and the government agencies. Most of the government programme officers were not well aware of the existence and activities of NGOs in the state. Policy makers and the medical professionals held the view that quality of health and family welfare services in the state were not up to the mark and especially so because of a difficult geographical terrain and scattered population. Respondents favoured mobile clinics and an increase in the honorarium of the health guides from Rs. 50 to 250 along with a provision of periodical revision from time to time. NGOs agreed in principle to become partners with the government for selected activities like providing clinical and family planning services, organizing health awareness camps and campaigning **for** *immunization and HIV/AIDS awareness. The above findings indicate that the situation is favourable for forging a partnership with NGOs for promoting primary health services in the state of Arumchal Pradesh.*

Keywords: NGOgovemment partnership, Primary health care, Local needs, Mobile clinics and Village health guide.

In India, a huge infrastructure already exists for providing health care services. But facilities are not properly utilized because of various reasons. The primary reasons are the lack of community participation and poor quality of services leading to low utilization of health facilities. Since the major thrust of government is to provide quality health services through existing health care infrastructure, a good option is to explore the possibilities of working together with NGOs for improving the quality of services as well as making ways for easy access to services.

India is only second to USA in terms of number of hospitals outside the government health sector run by the NGOs. A large number of well-organized NGOs are running dispensaries/hospitals for the poor and backward classes, and providing curative services in the north-eastern state of Arunachal Pradesh. If these NGOs are encouraged in terms of liberalised financial assistance, they can contribute in filling up the gap of *referral hospital at Taluka/district level and in urban slums. NGOs have* also made a place for themselves in the areas of manpower training and research. They are a\so capable enough to share the \oad ot training of the paramedical personnel with the government. In this context, an integrated approach is required for programmes implementation in which NGOs could effectively supplement the government efforts to enhance the primary health care. Government can make the non-profit organisatons as partners in (i) Health and nutrition education, (ii) Community participation, (iii) Environmental sanitation, provision of potable drinking water, construction of pits/sanitary latrines, (iv) Strengthening the rural women organizations *(Mahila Mandals)* for initiating social activities, (v) Training and orientation of peripheral workers, (vi) Innovative projects to demonstrate new approaches involving community participation and inter-sectoral coordination, (vii) School health programme, (viii) Involvement of universities and medical college students for promoting health care and quality of life, (ix) Adult education programme, (x) Control of sexually transmitted diseases and HIV/AIDS through education and counselling, (xi) Rehabilitation of physically handicapped, and (xii) Family planning programmes.

Government and non-governmental organizations operate in different work-cultures, have different orientations and are used to achieve their ends through different means. Making the two institutions work together for one programme is not an easy task. NGOs can play an

important role in finding new ways to deliver health and family welfare services, reaching the unreached population and mobilizing social support for utilization of the available services. Although there is a specific focus on Public-NGOs partnership as an essential element of health sector reforms, the collaboration/partnership has been of limited nature hitherto. NGOs involvement in these government initiatives has to be strengthened if the programmes are targeted to achieve their goals. Partnership means more than just undertaking a small component of the programme together. It means existing together, growing together, and sharing the learning and experience with one-another. It connotes commitment and trust, and shared interests in decision-making and responsibilities throughout. There must be genuine partnership between the two, but first, cooperation needs to be established.

There are several things where NGOs and government organizations perform various activities jointly but mostly these are ad-hoc in nature. However, there were several instances of success stories of joint collaboration between the government and NGOs. For instance, some NGOs are playing an important role in training of *Anganwadi* workers under the integrated child development schemes (ICDS). For example, Child In Need Institute (CINI) of Kolkata, West Bengal, trains a large number of *Anganwadi* workers, supervisors and trainers. The rural health project of the King Edward Memorial (KEM) hospital was established as a partnership between the State Government and an NGO to innovate and experiment within the existing public health policies so that the government could test its own health visions and, if successful, introduce them on a wider scale. The *Balwadi* nutrition programme started in 1970-71 is being implemented with the help of five national level Voluntary Organisations (VOs) like the Central Social Welfare Board, the Indian Council for Child Welfare, the *Harijan Sevak Sangh*, the *Bhartiya Adimjati Sevak Sangh* and the Kasturba Gandhi National Memorial Trust, Indore. The Family Planning Association of India (FPAI) in collaboration with the Municipal Clinics in Mumbai, carried out family planning programme, sex education, guidance and counselling in marital problems and treatment of sterility. Gandhigram Institute of Rural Health and Family Planning in Tamil Nadu is a pioneer NGO in the field of health and family welfare. Through community leadership and by empowering local leaders, this NGO is carrying out health and family welfare programmes besides community health and population studies. This NGO is an active partner

with the National Institute of Health and Family Welfare (NIHFW), New Delhi, to promote reproductive and child health training programmes for the functionaries of the health and family welfare department. Voluntary health association of India (VHAI), a renowned mother NGO of the country, has been actively collaborating with the government to carryout various health related activities at the grass-root level. Recently, the Ministry of Health and Family Welfare (MOHFW, GOI) has assigned the responsibility of running the Northern Regional Resource Centre (NRRC) to VHAI as a part of the on-going RCH programme. The aim is to disseminate information to the masses at the regional as well as at the grass-root level through the Mother NGOs and field NGOs in the eight northern states.

In the area of Health and Family Welfare, several NGOs (including mother NGOs) were working in the State of Arunachal Pradesh. With the above background, a feasibility study was planned to find out the views of the policy makers, planners, medical professionals, paramedical workers, community leaders and members for initiating a partnership between government and NGOs as an alternative approach for promoting primary heaith care services especially in north-eastern region of the country. The study was initiated with the following objectives:

(I) To find out the existing health care system in the rural population and the status of linkage between government and NGOs in the state of Arunachal Pradesh;

(II) To elicit the opinion of health managers, policy makers, professionals, representative from NGOs and community leaders, regarding the feasibility of developing partnership between government and NGOs; and

(III) To find out the perception of the community in seeking health and family welfare services from government vis-a-vis NGOs.

MATERIALS AND METHOD

The study was conducted in two districts including the capital district of Arunachal Pradesh in 1998. One PHC from each district and two sub- centres from each PHC (4 sub-centres) were selected. The study

involved in-depth interview with policy makers, planners, and programme managers. A series of schedules were also administered to collect information from the top level health planners including the Health Minister, Health Secretary, Director Health Services, Programme Officer, Medical Officer, District Media Education and Information Officer to the level of health supervisors and workers, community leaders and members, and representatives of selected NGOs working in the area of health and family welfare. Focus group discussions (FGDs) with community members were conducted regarding the health seeking behaviour, views and perceptions regarding hearth care services, and feasibility of developing partnership between government and NGOs. Ten to 15 community members and five leaders from each sub-centre were considered for FGD and in-depth interview. Five NGO representatives from each district working in the area of health and family welfare were selected randomly for interviews.

Demographic Profile of the State and Health Problems in the Area

Arunachal Pradesh is a north-eastern state with high concentration of tribals with diversified tribal cultures. It is the home of the people of the Mongolian descendents, speaking a variety of Tibeto-Burman languages and dialects. There are 21 major tribal groups with over 100 ethnically distinct sub-groups speaking over 50 distinct languages and dialects. Due to the existence of different forms of ecological adaptation, the state has various forms of traditional political organisations. 82 per cent of the state's area is covered with dense jungles. There were 13 Z//a *Parishads,* 79 *Anchal Samities,* 56 Community Development Blocks, 2,012 Gram *Panchayats,* and 3,649 inhabited villages as on 31 March 2000. The total population of Arunachal Pradesh was 1,091,117, as per the provisional result of the Census of India 2001, of which 70 per cent is tribal population. As against the decadal growth rate of 21.34 per cent at the national level, the population of the state has grown by 26.21 per cent during the period 1991 to 2001. The sex ratio of 901 females to 1,000 males is much lower than the national average of 933. Total literacy of the state rose from 41.59 per cent in 1991 to 54.74 percent in 2001 (64.07% in males and 44.24% in females).

The FGDs with the community members revealed that health problems such as waterborne diseases, jaundice, typhoid, diarrhoea,

gastro-enteritis, worm infestation, respiratory infection, skin diseases, malaria and tuberculosis were more prevalent in the state. The digestive disorders due to unhygienic food habits were frequently reported in the area. It was found that the supply of safe drinking water in the entire study area was inadequate. Focus group discussion with the community also highlighted that consumption of liquor (mostly country prepared) was adding to numerous health problems in the area. In this regard, community at large favoured that health education and preventive measures were very much needed to solve the most prevalent health problems and the community also gave feedback that hardly any effort has been made towards health education and control of diseases. The community members during the FGDs accused of both NGOs and government being highly apathetic towards the solution of health problems in the area and held both responsible for the present miserable health condition of the people in the localities.

Availability of Primary Health Care Facilities and its Bottlenecks in the State

As per the government of India norms, the state should have 276 sub-centres (SCs), 46 primary health centres (PHCs), and 12 community health centres (CHCs) as per the requirement of the population projection in 2002. Surprisingly, it was found that there were only 245 SCs, 45 PHCs and 9 CHCs in position as on 30 June 1999. Thus, there was a shortfall of 31 SCs, one PHC and three CHCs. In the existing setup, there was a shortfall of 14 doctors, 36 laboratory technicians, 13 pharmacists, 31 LHV/Health Assistants (female), 40 Health Assistants (male), two surgeons, 13 specialists and 97 auxiliary nurse midwives (ANMs). There was no shortfall of other manpower, though female multi-purpose worker (MPW-F) and male MPWs were available in surplus. As far as construction of building was concerned, 42 SC, 9 PHC and 2 CHC buildings were required to be constructed (date of latest Quarterly Performance Report (QPR) as on 31 December 1994). As per the 1991 census, average population covered by a sub-center in the state was 3,077; by a PHC 16,754; and by a CHC was 0.84 lakh. Similarly, average number of villages covered by a sub-centre was 14.89, by a PHC 81.09 and by a CHC was 405.44; and the numbers of sub-centers per PHC and per CHC were 5.44 and 5.00 respectively as on 30 June 1999.

It was found that most of the difficult and inaccessible geographical areas in the state were covered by government health facilities. The NGOs and private medical practitioners were providing few selected services in limited areas. The SCs were providing treatment only for minor ailments. For diseases, which cannot be managed at the sub-centre level, cases were either referred to the PHC or district hospitals. This was also a common practice that people first go to the sub-center for getting treatment for general health problems. The current study found that the community members could not differentiate the performances between the government facilities and NGOs which might be due to the fact that NGOs were not covering and actively involved in a large area.

By and large, community members and leaders were in favour of services from NGOs in their respective areas. They were of the opinion that NGOs are most welcome to serve the community and people would cooperate with them as and when required in future. The public opinion was in favour of collaboration between NGOs and the government for the delivery of quality health care services in the area. In this context, communities as well as different categories of health professionals and managers were in favour of mobile clinics and barefoot-doctors-scheme in order to increase the coverage of the health services in rural areas of the state. For this scheme, NGOs were eager to cooperate with the government with the provision that government would provide adequate training to the human resource. The main constraints for programme implementation at the CHC, PHC and SC levels were lack of information-education and communication (EC) activities, poor availability of safe drinking water, insufficient infrastructure and lack of facilities especially at the SC and PHC level. Only a few of the diagnostic facilities for blood, stool, urine and malaria parasite tests were available with them. The community stressed the need to upgrade the existing facilities. The trained persons were also found to be inadequate in different laboratories. Though supply of contraceptives was adequate, the willingness to accept contraceptives on the part of the community was found to be low.

The communities, at large, were satisfied to some extent with the existing health facilities available at the SCs and PHCs due to the provision of free treatment and free supply of medicine, availability of medical staff, and physical infrastructure and basic equipment. However, they were highly concerned about the inadequate supply of medicines to the

PHCs and SCs. They were even ready for partial payment for the cost of medicines, provided those essential medicines are available at the health centres. At the time of data collection, most of the SCs had only one ANM without any male health worker. Community members emphasized the need to strengthen the manpower at the SCs so that in case one paramedical was deployed in the field, the other could look after the minor ailments and emergency cases at the SC itself.

Status of Existing Outreach Services

In general, population in remote and low-density areas does not have adequate access to affordable health care services. As per the 2001 Census, population density was lesser than 13 persons per sq. km in Arunachal Pradesh, which was far below the national average of 325 persons per sq. km. Average village size was 2 to 9 households and distance from one to the other village was almost 12 km or more. In view of the hilly terrain, one health worker needed to walk seven to ten hours to travel the distance between two villages. In such a difficult terrain, as the Medical officers (MOs) put it, even a month's time was not sufficient to cover all the villages under a SC by one ANM. Population covered by a PHC in the state varied from 10 to 60 thousand and the area covered by a PHC ranged from 10 to 40 km. The distance of the nearest and farthest village varied from 7 to 35 km. Due to hilly terrain and scattered population, it was difficult for a health worker to visit even a 10 km distance in a day and cover the scattered population. It was observed that lack of communication and poor road facilities were major hurdles for catering available health services to the population in the state of Arunachal Pradesh.

The norms set by the government were not suitable for SCs and PHCs in terms of population covered. It needed revision in view of the scattered population and lack of minimum communication facilities. Interestingly, the study revealed that disparities in deployment of manpower at PHCs and SCs were chaotic due to political interference. It was further seen that urban health centres were over-staffed whereas PHCs and SCs were under-staffed. This imbalance in posting of staff had affected the performance of the health centres in rural areas of the state. There was a negligible sharing of resources between the districts, PHCs and SCs as far as infrastructural facilities such as equipment, vehicles,

communication instruments, supply of material etc. are concerned. Although government accommodations were available at the place of posting but it was not found optimally utilized.

At the PHC level, the proportion of new and old cases was found to be around fifty-fifty per cent, with the workload varying from 50 to 150 cases per day including both new and old cases. The study found that the problems faced by the doctors were irregularity in supply, short supply and sub-standard quality of drugs, undue delay in maintenance of equipment, cumbersome procedure for getting grant for maintenance, non-availability of transport facilities and lack of general maintenance of PHC building including operation theater and labour room. There was hardly any contingency fund available with the medical officer in-charge of the PHC to undertake even minor repairs.

In spite of the felt need of the community members, it was found that the government or the NGOs hardly organize any health service camps in the rural areas. The community leaders during the FGDs highlighted that the para-medical staff from the SC, during their door-to-door contact in the villages, provide only limited health education regarding malaria, water-borne diseases, safe drinking water, nutrition, maternal and child health (MCH) services, etc.

Opinion about Quality and Availability of Health and Family Welfare Services

Regarding the quality and availability of primary health care services in the state, health policy-makers and planners at the highest level (consisting of the Minister, Secretary and Director-Health Services) expressed that the quality of primary health care services was reasonably good but its availability was restricted only to the parts of high and middle altitude belts in Arunachal Pradesh. They agreed that with the further improvement in the quality of health care facilities like accessibility to health care centres, improvement of infrastructures, logistics and communication facilities in the state, the services would improve both in quantum and outreach. During the time of the study, it was found that there was no specific plan or policy of the state government to provide primary health care to each and every one living in the interior and difficult geographical terrains.

About the strategies for improving the hearth services in the rural areas of the state, policy-makers and planners were inclined to provide (i) incentives to medical and paramedical staff for posting in remote rural and difficult terrains, (ii) provision of at least 10 per cent of the state plan's share for health sector which was only between 2 to 3 per cent during the study period. With the increment in budget, number of existing PHCs and SCs could be increased for providing better health care services to the people at large. It was observed from the study that a distinct state-specific-policy decision in terms of population coverage per PHC and SC is essential in extending the health services to all parts of the state. In this context, the state government had undertaken efforts to revamp the DAI scheme and Village Health Guide Scheme in rural and tribal areas.

Possible Mechanism for Partnership with NGOs: Views of the Government

It was found that, health workers, supervisors, medical officers and programme officers were not much aware of the existence of NGOs and their activities in their respective areas in the state. These paramedical staff and medical officers were willing to involve NGOs in certain health services like first-aid, hygiene and cleanliness, nutritional education, motivation for MCH care, prevention of diseases, school health education programme and community health education in general. The government staff was also willing to involve NGOs in their day-to-day health activities. They were even ready to provide basic training, guidance and supervision to the NGOs in their work situation.

The paramedical staff also pointed that if some PHC activities were given to the NGOs, they were even ready to work under the supervision of NGOs provided the NGOs work and interact in a positive manner. They stressed that government service rules need to be amended to accommodate provisions of their working with the NGOs. Similarly, regarding handing over of PHC/SC to NGOs for total management of health and family welfare services on experimental basis, they were quite supportive of the idea. They further suggested that only those PHCs and SCs should be handed over to NGOs, which are not functioning well due to the different constraints in terms of posting of manpower and difficult terrains. At the same time, they viewed that

capabilities of the NGOs must be ascertained before making them partners with full accountability and responsibility.

Though the medical officers in PHCs and high level programme officers showed their willingness to cooperate with the NGOs in the health promotional activities, unlike their paramedical staff, none of them agreed on the aspect of handing over some of the PHCs/SCs to NGOs for the management of health and family welfare services on experimental basis. These health officials questioned about the credibility, capability, infrastructure, experiences and availability of trained paramedical staff of the NGOs in this regard. However, the PHC-MOs were not skeptical about the functioning and capabilities of the NGOs.

The paramedical staff was in favour of transferring certain health promotional activities to the village-level voluntary organizations such as *Mahila Mandate*, Youth-Clubs etc. The possible areas of involvement for these organizations cited by the paramedical staff were health education, motivation for family planning and MCH activities, environmental cleanliness and hygiene. The paramedical staff also expressed the reservation that due to the problems like hilly terrains and scattered population, they could not perform their duties properly. They also realized that NGOs could play a more vital role as facilitators during their fieldwork in connection with providing primary health care services in rural areas.

Several modalities were identified for cooperation with NGOs. Problematic areas such as supply of medicines, maintenance of equipment, like refrigerator, sterilizer etc were favoured to be taken over by the NGOs. The government officials viewed that it would not only reduce the difficulties of the health functionaries but also would improve the quality and availability of health services in the state of Arunachal Pradesh. According to the policy makers, EC programme may also be partially supplemented by the NGOs. However, the programme must ultimately be handled at the government-level.

In order to develop a future partnership between government and NGOs, the government officials suggested enough freedom to NGOs to work according to their own set of rules with the financial support and monitoring coming from the government side. In this connection, policymakers also suggested joint monitoring by the government and third party

NGOs. The performance evaluation of NGOs by independent organizations was highly favoured by most. Simultaneously, the policymakers highlighted the need for developing guidelines to provide basic training from the government side to the personnel of NGOs in the area of health and family welfare. On the issue of sharing manpower between government and NGOs, the idea emerged was to depute government health functionaries to work with the NGOs in certain inaccessible areas. Government officials supported the view that for operational research in developing health delivery modules, NGOs could be involved.

Most of the programme officers supported the involvement of NGOs in health care delivery system in rural areas on project basis in the specifically identified areas. They argued that NGOs are at nascent stage at the moment and they could not be given much responsibility from the very beginning.

State health officials suggested that State Health and Family Welfare Society for Voluntary Action set up during 1996 could take the leadership initiative to evolve mechanisms of partnership between Government and the NGOs in the health and family welfare sector. The Health Minister and the Health Secretary of the state identified certain areas related to EC activities where the involvement of NGOs would be of great help. According to them, joint efforts with regard to planning promotional activities, awareness and educational programme for social welfare such as improving the age at marriage, de-motivating for polygamy, women's literacy, gender equality, drug de-addiction and reduction of alcoholism etc. could be taken up on experimental basis.

Profile of NGOs and their Functioning

It is necessary to understand the organizational strength, financial capacity and manpower available with the NGOs to make them healthy and sustainable partners in contributing to the health care delivery system. On the basis of the above criteria and feedback from the State Government, three different types of NGOs were identified in the state of Arunachal Pradesh.

The first category included well-established NGOs, which had sufficient infrastructure, proper budgetary support with more than 10 years of standing with trained manpower and good organizational setup. Few

popular NGOs namely R.K. Mission, VHAI and Dony-Polo Mission and Arunachal Pradesh Women Welfare Council (APWWC) fall in this category. These NGOs were mainly engaged in clinical health services. Some of them like VHAI, and APWWC were engaged in health promotion, social welfare and training activities for NGOs staff. These NGOs had been receiving a good amount of fund from the government in addition to donation received from other sources. They also had a system of proper budgeting and maintenance of proper accounting procedures.

NGOs, those were registered within the five years prior to the study period and undertaking activities in different areas depending upon sources and availability of funds fell in the second category. Their area of function was at the district level and below. Financial recording and auditing system of these middle level NGOs were not very sound. These NGOs lacked trained manpower and had limited involvement in health related areas like health promotion and immunization activities.

The third category included the recently registered and unregistered NGOs who were trying to associate with the established NGOs for expanding their activities. However, such NGOs generally adopted small areas for their activities and for limited periods. These NGOs were in the process of getting financial aid from the government (State/Center) and other agencies. They lacked proper recording and auditing system and their main sources of income were charity and community donations.

Most of the second and third category NGOs did not have systematic action plans on regular basis. They used to decide their future activities based on the availability of funds and area-specific-needs. Generally, NGOs discussed their plans with the executive members in the organization. It was observed from the study that mother NGOs used to formulate their plans systematically with the involvement of the community in a phased manner.

Possible Mechanism for Partnership: Views of the NGOs

It was found that NGOs had agreed in principle to become partners with the government for providing health care services. The service areas identified by the NGOs for future collaboration were mainly health awareness campaign, clinical services, family planning and

immunization camps, promotion of hygiene and cleanliness practices, AIDS awareness campaign and eye camps. It was observed that NGOs introduced these health related activities in the community through participatory approach. In order to strengthen the partnership, NGOs stated the following for consideration. These were; (i) They should be involved right from the beginning in the planning process, (ii) Government should decide a clear-cut division of responsibilities between government agencies and NGOs taking into confidence the views of NGOs, (iii) Joint strategies to achieve different objectives should be worked out in consultation with the NGOs, (iv) NGOs should be considered as permanent partners with the government rather than on ad-hoc basis, (v) Government should take the responsibility to provide skill-based training to the NGOs staff on regular basis, (vi) Long term financial protocol should be developed between the government and NGOs in order to remove fear of irregular funding, if any, (vii) There should be a common platform for all the NGOs and the government should encourage to create a consortium of NGOs for providing smooth networking and functioning as partners in health care services, (viii) Government should simplify procedures in order to minimize delay for providing funds to the NGOs (ix) Government policy should allow their health personnel to be posted with the NGOs as and when required, and (x) NGOs can cooperate with the government by providing training and orientation to local traditional healers and practitioners by involving them in the promotion and delivery of health care services in remote areas.

Large number of NGOs may be allowed to take the responsibility of managing SCs and PHCs even in the remote rural areas, initially under the guidance of the department of health and family welfare. NGOs further expressed that while giving the responsibility to run these PHCs and SCs, government should not impose and interfere in the day-to-day functioning. NGOs also pointed out that they could manage government health centres with the existing physical infrastructure. They were confident of providing better and cost-effective services.

CONCLUSION

Suggestions were sought from various categories of respondents in order to improve the existing health situation in the state of Arunachal Pradesh. While discussing with the community members, leaders, and

representatives from NGOs, it was pointed out that indigenous system of medicine including herbal, traditional practices may be documented; indigenous health practitioners should be recognized and financially supported by the government. In case of bone-fracture and other orthopaedic problems, community members as well as health professionals appreciated the contribution coming from herbal treatment.

In the area of public health, medical officers in the PHCs suggested that orientation and in-service training of PHC staff should be strengthened. The posting of medical and paramedical staff at the PHCs and SCs should be based on the established norms rather than any other influencing factors or political pressure or nepotism. Another suggestion was that the paramedical staffs posted at distant and geographically difficult terrains must be provided additional increments or incentives in order to attract them to serve in the rural and remote areas. In this regard, a comprehensive policy for posting in rural areas should be involved. Communication facilities in terms of road connection, telephone and transport to the PHCs and SCs may be improved on a priority basis.

Regarding the involvement of qualified private practitioners on long vacant medical officers' posts at PHCs, none of the Programme Officers and Director-Health Services (DHS) favoured such an idea. In this context, some of the programme officers suggested a policy for placement of MOs in rural areas on a compulsory basis for two to three years with certain incentives. In order to overcome the constraints in providing qualitative health services through government health centres in rural areas, pooling of community resources by NGOs and sharing the same with the government health institutions was recommended. NGOs may be given grant-in-aid to cover the remote areas for providing health care services where government organizations failed to perform. Policy-makers and planners highlighted that current population norms meant for a PHC and a SC are not feasible to be covered by the health worker due to hilly and inaccessible terrains and scattered population in the state. The norms for the same should be redefined keeping in mind the local needs in specific areas.

In order to improve the coverage of health services, the apparent solution emerged that deployment of mobile clinics and introduction of village health guides (VHGs) scheme in remote areas with the provision of

honorarium of Rs. 250 per month and a provision of revision of the amount from time to time as against the existing Rs. 50 per month. The implementation of various national health programmes should be introduced based on the need of the local communities. In this regard, need-based and area-specific health plans should be prepared involving the NGOs. It was also suggested that in order to overcome the resource crunch in the department of health and for improving the health care services at PHCs, a policy could be worked out for sharing the resources at different levels in a rational way.

At the state level, there was hardly any initiative to involve the NGOs in the matters of policy-making, planning-process of health programmes and at the implementation level. It is felt that there could only be genuine partnership if effective collaboration is done at all levels. There are inherent differences in the philosophy and perspectives on the parts of the government organizations (GOs) and NGOs which do not make them natural partners. While the government tends to be bureaucratic and sectarian, NGOs generally subscribe more to a participatory and holistic approach in the project development and its management. While the government agencies tend to be more concerned with physical infrastructures and numerical results, NGOs place more emphasis on social development with special emphasis on project-outputs. As a result, their interests and priority do sometimes clash, and cause problems in programme implementation. Besides, there is no proper central-mechanism for developing and processing information about the NGOs[1] performance and their inputs in the government's programmes. Hence, their vital role in the field of health and Family welfare is not properly acknowledged and recognized.

At the time of study, involvement of NGOs in implementation of health programmes was purely ad-hoc in nature. However, the state government had initiated a scheme for funding the NGOs for certain activities. Since, the decision-making process was under government control and centralized, it is time consuming. Government did not have proper assessment system to recognize the well-established and better-performing NGOs in the state. In the process of providing grant-in-aid, reputed and result-oriented NGOs should be given priority and due recognition. There is a need to categorize the NGOs based on their standing, organizational structure, manpower, expertise in the health

sector, budgets etc. to share the responsibilities of the government accordingly. Thus, NGOs could become permanent partners of the government in health-sector reforms. NGOs suggested simplifying the funding procedures in order to avoid delay leading to de-motivation. NGOs were of the opinion that they would prefer to work in partnership with the government rather than as an alternative to the government setup within the given frameworks.

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अरूणाचल प्रदेश में प्राथमिक स्वास्थ्य परिचर्या सेवाओं में सुधार लाने के उद्देश्य से गैर–सरकारी संगठनों और सरकार में साझीदारी के बारे में एक व्यवहार्य अध्ययन किया गया था। ग्रमीण क्षेत्रों में स्वास्थ्य संबंधी आवश्यकताओं को पूरा करने के लिए वर्तमान स्वास्थ्य परिचर्या प्रणाली के संदर्भमें इन संगठनों की भागीदारी को सार्थक सिद्ध करने के लिए नीति–निर्माताओं, योजनाकारों, व्यवसायिकों, सामुदायिक नेताओं और सदस्यों के विचार एकत्र किए गए थे। यह पाया गया था कि राज्य में बेहतर स्वास्थ्य शिक्षा देने और आय–अर्जन योजना में अनेक अलाभकारी संगठन कार्य कर रहे थे। तथापि, समुदाय की आवश्यकताओं को पूरा करने के लिए स्वास्थ्य और परिवार कल्याण संबंधी सेवाएं उपलब्ध कराने के लिए शायद ही कोई गैर–सरकारी संगठन और सरकारी एजेन्सी संयुक्त रूप से कार्य कर रही थीं। राज्य में कार्यरत गैर–सरकारी संगठनों की गतिविधियों के बारे में अधिकांश सरकारी कार्यक्रम अधिकारियों को पर्याप्त जानकारी भी नहीं थी। नीति–निर्माताओं और चिकित्सा व्यवसायिकों का विचार था कि कठिन भौगोलिक परिस्थितियों के कारण राज्य में दी जा रही स्वास्थ्य और परिवार कल्याण सेवाओं की गुणवत्ता उपयुक्त नहीं थी। उत्तरदाताओं द्वारा चलित क्लिनिकों और स्वास्थ्य गाइडों को दिए जाने वाले मानदेय को रू 50रू0 से बढ़ाकर 250 किए जाने और समय–समय पर इस मानदेय के सामयिक परिशोधन किए जाने की सिफारिश की गई थी। गैर–सरकारी संगठनों ने क्लिनिक और परिवार कल्याण संबंधी सेवाए प्रदान करने स्वास्थ्य संबंधी जागरूकता शिविर आयोजित करने, टीके लगाने और एचआईवी/ एड्स के बारे में जागरूकता लाने के लिए अभियान चलाने जैसी गतिविधियों में सरकारी संस्थाओं से सैद्धान्तिक साझेदारी स्वीकार की थी। अध्ययन से प्राप्त उपरोक्त निश्कर्शो से पता चलता है कि अरूणाचल प्रदेश में प्राथमिक स्वास्थ्य परिचर्या सेवाओं को बेहतर बनाने के लिए गैर–सरकारी संस्थाओं की साझेदारी बनाने के लिए स्थिति अनुकूल है।

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UNSAFE ABORTIONS: SOCIO-DEMOGRAPHIC PROBLEMS AND THEIR MANAGEMENT

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Abstract

Nearly half of the estimated 40-60 million induced abortions are illegal and/or unsafe. In devebping countries, approximately, 2,00,000 maternal deaths are attributed to the unsafe abortbns. In India, 6.7 million abortions are carried out in unhygienic conditions. The mortality rate is reported to be 7.8 per 1,000 random abortions, most of which are illegal. The risk is seven times more in women with second trimester abortions. The common complications in such cases include excessive blood-loss, pelvic infections, uterine perforation, cervical injury and thrombo-embolism. Measures like conducting abortions by trained manpower, ensuring adequate health infrastructure, involvement of NGOs and creating awareness about contraceptives are expected to bring down the unsafe abortions to a great extent.

Keywords: Unsafe abortion, Health system infrastructure, Trained manpower, Awareness and education.

Abortion *(Garbhpata)* has been recognized as a method by the ancient Indian physicians like Charak and Shushruta. The word 'abortion', however, is derived from a Latin word 'Abortiri', which means detachment of a thing from its proper site. Mercury was recommended as an abortifacient nearly 500 years ago in an ancient Chinese work. The Greek and ancient Romans also practiced abortions to have well ordered population. The justification of the procedure was that the Roman law did not consider the foetus as a human being.

Definition

Abortion is 'termination of pregnancy' at any time before the foetus has attained the stage of viability. This has been fixed administratively at 28 weeks, which corresponds to a foetal weight of 1,000 gms. In developed countries, this limit has been brought down to 20 weeks of pregnancy with expert neonatal care and corresponding to a foetal weight of 400 gms[1]. WHO defines 'unsafe abortion' as 'a procedure for terminating an unwanted pregnancy' either by persons lacking the necessary skills or in an environment lacking minimal medical standard or both2.

Classification of Abortions

Abortion may be spontaneous or induced, induced abortions are deliberately induced and these may be legal or illegal. The spontaneous abortion can be further categorized into threatened, inevitable, incomplete, complete, missed and septic abortions. Abortions, whether spontaneous or induced, are almost always fraught with hazards resulting in maternal mortality and morbidity[3].

Magnitude

Various studies show that the proportions of abortions range from 9 to 15 per cent of the total pregnancies. In some countries like Hungary, the proportion of legal abortions exceeds live births. The actual incidence of abortion world-wide is not known. But the estimates range from 30 to 55 million a year. This is nearly 40 to 50 per 1,000 women in the reproductive age with an abortion ratio of 260 to 450 per 1,000 live births[4]. In India, it is estimated that about 6 million abortions take place every year out of which 2 million are spontaneous and 4 million are induced. Of the induced abortions, nearly five to six lakh are legal and the rest are estimated to be illegal[1]. The global estimate for the incidence of unsafe abortion given by the WHO is 16 per 1,000 women in the reproductive age group of 15 to 49 years. It is estimated that 63 pregnant women die in one-lakh unsafe abortions globally. The proportion of maternal deaths due to unsafe abortion is 13 per cent in less developed region of the world[2]. Hospital records are usually incomplete or under-reported as far as illegal abortions are concerned. Hospital studies indicate that 10 to 50 per cent

of the unsafe abortion cases need medical attention. However, all women who undergo unsafe abortion do not seek health care even when complications arise. Their decision to seek help depends on the age of the woman, accessibility of health services, social attitudes and so on.

Factors Associated with Spontaneous Abortion

Various epidemiological variables associated with the risk of spontaneous abortion are age at menarche, smoking, and gravida. Spontaneous abortion rates are found to be 1.5 to 2 times higher among women with the menarcheal age of 12 years or less than those with a menarcheal age of 14 years or above. Studies show that women who smoked heavily throughout pregnancy had a spontaneous abortion rate of 14.5 per cent as compared to 7.8 per cent of non-smokers. The risk has been estimated to be 11.79 per cent for 2nd gravida, 12.38 per cent for 3rd, 13.86 per cent for 4th, 15.30 per cent for 5th and 18.16 per cent for 6th gravida among the 'Blacks' respectively. A similar risk of 10.20,10.74, 11.41,10.92 and 11.35 per cent during different periods of pregnancy was estimated for 'Whites' respectively. Previous abortion, pregnancy loss and previous defective offspring are also likely to result in spontaneous abortions.

Etiological factors for spontaneous abortions are 'genetic factors', such as chromosomal anomalies, maternal infections, cervical incompetence, uterine abnormalities and hormonal causes.

Public Health Importance of Induced Un-safe Abortions

Each year half of the 40 to 60 million abortions performed in developing countries are illegal or performed in an unsafe manner[4]. Thus, abortion accounts for 2,00,000 maternal deaths annually in developing countries. Treating women who had illegal abortions strains the health system while the concerned women face long-term morbidities and social disabilities. Abortion will continue to exist as long as women face unwanted pregnancies and unwanted pregnancies will continue to occur until women gain the power to dictate and control their sex behaviour[5].

In India, abortion is legal but legal abortion is difficult to access. So, majority of India's estimated 6.7 million abortions carried out annually

are in unsanitary and unsafe conditions. These are due to the inaccessibility of abortion services, unaffordable private services, ignorance on the availability of such services and lack of confidentiality. Moreover, women who seek an abortion at unauthorized service facilities or from unskilled persons, put not only their health at risk but also their lives. Although unsafe abortion is a public health problem at all ages, it is particularly so in case of young women. The young women often have poor access to family planning methods and facilities and are less likely than the older women to have the contacts and money to obtain a safe abortion. Furthermore, abortion-related morbidity and mortality are much higher in the second trimester of pregnancy. Thus, unsafe abortion is one of the most neglected areas of health care[6].

Characteristics of Women Seeking Illegal Abortions

Like the data on various variables related to illegal abortion, information on the social and demographic characteristics of women resorting to illegal abortions are also fragmented and biased. A variety of factors including reproductive behaviour, accessibility and use of effective contraception, socio-economic conditions and cultural practices do influence the behaviour of women seeking illegal abortions.

Consequences of Unsafe Abortions on Health

Mortality and morbidity from illegal unsafe abortions vary according to the conditions under which the abortion is performed. The type of procedure followed in conducting the abortion, the skill of the person performing it, the stage of gestation, age, health and parity of the woman etc. have impact on the mortality and morbidity of the concerned women. It is difficult to get an estimation of the fatality rate for illegal abortions since the number of procedures performed is unknown or under-reported. In developed countries, abortions are legal and statistics is accurate where the mortality ratio ranges from 1 to 3.5 per 1,00,000 abortions[7]. While in India, the mortality rate is reported to be 7.8 per 1,000 random abortions, most of which are illegal. Studies indicate that risk of death is 7 times higher in women who wait till the second trimester to terminate the pregnancy[8]. Another study indicates that deaths range from 100 to1000 per one-lakh cases of illegal abortion in developing countries[9].

Morbidity

Unfortunately, data on morbidity due to illegal abortions are very limited and fragmented. In general, illegally induced abortion is considered as a reason for frequent and severe short-term complications with long-term sequel. Because illegal abortions are performed often by unqualified persons under unhygienic conditions and sometimes at a later stage of pregnancy, they create a serious public health problem. The most common early complications are excessive blood-loss, pelvic infection, uterine perforation, cervical injury, thrombo-embolism, anaesthetic complications and shock. The late sequel includes infertility, ectopic gestation and increased risk of spontaneous abortion etc[5].

RECOMMENDATIONS

Planning and managing abortion services depend up on a number of factors such as (i) whether services are public, private or nongovernmental; (ii) current situation in terms of laws and regulations, (iii) accessibility to safe abortion care, (iv) quality of care, (v) competencies of the service providers; (vi) established norms and standards for services; (vii) definition of service provider's skills, training, supervision and (viii) certification process, monitoring and evaluation[5].

The following measures could be considered for improving the services with regard to unsafe abortions:

Community Level Measures

- Public health education/information on reproductive health, including family planning and abortion should be initiated for all the concerned.
- Community-based distribution of appropriate methods of contraception; including emergency contraception must be introduced.
- All the health workers should be trained to provide information on referral to avail of legal abortion services.
- All the health workers must be trained to recognize abortion complications and promptly refer the cases to the appropriate service centre.

- Transportation services for abortion and management of complications of unsafe abortion should be made available.
- All the health workers and other key community professionals like police or teachers should be trained to recognize signs that girls or women have been subjected to rape or incest and provide referral to health facilities or other social services.

Primary Health Centre Level Measures

- All the health care workers providing reproductive health services need to be trained to provide counselling on family planning, unwanted pregnancy and abortion, and the prenatal diagnostic test (PNDT) act.
- A broader range of contraceptive methods; including lUDs should be made available.
- Vacuum aspiration up to eight completed weeks of pregnancy is to be provided.
- Medical methods of abortion up to nine completed weeks of pregnancy should be provided.
- Clinical stabilization and provision of antibiotics to women with complications of unsafe abortion should be provided.
- Vacuum aspiration for incomplete abortion can be provided.
- Prompt referral and transport for women who need services for abortion or for the management of abortion complications that cannot be provided on the site must be facilitated.

District Hospital Level Measures

- All elements of abortion care mentioned for the primary level should be made available at the district hospitals.
- Provision of sterilization in addition to other contraceptive methods should be made available.
- Abortion services for all circumstances and stages of pregnancy in which it is permitted by law must be provided.
- Management of abortion complications should be handled properly.
- Awareness programmes to disseminate information on unsafe abortion and other related matters like use of contraceptives, safe-sex

etc. should be undertaken in the catchment areas under the district hospitals.

- Pre-service and in-service training programmes for all relevant cadres of health professionals in relation to abortion service including counseling and PNDT act should be made mandatory.

Referral Hospitals (Secondary and Tertiary) Level Measures

- All elements of abortion care mentioned for the previous levels must be included in the list of secondary and tertiary level measures.
- Management of all abortion complications including those which cannot be managed at district level should form part of the measures at the referral hospital level.

Other Measures

- Community level education campaigns should target women, household decision-makers and adolescents about the availability of safe-abortion services, practices and the dangers of unsafe abortion.
- Safe and legal abortion services should be made more attractive to women and household decision-makers by (i) increasing geographic spread; (ii) enhancing affordability; (iii) ensuring confidentiality and (iv) providing compassionate abortion cares including post-abortion counselling.
- Updated and simple technologies which are safe and easy like the manual vacuum extraction that is not necessarily dependant on anaesthesia, or other non-surgical techniques which are non-invasive by nature should be adopted.
- Collaborative arrangements with private sector health professionals, NGOs and the public sector must be promoted to increase the availability and coverage of safe abortion services including training of mid-level service providers.
- The current cumbersome procedures for registration of abortion clinics should be withdrawn. Establishment of additional training centers for safe abortions in the public, private, and NGO sectors should be simplified and facilitated. The health care providers must be trained with regard to all aspects of clinical services for safe abortions.

- Standards for abortion services should be formulated and notified to all concerned. Enforcement mechanisms at district and sub-district levels are to be strengthened to ensure that these norms are followed.
- Norms-based registration of service provision centers should be followed.
- Appropriate post-abortion care, including management of complications and identification of other health needs of post-abortion patients should be provided and linked with appropriate services. As part of post-abortion care, physicians may be trained to provide family planning counselling and services such as sterilization and reversible modem methods such as lUDs, oral contraceptives and condoms.
- Syllabi and curricula for medical graduates should be modified as well as to provide practical training on the newer procedures and be incorporated in the continuing education programmes.
- Provision should be made to ensure services for the termination of pregnancy at primary health centres and community health centres.

Some of these issues have been addressed in the on-going RCH programme across the country. Moreover, there is a need for some operation research studies in this area such as operationalization of safe abortion services at the PHC level, study of unwanted pregnancy and abortion related perceptions; utilization pattern and problems; quality of care; and functioning of existing laws against selective (gender based) abortion to decrease the load and the consequences of unsafe abortions. There should be attempts to enhance the knowledge and awareness of the traditional birth attendants (TBAs) and private medical practitioners with regard to safe abortion services and prevention of complications of abortions.

Lkkjk'k

अनुमानतः लगभग 40–60 करोड़ गर्भपातों में आधी संख्या में गर्भपात गैर–कानूनी और अथवा असुरक्षित होते हैं। विकासशील देशों मे लगभग 2,00,000 माताओं की मृत्यु इन असुरक्षित गर्भपातों के कारण होती है। भारत में अनुमानतः 6.7 करोड़ गर्भपात अस्वास्थ्यकारी स्थिति में किए जाते हैं। इन गर्भपातों से होने वाली मृत्युदर 7.8 प्रति 1000 माना गया है, जिनमें से अधिकांश गैर–कानूनी होते हैं। गर्भधारण के पश्चात दूसरी तिमाही में गर्भपात कराने वाली महिलाओं में जोखिम 7 गुणा अधिक आंका गया है। इन मामलों में होने वाली सर्वाधिक समस्याओं में अत्याधिक रक्तस्राव, उदरीय–संक्रमण , सर्वाइकल इन्जरी आदि शामिल है। प्रशिक्षित चिकित्सकों द्वारा गर्भपात कराना, पर्याप्त स्वास्थ्य ढांचा सुनिश्चित करना, गैर–सरकारी संगठनों की भीगीदारी, तांम गर्भनिरोधक उपायों के बारे में जागरूकता उत्पन्न करने जैसे अनेक उपायों की सहायता से काफी हद तक असुरक्षित गर्भपात में कमी लाई जा सकती है।

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