MAINSTREAMING GENDER WITHIN INDIA'S REPRODUCTIVE & CHILD HEALTH (RCH 2) PROGRAMME

Final Report, 21 January 2004

Submitted to
United Nations Population Fund (UNFPA)
New Delhi

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MAINSTREAMING GENDER WITHIN INDIA'S REPRODUCTIVE & CHILD HEALTH PROGRAMME

Part 1: Key concepts and assumptions

1.1 Gender mainstreaming: what it is and what it is not

The words 'gender mainstreaming' evoke a wide range of responses, some people view it as a vehicle to change perceptions of women in society, some others equate it with training and there are many who zero in on fine-tuning indicators to capture gender dimensions of inputs as well as outcomes. It would therefore be appropriate to clarify what it is and what it is not – at least in the specific context of this document.

First, in the Indian context, larger social and economic equity frames how gender plays itself out. Let us take the example of the health system. While an overall decline in access, infrastructure, functionality, quality and attitudes affect all, given the prevailing social inequalities and hierarchies, these factors affect the poor much more than they affect the more privileged sections of society. Equally it affects poor women much more than women from more privileged sections of society. Even among the poor the situation of Dalit and Tribal communities is more severe as they shoulder the burden of economic poverty and social discrimination. A recent qualitative study of women and children in diverse poverty situation revealed that basic indicators like age of marriage, immunisation and delivery assisted by skilled attendants is very low among the lowest quartile of the economic ladder[1]. Equally, an overwhelming proportion of the poor are socially disadvantaged. Therefore gender cannot be viewed in isolation of social and economic status of people.

Second, gender is not an add-on, it cannot be relegated to a "component" and it is central to the plan and draws its legitimacy from the overall goal and vision of the RCH programme. Therefore, gender is an integral part of programme design, implementation and monitoring processes. Equally, effectiveness of gender mainstreaming depends on our ability to address it alongside issues of community participation, social equity / disparities reduction and responsiveness administrative structures to the existential reality of the people it seeks to serve.

Third, training officials and service providers or functionaries and sensitising them about the status of women, the indignities being faced by them on a daily basis, gender based violence, access to education, health care, nutrition, and control over

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[1] While the average age of marriage in the different states as a whole are 19 (Uttar Pradesh), 20 (Karnataka) and 18 (Andhra Pradesh), the mean age of marriage in the profiled households is much lower at 13, 15 and 15 respectively. Clearly, very poor households in all the three states record a much lower age of marriage than the state average. The combination of low awareness and poverty of individual households contributes to both poor health of mothers and low birth weight of babies… 109 of 110 deliveries in UP, 8883 out of 89 in Karnataka and 68 out of 76 in Andhra Pradesh were conducted at home. Vimala Ramachandran et al. Through the life cycle of children – factors that facilitate successful primary school completion; Economic and Political Weekly, November 2003 (Article based on a qualitative study of children in diverse poverty situations that was funded by The World Bank, New Delhi 2003)

fertility, is not sufficient. Experience over the last decade, especially in India, has demonstrated that trainees may have the necessary information and may also be aware of gender related issues but fail to see its immediate relevance to their work[2]. This leads to a kind of paralysis of action. Equally, training a group of people drawn from different districts and departments has limited value because the trainees go back and work among people who have not shared the same experience. It can, at best, change the attitudes of a few individuals. They also gradually lose their enthusiasm when they are isolated. Training programmes that involve a group of people who work together and have different responsibility in the same organisation have greater impact. They not only reinforce and encourage each other, but also helps create a positive institutional environment.

Recognition of the marginal impact of gender sensitisation training led practitioners to dwell into the reasons for such outcomes. Analysing the problem, it becomes evident that the fundamental issue is that gender sensitisation is not a one-shot event, but a long drawn out process. It may begin with a training programme leading to managerial changes. Equally, gender training is not to overwhelm people with information and analysis, but to enable them to identify what they can do in their respective spheres of work and make the system responsive to the needs of poor women. Lasting impact can be achieved only if planning, organisation and management issues across the board are addressed simultaneously.

Essentially, what is being argued is that gender mainstreaming is:

- Not an add-on, not components that can be included into a project or a document, but one that is central to and emanates from the overall vision and goals of the RCH programme;
- An integral part of the equity strategy: gearing the system to respond to the reproductive health needs of marginalized social groups (caste / community) and to the poor (poverty);
- Not only about "clients" but also about providers and institutional environment in which the RCH programme is located;
- Not only about activities and services, but also about attitudes and skills of people who provide the services;
- It is about educating the community to make informed choices and providing a platform, a forum to interface with the health delivery system
- It is about improving responsiveness and efficiency of the system – so that it caters to the needs of the poor and of women.

Is this a realistic approach in a country where women's access to healthcare is influenced by a range of societal as well as attitudinal barriers?

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[2] As discussed in detail in Part 3 of this report, the ability to act on information provided in training programmes involves three stages: three steps, namely:

- Internalisation of the information provided in the training and believing the information is authentic;
- Conviction to act on that information; and
- The confidence to act on one's conviction.

Table 1: Factors that influence women's access to healthcare

Economy, society & culture	Systemic issues	Mindset and attitudes
- Poverty, powerlessness - Status of women - Poor women caught up in survival battles - Perception of self - Post puberty practices and child marriage - Burden of work - Access to family income and resources - Domestic violence - Son preference - Stigma of infertility	- Physical access - Availability of providers - Dysfunctional facilities - Location and timing - Quality of care - Cost of care - Clinical, communication and managerial skills of providers - Over-medicalised services - Women specific services - Multiple windows for services - Reliable referral services	- Population control mindset - Focus only on women in reproductive age groups - Stereotyping and bias towards minorities and marginalized social groups - Attitude of managers and service providers towards the poor, especially women. - Attitudes of providers towards adolescents & women out of wedlock - Absence of a rights perspective.

We are well aware that the healthcare system cannot fix structural inequalities that are prevalent in our society and the economy. We are also aware that it is indeed unrealistic to expect healthcare service providers to become social activists. But what is indeed possible is to ensure that service providers are sensitive to the predicament of poor women, that services become available within a short physical and social distance and that women are treated with dignity, care and kindness when they approach a health facility or a service provider.

At this juncture it is important to acknowledge that GOI's efforts to tackle the phenomenon of **sex selective abortion** is indeed commendable. Recent research studies on abortion reveal that awareness of the PNDT Act is almost universal – among providers as well as majority of the population (AAP-I reports, Cehat and HealthWatch 2003). The RCH programme could indeed learn a great deal from proactive communication strategy adopted by the government. Such strategies could be of great value to educate people about the facilities available at each level and the rights of the clients (women, men, children and adolescents) and their right to be treated with dignity and care. In the same vein state specific campaigns on maternal mortality and infant / child mortality could also yield encouraging results.

What then should be the priorities of the RCH programme? Here are some concrete **examples** of how gender issues impact women's ability to avail of services and what is possible within the ambit of the RCH programme.

Table 2: Gender sensitive RCH programme, what is possible

The 'gender' issue	What the RCH programme can do
Lack of control over one's body and one's reproduction: - Need for spacing children / avoid frequent pregnancies - Unwanted pregnancy - Stigma of infertility - Family and sexual violence - Vulnerability to sexually transmitted diseases & HIV <u>Son preference resulting in sex selective abortion</u>	- Information about contraceptives, - Access to contraception – with focus on reversible methods as well as terminal, regularity - Wide Access to safe abortion services in case of unwanted pregnancy (no insistence on consent of husband/ family members) - Counselling of both partners and infertility treatment - Access to responsive providers / facility within reach - Counselling & treatment for RTIs / STDs for both partners - Choice and rights of women (not encouraging family members to force decisions, informed consent in privacy) - Regulation of private sector and enforcement of the PNDT Act
<u>Poor nutrition</u> - Anaemia - Results in high maternal mortality and morbidity - Low birth weight of babies - Stunted growth – of young / adolescent mothers	- Holistic care of pregnant women - Health and nutrition education of other members of the household - Closer interface with ICDS for nutrition of adolescents, pregnant & lactating mothers
<u>Lack of mobility</u> - Care seeking outside the home a man's prerogative - Higher workloads - Lack of confidence in dealing with " the outside world" - Women need permission and funds to pay for services, medicines - Cannot leave young children and domestic animals unattended while seeking care for self or child	Need for more meaningful access to maternal and child health services, i.e., - Provider on call or within close reach, health facilities can provide a range of services - Fixed day service within reach - Assured access to medicines - In case of hospitalisation – childcare facilities made available in hospitals / health centres
<u>Lack of access to resources</u> - Finance - Lack of control over ones income	- Reduce cost of care - Community health insurance and financing schemes to cover reproductive health needs
<u>Lower levels of education</u> - Unable to comprehend written directions or instructions - At higher risk of being exploited while seeking services	- Educational messages through alternative channels - Help in negotiating health services, especially at large, unfamiliar institutions
<u>Value attached to care seeking & stigma</u> - Several RH needs (eg, maternal care, contraception) not seen as "illness", hence care not sought - Stigma attached to unwanted pregnancy and STIs	- Community awareness on RH needs and services - Discrete services for abortion / STI available as close as possible - Observance of privacy and confidentiality in health facilities

Box 1: Rethinking IEC

Information, education and communication (IEC) has been at the centre of family planning programmes for a number of decades. But thinking about IEC was essentially shaped during the earlier era, when the programme was not only top-down, but also when the *raison d'être* of family welfare was to 'educate' people about small family norm and the need for population control. It involved a one-way transmission of information about the benefits of small family size and available contraceptive methods combined with 'motivating' people to change their reproductive behaviour. There was little recognition that policy-makers and service providers may themselves need to understand people's and especially women's needs better, or be sensitised to their rights. Over the last decade or so, IEC in India has become more sophisticated in its methods and use of different mediums, but its core approach and basis has changed very little.

Clearly, this has been inadequate, especially for the RCH programme. Not only do people on the ground need contraceptive information, but mindsets need to be changed about the aims and approaches of population policy and of the reproductive health programme. *And this applies to everyone – policy-makers, politicians, civil servants, technical and medical personnel, intermediate and ground level service providers, social and corporate leaders, and the public at large.* The historical baggage of the erstwhile IEC programme has to be shed. Analysing the situation, most experts in this field admit that the top-down approach and its ideological foundation do not lend themselves to a people-centred and gender sensitive strategy.

A revamped advocacy strategy would have to start by analysing where the knowledge and awareness gaps are in light of the RCH II and I programme. The broad categories could be along the following lines:

- Information needs of *different groups of people* (especially socially disadvantaged or hitherto marginalised groups such as poor women and men, adolescent girls and boys) This could include:
  - Reproductive health information including the full range of sexual and reproductive health issues and family planning
  - Knowledge about their rights in relation to health services, and above all their entitlement as citizens when they step into health centres and hospitals and what services they can legitimately expect from outreach paramedical workers
  - Sexual and reproductive rights, and gender equality including the now-burning issue of sec selective abortions and declining sex ratios.
- Knowledge for *service providers* including:
  - Training in an expanded range of service provision including RTIs, safe abortion, etc
  - Sensitisation and well as developing enforceable protocols for improving quality of services
  - Sensitising them as well and ensuring that services are provided in a humane and dignified manner.
- Awareness building among *administrators, politicians, and corporate leaders* particularly about issues such as high maternal mortality, child health issues and most importantly about the need for a holistic approach to population and development issues.
- Sensitisation of *the public at large* through various forms of media – encompassing rights of clients to quality services, about PNDT Act and so on.

The RCH programme has to explore meaningful partnership in order to bring about behavioural and attitudinal change across the board. In this context it may be useful to consider whether the term 'IEC' is useful any more, or whether it carries so much old baggage that we can replace it with the more appropriate term, 'advocacy'.

Source: Gita Sen and Vimala Ramachandran: Background Paper for Strategic Planning Exercise, UNFPA, 2001

1.2 Developing a shared vision and goal of RCH programme

The starting point is to ask whether everyone, up and down the line, has a shared understanding of the goals of RCH II programme. This is important because the larger vision gets fragmented into "tasks" and "outputs" as it is communicated down the line. As a result, not everyone is aware of the larger policy context and why the government decided to initiate reforms. For example in India the reform programme is interpreted as removing family planning targets and the larger goal of reaching an essential package of services (maternal and child health, contraception and management of related diseases) to the poor and the vulnerable is often missed out. We are then confronted with a situation where complementary services end up being positioned as competing targets. Therefore articulating and communicating the larger goal and vision of the programme, enabling workers at all levels to identify what they can do and what they are expected to do towards achievement of the larger goal, is the first step. Bridging the gap between the stated policy intention of the government and concrete action at different levels remains a big challenge.

1.3 The policy environment in India

The Approach Paper to Tenth Plan, GOI clearly articulates the framework within which the RCH programme is located. The document argues:

- Economic growth is not the only objective for national planning. Development objectives are defined not just in terms of increases in GDP or per capita income but focuses on the enhancement of human well-being.
- This includes not only an adequate level of income and adequate food consumption but also access to basic social services especially education, health, availability of drinking water and basic sanitation – key to enhancing health and well being of people. The document unambiguously argues that the improvement in the health status of the population is the major thrust area in social development
- Among other social sector interventions, the plan highlights that this can be achieved through improving access to and utilization of Health, Family Welfare and Nutrition Services with special focus on under-served and under-privileged segments of population. Three health specific goals being:
    - Reduction in maternal mortality;
    - Reduction in infant mortality; and
    - Reduction in decadal population growth
- The plan is also clear that the main focus on under-served, under privileged, with social equity and gender just policies being the key to reaching out to the most disadvantaged.

The overall thrust of the Tenth plan is in sync with Millennium Development Goals of the international development community:

- Eradicate poverty and hunger
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS, Malaria and other major diseases
- Ensure environmental sustainability

Goals of RCH II

There is one issue on which most practitioners agree, i.e., we cannot turn the entire system around in one go. While the larger goal is important and has to be kept in mind, it is important to set intermediary goals. For example, reducing maternal mortality, infant mortality and unwanted fertility may be the immediate and identifiable goal of a programme. This is rarely contested and it is therefore possible to build a consensus among political parties, religious leaders, community leaders, women's organisations and indeed the health professionals. Maternal mortality is also one of the most sensitive indicators of the value society places on the lives of women. Equally infant and child mortality is yet another area that demands greater responsiveness and sensitivity of the health delivery system. Access to contraception is at the heart of both maternal health as well as the well being of children (preventing short birth intervals affect nutrition, growth and overall development of children as well as the health of women). These complementary goals are therefore a litmus test for measuring the effectiveness of a health programme. Gearing the entire system and getting the support of a range of stakeholders, could be a doable and achievable intermediary goal. Such an approach could create a window of opportunity to give generate the momentum for change.

Within the policy environment provided by the Tenth Plan of Government of India, the goals of RCH II can be articulated as follows:

- Improve health status and well being of people through:
    - Enhanced access to and utilization of services for maternal and child health, contraception and related nutritional and infectious diseases
    - Creating awareness and educating people, especially women, to make informed choices and negotiate the system from a position of strength
    - Gearing the healthcare delivery system to be responsive to and reach out to the most disadvantaged and vulnerable

Table 3: Access for whom and of what

Universal Access to providers and services is the key	
For Whom	Of What
- Backward areas and vulnerable groups (EAG states) - Women, who are not only the primary users of services but whose existential reality is circumscribed by social and gender relations - Men in improving health and well being of families - Adolescents to break the inter-generational spiral of ill-health, malnutrition and high mortality / morbidity	- Maternal health, including safe abortion - Newborn and child health, including immunisation - Contraception (spacing and terminal) - Nutrition related problems and diseases - Services for RTIs/ sexually transmitted diseases - Education and awareness for the above

Gender considerations in child health:

Gender analysis has tended to focus more on reproductive health of women. It would however be important for the RCH programme to turn the spotlight on how gender impacts on child health.

Girls are not biologically more vulnerable to disease as compared to boys. However, by placing a higher value on boys, families promote inequity in child health by neglecting home-level care and treatment of girls. Families are especially likely to discriminate against girls for services that are difficult to access or for behaviours that are difficult to practice. For example, in rural Haryana, gender differences in seeking primary care were found to be substantially less than that for seeking hospital or inpatient care (*Rajiv Bahl, personal communication).*

By viewing child rearing exclusively as a woman's role, families as well as health systems generate the expectation that promoting and maintaining child health is in the mother's domain. This not only further burdens her, but also significantly restricts her mobility. The situation is compounded by the fact that while being largely responsible for childcare, the mother may lack autonomy to seek treatment for her sick child from outside her immediate neighbourhood or village. Male migration for economic reasons is prevalent among poorer families. In the event of illness in a child, the family's ability to contact an appropriate provider or comply with long-term treatment is compromised by non-availability of the husband or other male member. An adverse impact on child health outcomes has been corroborated by evidence from southern Rajasthan (ARTH, 2003). Implications for child health interventions include the need for educational messages on child health to target men and other family members, and to move services, including inpatient care for life-threatening conditions closer to poorer communities.

1.4 Basic minimum conditions for realisation of RCH II goals

Realisation of the above goal is contingent on the following basic minimum conditions:

1. Availability of facilities and providers
2. Wider range of services, especially at the primary level
3. Reasonable cost of services
4. Good quality, both from a technical standpoint, and in terms of responsiveness towards women

These dimensions form the basis for action proposed in the operational framework, given later in this document. The above needs to be planned:

i. Keeping in mind that backward regions that have to make the maximum strides (EAG, specific Blocks / Districts)
ii. Keeping in mind that poor need meaningful access to government services
iii. Keeping in mind that women, especially in backward regions and those who are poor are most disempowered
iv. Keeping in mind that we need to forge synergy rather than competition between sub-sectors (maternal health, child health, contraception) within RCH programme

Given that we cannot do everything in one shot or in one go, prioritisation for what needs to be done immediately, in the medium term and in the long term:

a. Keeping in mind that there has to be a consensus on what we can so when
b. Keeping in mind that service providers need not only skills but also a conducive institutional environment
c. Keeping in mind that service providers have to be made more accountable and also that attitudes / prejudices become an inhibiting factor

d. Keeping in mind that women workers are at the bottom of the service chain and are themselves vulnerable, therefore need greater support.

1.5 Challenges facing the RCH Programme:

1. **Wide regional differences**: The most formidable challenge facing RCH II is the existence of wide regional and group differences across the country. These differences cut across service environment, overall functioning / efficiency of health care services, status of women, infrastructure and communication. Pockets of extreme backwardness exist in relatively forward areas.
2. **Gender issues vary across regions**: While broader issues of gender inequality may be common to most regions of the country, there are wide variations on how it manifests on the ground. Women's mobility, early marriage, son preference, sex ratios have been debated a lot in India. The important issue here is that these factors do not affect women alone, they also affect the institutional environment, leading to professional inequality where some cadres are more under resourced (training, support, back-up given to ANMs) in some areas than others. Equally, issues of safety and security affect women providers more in some areas than others.
3. **En-gendering existing schemes in H&FW**: While the RCH programme was intended to encompass all existing schemes / programmes for maternal health, child health and family planning, older schemes like the one for support to non-governmental organisations for providing sterilisation services though grants for additional beds / operation theatre continue to focus on female sterilisation only. This scheme needs to be amended to encourage the non-government sector to promote NSV and vasectomy.
4. **The RCH programme does not stand-alone**: The effectiveness of the RCH programme is inextricably linked to the overall functioning of the health delivery system. Programme specific solutions may have limited impact as generic health system issues of functionality of health centres, skills of and support to frontline workers, supplies and logistics, all these impact on the efficiency of the system (institutional environment).
5. **Contradictory message communicated down the line**: One of the most cited challenges is the percolation of contradictory messages / targets down the line. Often maternal health services are seen as being in competition with contraception services (mostly terminal methods being promoted), when the two are inextricably linked. Equally, the campaign mode for immunisation or special RCH camps is positioned in competition with regular and routine services. This has been highlighted in the Planning Commission review of the Ninth Plan as the biggest challenge facing the programme. The important issue here is that campaigns and special camps need not be seen in competition with routine services, but as one that complements it.
6. **Synergetic relationship between public and private sectors:** It is now acknowledged that quality and cost of services in the public sector influences quality in the private sector, they are linked. Where the public sector is dysfunctional the private sector is rapacious. Conversely, where the public sector is functioning and is of reasonable quality, both cost and quality in the private sector is not that high. Poor quality of care and poor accessibility of public sector services affect women who either opt out of health services altogether or selectively access services in the informal private sector. Therefore regulation of the private sector needs to be given top priority –

especially in the light of the evidence of an exponential increase in sex selective abortions. It is important to acknowledge that regulation does not automatically imply restriction. Professional associations like FOGSI and Medical Council needs to play a more proactive role in enforcement of the PNDT Act.

7. **Making private hospitals provide subsidised care:** The government has to find mechanisms to ensure private hospitals that have received subsidies in the form of land, import duty exemption and other tax breaks provide free / subsidised RCH services (for example, cases referred to by PHCs / CHCs / District Hospitals) to the poor, especially poor women and children. At least 20 percent of beds and OPD time needs to be earmarked for subsidised treatment / care. This will enhance women and children's access to good quality referral services.
8. **Adolescents do not need separate services, but need same services delivered in a more sensitive manner:** Adolescents account for 23 per cent of population – 230 million in the 10-19 age group. Reaching out to them will help us break the inter-generational cycle of early marriage, ill health, high mortality / morbidity and low contraception prevalence. It is important to remember that if we are able to influence the health seeking behaviour of adolescents, given the proportion of adolescents in India, the next decade will witness rapid improvement on all fronts: health, mortality, morbidity and population growth. It is here that the RCH programme needs to forge partnerships across departments, especially education and with corporate bodies and non-governmental organisations.

Part 2: The Operational Framework

2.1 Basic assumptions

We have made certain assumptions in proposing a framework for action to mainstream gender:

1. RCH programme interventions can turn out to be gender-blind, and in a few cases, even gender unequal, unless their differential impact on disadvantaged women is assessed methodically. Examples include the government's "Sterilisation bed scheme for NGOs", which covers tubectomy without provision for vasectomy, and the expectation that poor women needing emergency obstetric care would be able to access transport funds from gram Panchayats, or that health workers would necessarily educate husbands about vasectomy, before motivating women to undergo sterilisation.
2. Professional and gender inequity within health systems reinforces inequity in service delivery, hence the roles and lines of authority among health personnel might need to be re-examined, for mainstreaming gender equity in a programme.
3. Gender equity is influenced by a range of issues that include the manner in which financial and human resource allocations are made, and how medical technology and clinical skills are selected and deployed. To address these, interventions for gender equity must be driven as a core priority of line managers and functionaries, backed by policy commitment. It cannot be left to a few "gender experts" to address. Interventions too, need to go well beyond training individual providers.
4. Given the complex and contextual nature of gender inequity across different states and regions, a strategic approach that adopts a few critical steps for mainstreaming gender, would be preferable to a comprehensive one. The operational framework therefore focuses on a few key interventions.
5. Health system interventions for mainstreaming gender should target the primary and secondary levels in a district. Interventions at tertiary level are likely to offer marginal return on investment, except for influencing pre-service medical and nursing training.

2.2 Four actions at four levels

Four core programme attributes directly influence access and hence utilisation of services, i.e., availability, range, cost and quality. Since health inequity in turn is concerned with differential rates of service utilisation, these attributes may be considered as actionable determinants of equity for a health programme. From the standpoint of mainstreaming gender within the RCH programme, we therefore describe these as follows:

1. Enhancing the availability of women primary health providers
2. Moving technology and skills closer to women
3. Reducing economic barriers
4. Making services responsive and accountable

The above dimensions have been tackled at four levels:

1. Policy and planning levels: These comprise legal, regulatory and policy measures, including measures at the macro level, to enhance or re-deploy resources for enhancing gender equity
2. Programme level, comprising management, including resource deployment and oversight functions
3. Family and community levels, comprising "demand-side" actions for facilitating change in the utilisation off health services
4. Service level – the interface at which measures to mainstream gender result in positive outcomes. Actions at the first three levels should lead to outcomes at this level.

In addition, we propose an overarching set of actions under the rubric of building a positive institutional environment. The attached operational framework chart (table 1) depicts use of the framework to suggest strategic interventions for mainstreaming gender within the National RCH programme

2.3 Enhancing the availability of women health providers

Women are more likely to use primary health services if a person (preferably a woman) that they know and trust makes these available closer to home. A review of the range of essential RCH services (including skilled attendance at delivery) that need to be delivered in less accessible areas suggests that currently, the auxiliary nurse-midwife best fulfils the criteria of "primary RCH provider". However, she is often not available in her work area, or visits irregularly, especially in EAG states. A study of ANMs' residential status in one district of southern Rajasthan revealed that 62% ANMs commuted ("daily up-down") to their work areas from villages and towns in the vicinity. A combination of circumstances including inadequate amenities, children's education, lack of family support, physical insecurity and the threat of sexual harassment have been found to contribute. We therefore propose the following measures to help ensure that marginalised women in the community have access to ANMs for their primary RCH needs.

2.3.1 Distance and workload norms for health facilities

The location of primary health facilities is based on population norms[3]. Although these norms are different for hilly and tribal areas, wide variations exist within states and districts. Women living in areas with scattered population have less access to facilities like subcentres and primary health centres. Transport connections tend to be weak in a remote area, and at the same time its inhabitants (especially women) women shoulder a busier daily routine. This minimises the chances that an outreach worker like an ANM would find them at home in the course of a hurried daytime village visit. This leads to a situation in which health workers struggle to deliver services, while women struggle to access them for health needs. Poor and dalit (Scheduled Caste) women are the worst affected by the absence of services. Using RCH survey data for Rajasthan, we performed a correlation between ANC coverage and two indicators: its population per (health) institution (PPI) and area covered per institution (API). While there was a strong correlation of ANC coverage with API (coefficient of correlation: 0.5), the correlation with PPI (0.15) was weak. This

[3] These include one PHC per 30,000 (20,000) population and one subsidiary health centre or subcentre per 5000 (3000) population. Figures in parenthesis represent norms for hilly and tribal areas

suggests the need to set up the health facilities (largely sub-centres) on area or radial distance norms rather than on population norms (figure-1). Similarly, poorer communities tend to have higher fertility and mortality, implying a heavier service workload for health staff as compared to better off communities. Locations and investments (equipment, supplies and staff) in health facilities need to factor these variations within districts.

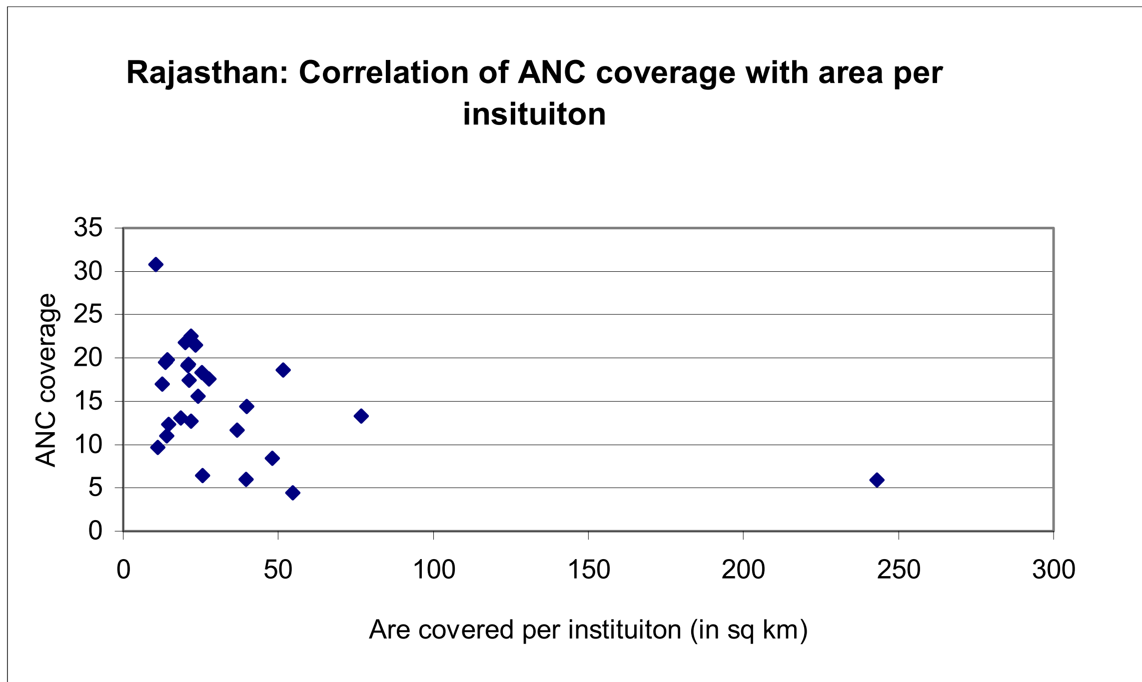
2.3.2 Keeping the sub-centre open & re-organising services for better access

The outreach roles of an ANM make her availability unpredictable for women in the community. Women tend to avoid visiting the sub-centre because more often than not, it is closed. Measures therefore need to be introduced, to assure availability of ANMs at sub-centres. The following options may be considered:

- Pairing ANMs so that in rotation, one is always available at the sub-centre while the other is on field
- Appointing an assistant ANM – in tribal areas this could be a local tribal girl supported through high school and a paramedical training course[4]. The assistant ANM could be given the bulk of non-clinical and outreach roles, depending on her level of training. Measures for upgrading of assistant ANMs to full ANMs after further training might be piloted, as a way of ensuring that more local/ tribal women become ANMs.
- Restricting the ANM's outreach duties so that she is available daily for extended periods of time at the sub-centre. While this would not involve the cost of an additional person, it would require a trade-off between the ANMs' outreach and clinic roles. Informal providers (rural practitioners) have used this approach effectively for primary curative services; the challenge would be to use it for preventive services within the formal system.

[4] VGKK, Karnataka (Dr H Sudarshan) experience of carrying this out in a tribal area (BR Hills) of rural Karnataka is noteworthy. Way back in 1989, Dr Sudarshan recognised the need for local tribal women and men to become ANMs / School Teachers / MPWs. Taking a long-term view, VGKK created the conditions for young tribal girls to complete middle school and proactively encouraged them to enrol for ANM training programme. After a period of 5 to 8 years of persistent efforts in the area of education, the first batch of Soliga tribal girls were able to complete the ANM training course, after which they were appointed in the area. A long-term strategy is therefore the only solution to create a pool of educated and qualified people from socially disadvantaged communities. Having no choice but to enrol in poor quality schools, children from socially disadvantaged groups and from poor families barely manage to complete primary or at best middle school. Even then, a majority of them are barely literate – thereby making it impossible for them to compete with their peers from private and better quality government school to enter professional courses. (Personal communication of Vimala Ramachandran and experience sharing in HealthWatch meetings)

Figure 1: Impact of access on coverage of antenatal care: districts of Rajasthan



2.3.3 Supportive environment for women frontline providers

Based on our earlier work with ANMs in one district of Rajasthan[5], we propose the following measures to create a supportive environment for ANMs and similar nurses. These measures are founded on the premise that accountability on part of ANMs would increase, were they to be supported in their work. This in turn would promote greater gender equity within the primary health system and by extension, in the community.

- Set up *district-level* Complaint Committees to look into grievances of sexual harassment. Complaint Committees have been mandated by a Supreme Court ruling, but are not available to health workers at the peripheral level. The same committees may take a pro-active role by reviewing and to suggesting ways to improve the living and working conditions of women workers.
- Make panchayats directly responsible for ensuring the safety and security of the women health workers, including ensuring a safe residence close to family habitation.
- Relocate subcentres of remote areas from the outskirts to the middle of village, and provide basic amenities. In several situations, it might not be feasible to right away relocate subcentre buildings, even if they have been built far from habitation. In such cases, the ANM may be provided rented accommodation within the village as an interim measure.
- Introduce explicit transfer and posting rules that take into consideration the family and health needs of women workers. The latter would include helping women workers meet their own reproductive health needs.
- Women (staff) should supervise and support women: Over the years, the ratio of women supervisors (LHVs or female health assistants) to ANMs has been

[5] "Daily Up-Down": Why would an Auxiliary Nurse-Midwife of Rajasthan prefer to reside within her work area?" Mohan P, Iyengar SD, Mohan SB, Sen K. ARTH, 2003.

declining in states like Rajasthan[6], leading to inadequate supervision and support of ANMs on field. A lack of methodical and humane supervision has bred a sense of hopelessness among frontline workers, about the system's concern for them. We propose that number of LHVs be increased, and that the LHV/ANM indicator be monitored regularly. Specific measures would be needed to provide mobility and security to LHVs during field supervision, especially in interior areas. This could extend to giving them the facility of a two-wheeler with a (male) colleague or multi-purpose health worker acting as driver cum escort. Such anarrangement has proved successful in some NGOs. Within the RCH1 programme, ANMs were offered loans for purchasing two-wheelers for enhancing their mobility, a scheme that has not been considered as successful. In this case we are proposing a larger investment for improving the female *supervisor's* mobility by teaming her with a junior colleague.

- There is large social and professional distance between ANMs/LHVs and medical officers/ public health managers who run the district health services. Difficulties faced by individual ANMs and LHVs tend to get ignored or trivialised, even though they seriously affect the their work efficiency. We propose the creation of a promotional post of (female) District Nursing-Midwifery Officer, to be staffed from within the ANM-LHV cadre. Such a person would be expected to combine monitoring and supervision roles with acting as a bridge between the paramedic cadre and health officials. She could additionally anchor district level arrangements to support ANMs and LHVs.

2.4 Reducing economic barriers

Economic barriers discourage people from seeking appropriate and timely care. This applies more so in the case of women because on the one hand they have little control over household money, while social norms dictate that they endure illness and not disclose their health needs to the family. We suggest the following approaches for reducing economic barriers to health care utilisation:

2.4.1 Reducing the cost of care

***By improving access to ANMs, and upgrading their skills and roles*:**

By bringing the services closer to women (as described above), opportunity and direct costs are expected to reduce. Apart from lower transport cost, even informal fees charged by a paramedic would be lower than that charged by a doctor. Making emergency transport funds available with ANMs, along with flexible guidelines[7] for their use, could improve the ANMs effectiveness and credibility while also reducing the cost of referral care.

2.4.2 Improving the ability to meet health expenditures

Women-centred health insurance schemes

Sudden and high expenditure related to acute catastrophic illness have been shown to push families into extreme poverty. The high cost of emergency treatment remains a barrier to service utilisation. Making health insurance accessible to families for specified RCH needs would help to lower the economic barrier faced by women.

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[6] Annual Report 2002-3. Dept of Medical Health & FW, Govt of Rajasthan.

[7] For example, there are chances of over-referral by ANMs, of women suspected to have maternal complications. The ANM should not be penalised if the referral hospital reports a normal condition.

However, there currently are few examples of community-based health insurance, while the existing large-scale health insurance schemes are gender-blind. One sees this in two schemes – Mediclaim, which excludes women's reproductive illnesses, and Government of India's Universal Health Insurance Scheme (see box below)

To make insurance schemes more women centred, the following are recommended:

- ⇨ Cover expenses for services that women uniquely need, such as maternal complications, elective abortion, infertility treatment and gynaecological surgery
- ⇨ Make budget provisions for the above
- ⇨ Make it cheaper and simpler for poorest or dalit women to enrol in the scheme
- ⇨ Provide incentives or financial provisions to the insurance company to sell these policies
- ⇨ Monitor coverage and utilisation of the scheme, especially by marginalized women

Box: 2: Universal Health Insurance

The "Universal Health Insurance" scheme was launched on 15 August 2003. It was promoted as a scheme to provide health insurance to all, especially poor families in rural areas. The scheme envisages reimbursement of health expenditure up to Rs 15,000, at an annual premium of Rs 365 pe person (ie. Re 1 per day) or Rs 548 per family of five. The package of services reimbursable under the scheme excludes deliveries (whether normal or complicated), abortion and STD treatment, these being services that women need. The cost of premium is high for the poorest women. There are no subsidies for the scheme, nor are there any provisions or incentives for the nodal insurance company (New India Assurance Company), thereby making it unattractive for them to promote the scheme. Thus exclusion of RH services for women from the package, a high premium and lack of incentives to insurers limit the scheme's effectiveness for poor women.

Community based health funds

While insurance might be useful for meeting the high and catastrophic but occasional costs, women may not have access to liquid cash for meeting the more frequent cost of outpatient care. Linking health funds to women's micro-credit groups could potentially enhance women's access to liquid cash— this has been suggested as the community health financing mechanism most likely to enhance representation of women[8]. A few agencies[9] in the country have assisted micro-credit groups to operate contingency funds (large proportions of which are used for loans to meet healthcare expenditures). On the similar lines, health funds could be created within the micro-credit groups, as a resource to be used only for meeting women's (and infant's) healthcare expenditures.

However, a precondition is that the groups in question must be strong, mature and cohesive – this has occurred in India on a meaningfully large scale only where NGOs or similar agencies have systematically nurtured and in some case, federated micro-credit groups. Though it is beyond the scope of health department to organise women in such groups, it could encourage government[10] and non-governmental efforts and support formation of "health funds" within existing groups. This could

[8] Standing H. Frameworks for understanding health sector reform. Engendering International Health: The challenge of equity. 2002 (Eds) Gita Sen, Asha George, and Piroska Ostlin. Massachusetts Institute of Techology. P 358.

[9] People Education and Development Organisation (PEDO) in Dungarpur, Rajasthan is one such organisation.

[10] The ICDS of the Women & Child Development department has been promoting micro-credit groups in some states including Rajasthan

therefore emerge as an area of convergence between the health systems and agencies forming self help groups like WCD and water resources departments.

2.5 Moving technology and skills closer to women

2.5.1 Attributes of medical technology

Although reproductive and child health technology has been presumed to be innately gender-neutral, the manner in which it is made available to the community can affect gender equity and reproductive rights. Prenatal sex selection stands out as a stark example of gender-unequal technology, for the manner in which techniques originally intended for detecting sex-linked genetic disorders were subverted for de-selecting female foetuses. In another side of the same argument, denial of access to essential RCH services to women because of unnecessary and over-medicalised restrictions on who can use technology and whether or not they can be trained to use it, can also be seen as being gender-unequal measures. Poor access in interior areas can be enhanced, if the health personnel that were more readily available locally, were to be given the skills and support to deliver clinical services as and when needed.

For public health programmes that are implemented through the primary health care systems, certain key attributes determine the extent to which medical technology influences access and hence gender equity. These attributes are as follows.

Safety: If a technology is robust and produces minimum adverse effects under field conditions, a less specialised provider could use it. Examples include manual vacuum aspiration and medical methods for elective abortion, management of childhood illness using IMCI protocols, and bag and mask resuscitation of neonates.

Simplicity of use: Clinical protocols that avoid unnecessary procedures or medication can be used in peripheral, low-resource settings, since they lower costs without compromising effectiveness. For example, delivery care that allows the woman to deliver in a position of her choice, and avoids enema, pubic shaving and routine episiotomy, leads to better outcomes while preserving the dignity of women. Similarly, avoiding general anaesthesia or heavy sedation for elective abortion minimises risk while reducing costs and recovery time.

Encouragement of choice: Technology can either enable or diminish women's ability to choose. For example, urine pregnancy test kits, emergency contraceptives and long-acting reversible contraceptives allow women more choice in regulating their fertility. In respect of contraception, methods that allow women to adopt *and discontinue* contraception without restriction, give them greater autonomy in matters of fertility regulation and hence promote gender equity. Unlike terminal methods, reversible contraceptives offer women the option to discontinue. They thereby afford greater choice to a large segment that is not ready for sterilisation.

Containment of cost: Recognising the constraints that women face in terms of mobility, lack of resources and family support, service protocols should minimise costs and the need for repeated follow-up.

Evidence based: The technology chosen should proven to be effective in managing a condition, in addition to being safe and simple. The Cochrane data - base, the WHO Reproductive Health Library and WHO Medical Eligibility Criteria for contraceptive use provide updated evidence on the safety and

effectiveness of different clinical practices. For example, active management of the third stage of labour, use of magnesium sulphate for eclampsia and partograph for labour lead to better maternal health outcomes.

Inequitable deployment of technology and restrictions on the acquisition of clinical skills by primary health workers result in denial of services to those most in need of them. Adoption of medical technology, clinical and facility management protocols that satisfy the above attributes to the best possible extent would therefore facilitate greater access to services and thereby reduce inequity.

Currently, most services are concentrated at tertiary and secondary levels, and within these levels, in the hands of doctors rather than nursing or midwifery personnel. Where specialists or doctors are either not available or visit infrequently, essential services remain inaccessible, especially to poorer women in EAG states. We therefore propose methodical steps to devolve medical technology and clinical skills to the primary and secondary health level.

2.5.2 Levels of devolution

To improve access to wider range of services, more services therefore need to be delivered at the primary and secondary levels, with more skills devolved to ANMs, LHVs and staff nurses across three levels (i-iii), and to the graduate doctor at two levels (iii-iv). In the public health system, the service levels are:

i. ANM at home level
ii. ANM, LHV or staff nurse[11] at sub-centre or sector level primary health centre (PHC), or equivalent in the private sector
iii. Graduate doctor or experienced LHV/ staff nurse at PHC or CHC
iv. Specialist and/or graduate doctor at CHC, sub-district or district hospital

Technology and skills can be moved to four levels as shown in table 2. Four major services would become more accessible as a result, as described below.

2.5.3 Delivery, obstetric first-aid and basic emergency care

Since the time between onset of maternal complications and death can be very short, women living in interior areas may not have sufficient time to reach an emergency obstetric facility. It is therefore crucial that a skilled health professional is present at the time of each birth[12], so that complications can be detected in time and the woman is treated or stabilised before referral. The latter would allow more time for the woman to reach hospital. Some countries have trained midwives or nurse-midwives to practise life-saving skills to deal with maternal complications (see boxes below). WHO – SEARO has developed guidelines on life saving skills for midwives of the Southeast Asian region[13]. Graduate doctors or experienced nurse-midwives working out of sector PHCs or CHCs would provide basic emergency obstetric and neonatal care, to back up the ANM at home and sub-centre levels.

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[11] Given the differences in basic training and acceptability to women, this refers to female staff nurses
[12] Millennium Development Goals. UNITED NATIONS, 2000.
[13] World Health Organisation. Regional Office for South-East Asia, New Delhi. "Standards of Midwifery Practice for Safe Motherhood". Volume 1- Standards document, 1999.

The government is currently considering a proposal to create a cadre of practising "skilled birth attendants" by training young women into midwifery roles. While any move to enhance the number of midwifery trained persons is laudable, iwe must keep in mind the fact that India has a total of *** ANMs and LHVs, whose primary role includes midwifery. Training and equipping this large existing human resource for providing delivery services should therefore receive equal, if not greater priority than the creation of a new cadre.

Box 3: Skilled attendance or institutional delivery for preventing maternal deaths?

Current policy encourages institutional deliveries in all states, especially non-EAG states. For EAG states, a diluted approach of supporting TBA training for home delivery has been proposed. Insofar as "institutional delivery" is restricted to facilities having doctors, access would no doubt be limited in EAG states. *However, a policy shift in favour of skilled attendance at home and facility-based delivery would improve access by relying on trained ANMs and LHVs who are available in larger numbers across EAG states.* Further, "institutions" should be taken to mean those facilities where skilled attendants are available, and not merely those where doctors are available.

Box 4: Skilled attendance: experience from two countries

In Botswana, health clinics covering 5000-10,000 population are staffed by registered nurses and provide services round the clock. Nurses and midwives form the backbone of the health care system and are the main providers of maternal health care. Nurses with midwifery skills provide routine and more complex family planning, antenatal, delivery and postnatal care while midwives trained in life-saving skills attend obstetric emergencies. Sixty eight nurse-midwives have undergone a six week in-service training program that has built up additional skills: The skills include uterine evacuation for incomplete and inevitable abortion, vacuum extraction, manual removal of retained placenta, repair of third degree lacerations, breech extraction, and newborn resuscitation.

In Malaysia, maternal mortality ratio has declined from a level of 1100 per 100,000 live births in 1933 to 39 per 100,000 live births in 1995. A central factor in this decline has been high-level government commitment to ensuring that quality maternal health services are accessible to vast majority of the population, particularly in under-served and rural areas. Skilled birth attendants (primarily midwives) are the first point of contact for maternity care at home, in village health clinics and in hospitals. Between 1949-1997, the percentage of live births attended y a skilled health provider increased dramatically – from approximately 30% to over 95%. Community health nurses/ midwives in Malaysia (with 2 ½ years training) have been trained to administer oxytocics and intravenous infusions for postpartum haemorrhage, and to use the partograph to prevent delay in referral. Staff nurses and public health nurses provide additional services. Since the 1970s, the primary indicator used for evaluating the maternal health programme has been the proportion of births attended by a skilled birth attendant.

Source: Family Care International, 2002. Skilled Care during Childbirth: Country Profiles.

2.5.4 RTI/STD management at primary level

Community based studies have shown that a large proportion of Indian women suffer from RTI/STDs, and most of them have do not seek any care for them. Given the private nature of symptoms and the low mobility of women, management of RTI/STI syndromes needs to be possible at the primary level. Moreover, it is essential that providers screen clients for RTIs/ STIs before Copper-T insertion. WHO and other agencies have been promoting STI management in low resource settings since 1988. Syndromic management relies on the recognition of symptoms (and risk assessment) for the diagnosis of STIs but not on laboratory diagnosis.

Algorithms that rely on clinical (speculum and pelvic) examination are more accurate than those that rely only on symptoms, and can be provided by a trained nurse-midwife. There are experiences in several countries[14], (from Africa, Nepal, Indonesia, etc.), where health workers have been trained in syndromic case management of STIs.

2.5.5 Medical abortion and MVA

Research on abortion has shown that rural health facilities severely lack personnel to carry out abortion, and large numbers of women continue to undergo abortion under unsafe conditions. Studies on informal abortion providers in Madhya Pradesh[15] and Rajasthan[16] have shown that a variety of providers use different methods of abortion in rural areas. Technologies such as MVA and medical abortion are safe and can be provided through graduate doctors. In several countries including Bangladesh and South Africa, MVA is being provided even through nurse-midwives. Medical abortion has the advantage of being non-invasive, with minimal facility requirements, hence it could be introduced in PHCs for use by doctors and paramedics, provided a referral link to surgical abortion services is made available. On another note, legal and administrative measures (the PNDT Act and measures for its enforcement) to regulate the medical profession's use of sex selection techniques have gained strength over the last few years – these need to run in parallel with measures to enhance access to safe abortion, especially first trimester services.

2.5.6 IMCI case management through nurse-midwives

Experiences from other developing countries suggest that it is feasible to deliver a wider range of services closer to the community through paramedics, including management of childhood illnesses.

Box 5: Nurses can manage sick children effectively[17]

In Uganda, Nurses with 1-2 years of pre-service training were further trained to manage sick children using the Integrated Management of Childhood Illnesses (IMCI) approach developed by WHO and UNICEF. Nurses appropriately referred 22 out of 27 children requiring referral. They also correctly managed sick children with antibiotics in 44 instances out of 49 children who required antibiotics. Antimalarials were appropriately prescribed in 28 cases out of 31 children that were classified as having malaria. Of 11 children presenting with dehydration, 8 children were successfully managed with Oral Rehydration Therapy. Subsequent experiences in other countries have also shown that paramedics can successfully manage sick children after being trained in IMCI approach.

2.5.7 Enabling conditions

The devolution of technology and skills closer to women will require certain enabling conditions as follows:

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[14] World Health Organisation. "Integrating STI management into family planning services: What are the benefits?". 1999. p 26-28.

[15] George Alex. "An enquiry into provision of abortion services in Madhya Pradesh: Final report submitted to AAP-I secretariat CEHAT, Mumbai". August 2003.

[16] Action Research & Training for Health. "Situation analysis of abortion services in Rajasthan: Presentation at AAP workshop". Bangalore, May 2003.

17 Lambrechts T et al: Integrated Management of Childhood Illness: First Experiences. Bull World Health Organ. 1999, 77(7): 537-616)

a. Changes in the regulation of RCH technology

Licensing the use of appropriate technology by frontline workers: For example, modifying the MTP Act or Rules to allow use of medical abortion drugs by MBBS doctors (or even ISM physicians and experienced nurse-midwives) after pre-service or in-service training would expand access to safe abortion. Similarly, either a change in the schedule status of certain drugs (as was done for the low-dose combined oral pill) or obtaining specific clearance from the Drug Controller (on the lines of clearance for use of co-trimoxazole for ARI) would enable nurse-midwives to use IMCI protocols.

Nursing council regulations need to allow more independent roles for nurse-midwives, including ANMs and LHVs. Because of limitations to the availability of doctors in rural and economically backward areas, it becomes crucial that nurses and ANMs are directly able to provide basic RCH services. As an alternative, midwifery councils[18] may be established by the centre and states, since midwifery unlike nursing, is a well-accepted independent service function. Madhya Pradesh has recently established a midwifery council and a graduate programme in midwifery. Other states could consider graduate or diploma courses (and upgrades for existing ANMs/LHVs) self-regulated by a midwifery council that allows adequate representation and powers in the hands of midwifery professionals.

The use of life-saving drugs, including injectable oxytocin, intravenous fluids, magnesium sulphate and injectable antibiotics should be allowed in the hands of specifically trained staff working in interior areas. India has experience with the use of co-trimoxazole in a national programme for preventing death from pneumonia, and more recently in a research setting, with the use of gentamycin to prevent death from neonatal sepsis[19]. The critical factor in favour of liberalising use of these drugs is the human rights argument that they would help prevent deaths that are currently occurring in large numbers, because of lack of access to services.

Box 6: Integrated Skills Training for ANMs, LHVs, staff nurses (RCH-1)

Training modules developed by NIHFW for ANMs, LHVs and staff nurses under RCH1 do not cover the following:

Confirmation of pregnancy through pelvic examinations and pregnancy test

Identification of RTIs/ STDs through speculum examination, and their treatment

Diagnosis of labour and its management, use of partograph, use of pelvic examination to monitor labour

Obstetric first aid to manage life threatening obstetric emergencies: For almost all complications (postpartum haemorrhage, eclampsia, sepsis, incomplete abortions), the ANMs are advised to refer, and not to provide any stabilising or substantive care.

Training curricula for nurse-midwives that leave out pelvic examination skills for managing labour essentially disempower the provider, while denying women a vital diagnostic service. The resultant over-referral for a range of locally treatable conditions (including referred deliveries that ultimately turn out to be normal in the hospital) can seriously erode the credibility of nurse-midwives in the eyes of community. In such a situation, poor families often resort to adventurous but unregulated and under-trained village practitioners for definitive treatment. A baseline study[20] of family planning service skills of ANMs and LHVs of Udaipur district by ARTH in 2002 showed that a majority of ANMs had not conducted a single pelvic examination during pre-service training, nor had they inserted a single Copper-T.

[18] "Report of the task force in midwifery education in Madhya Pradesh", September 2002.

[19] Trained village women in the field area of SEARCH, Gadchiroli, Maharashtra

[20] Copper-T Choice & Quality Project, District Udaipur. Final Report, 2003. Action Research & Training for Health (ARTH), Udaipur

b. Investments in pre service and in-service training

Pre service medical and nursing training should enable doctors, nurses and ANMs to function as skilled attendants of reproductive and child health care. Despite provisions in the curriculum, pre service training does not give student ANMs, GNMs and even doctors (especially if they are male) sufficient practical learning opportunities to become skilled attendants.

We propose the following actions:

- Revise the curriculum for nurses, ANMs, MBBS doctors and ISM doctors[21]: Include skills that will allow the trainee to function as a skilled birth attendant and as a skilled provider of other essential RCH services. This would include life-saving obstetric skills and clinical skills that promote reproductive rights (pregnancy confirmation, medical abortion).

  Invest more in building skills and competencies: This would require increasing the duration of clinical posting, for which the number of training sites must increase. Several nursing training institutions are based in medical college hospitals that use more medicalised protocols and restrict clinical procedures to specialist doctors or post-graduate medical students. Nurse-midwives and ISM doctors would get few practical learning opportunities in a hierarchical environment that privilege MBBS and MD/MS students over them. One solution would be to designate district and sub-district hospitals and CHCs having adequate (current or potential) caseloads as training institutions for nurses, ANMs and ISM providers. Some of the staff posted at these facilities should be designated as teaching faculty -- this would add to their own credibility. In line with this move, the current nurse-tutors who are often classroom bound must be given mainstream clinical duties to sharpen their own skills. Experienced LHVs or staff nurses may similarly be given teaching positions.

  Link clinical skills to gender and social issues affecting the utilisation of services. A skilled provider needs to be sensitive and humane, too. Training to build attitudes among providers would include attention to gender and social issues in reproductive and child health (including social, economic constraints facing women, circumstances that force certain RH needs on women); reproductive rights; counselling and informed consent, special needs of adolescents and vulnerable groups, etc. A critical step for achieving this would be for trainers to actually demonstrate how humane and gender-sensitive services can be provided. Extensive use of manikins would allow for more practice of skills like pelvic examination, copper-T insertion and delivery, while minimising the need for repeated handling of (women) patients.

c. Adapting standards and protocols

Generic service protocols are available from international agencies like WHO, and several have been adopted by Government of India. On a periodic basis, these protocols need to be adapted to the needs and capacities of different regions or states, simplified and translated for use by frontline workers. The group that carries out such adaptation must be able to foresee the impact of the protocols on gender equity, quality, choice and reproductive rights under operational conditions – this might require the inclusion of a few non-clinical persons who understand health care

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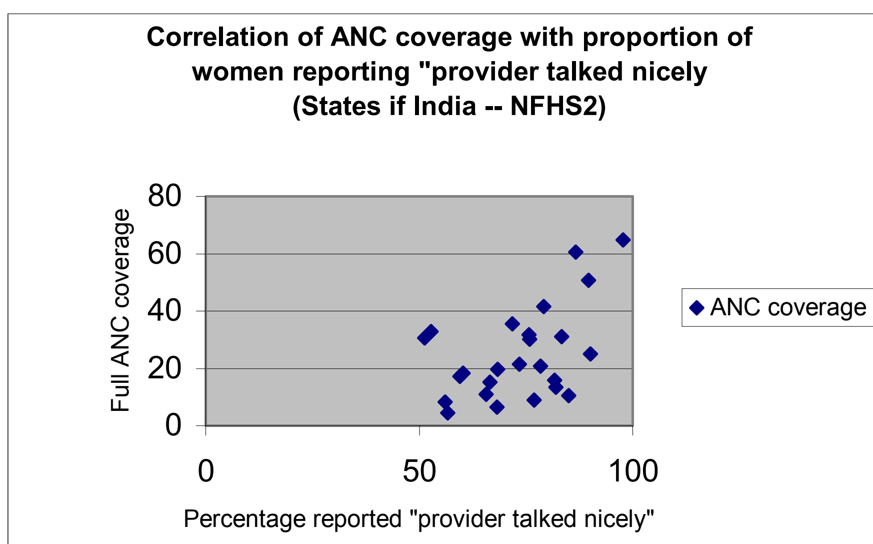
[21] Practitioners of ISM are often available in rural areas, but are not equipped to provide basic RH services including services for obstetric first aid.

as well as doctors and paramedics who work at peripheral levels, within the group. All protocols for immediate care should become available in the form of local-language charts or posters to act as "standing orders". On another note, acceptor cards for pregnant or parturient women or contraceptive users should provide practical and pictorial information about follow up and whom to contact for problems, or about the right to discontinue (contraception).

d. Arrangements for "assisted referral"

Provision of a wider range of services at the primary level would be feasible only if the referral system functions well. When the community becomes aware that a peripheral level worker would be able to identify those needs that are beyond her competence, stabilise the patient and make arrangements for a higher level of care, they put far more trust into peripheral level worker. Further, to enable the frontline worker to confidently provide a wider range of services at the primary level, it is important that referrals by a peripheral worker are respected and not ridiculed by staff at the referral hospital. Hospital staff need to accept that when frontline staff refer patients on the basis of failsafe clinical protocols, a certain degree of over-referral is inevitable. Hence following a normal outcome, they must not advise family members that the referral was unnecessary, since that would damage the frontline providers' credibility. At the same time, the programme must monitor feedback on over-referrals and late referrals. A set of actions for "assisted referral" has been outlined in the box below.

Figure 2: ANC Coverage



Box 7: What is Assisted Referral?

- *Service protocols that include appropriate referral criteria*
- *Sourcing of a reasonably costed means of transport by the referring institution (with payment of the cost in case of vulnerable families)*
- *Written communication between primary and secondary levels*
- *Accompanying indigent families to hospital*
- *Assistance in negotiating admission and start of treatment at the referral facility*

e. Performance appraisals to reflect RCH priorities

Public health priorities are not only reflected in official policy documents, but also in form of memos, guidelines, awards etc given to managers and service providers, and in signals conveyed at routine review meetings. District health systems in most states are currently pre-occupied in monitoring sterilisation performance. Notwithstanding the absence of central sanction, several states use a range of punitive measures to enforce better sterilisation performance, to the detriment of provider morale and women's access to essential services. Given that reduction of maternal and infant mortality is a central priority, it needs to become a core aspect of performance monitoring and appraisal. For example, districts and blocks may be graded on the basis of proportion of births attended by skilled attendants, and utilisation of emergency obstetric and neonatal/ infant care. Health facilities and providers should be rewarded for the number of deliveries conducted or sick children treated by them. The government's recent plans to grade health facilities is a welcome step in this direction, however we do not have adequate information at this stage to comment on the criteria for categorisation of health facilities.

2.6 Making services responsive and accountable

The World Health Report 2000 on health systems highlighted evidence that certain non-clinical outcomes of care-seeking services influence service utilisation. Humane treatment and respect for the clients' rights and dignity are ethical measures themselves, and also evoke a positive response -- there is evidence that providers' caring behaviour encourages women to seek services. We have estimated the correlation between the ANC coverage of districts of Rajasthan with the proportion of surveyed women who reported that the "health worker talked nicely on their last visit". There was significant correlation (coefficient of correlation: 0.5), suggesting that improved providers' behaviour does affect utilization of services by women (figure-2). A randomised controlled trial conducted by ARTH assessed the impact of training primary care physicians on responsiveness and counseling skills, on the care-seeking behaviour of families. Results suggested that the families that came into contact with trained physicians were significantly more likely to seek appropriate care for subsequent illness episodes as compared to control group physicians[22].

We propose the following steps for improving the responsiveness of health services to considerations of equity, rights and quality:

2.6.1 Training of state and district managers on gender mainstreaming

Training investments as above would need to build in social, gender and economic analysis of health, health services and care-seeking among managers and providers, so that they may apply a fresh understanding of these issues to their own work

2.6.2 Training providers to become more responsive

Both pre service and in service training can incorporate approaches that would promote gender equity. This training should not only sensitise the managers and providers on the gender, social constraints affecting health seeking behaviour, but

[22] Mohan P, Iyengar SD, Martines J, Cousens S, Sen K. Impact of counselling on careseeking behaviour of families: a cluster randomised trial in Rajasthan, India. ARTH, 2003

should also prepare them to take concrete actions to promote gender and social equity within health facilities.

Experience in India over the last 15 years has shown that training is starting process for mainstreaming gender mainstreaming and social equity concerns. The tragedy is that administrators and trainers alike expect miracles from training programmes or short modules inserted in training programmes. Part III of the report titled Moving from Gender training to mainstreaming explores this idea further and links training to inputs necessary to bring about systemic changes.

Box 8: Illustrative list of health providers can do

An illustrative list of the actions that health providers can take to reduce gender equity while providing services:

- *Reducing waiting time and follow-up visits for women*
- *Avoiding husbands' or family members' consent for providing abortion services*
- *Respectful behaviour during obstetric emergencies, while providing abortion services or in dealing with violence victims*
- *Letting women choose, rather than their husbands*
- *Not forcing their own preferences on women*
- *Communicating with families and TBAs*
- *Paying attention to privacy and confidentiality*
- *Charging less from poor women*

2.6.3 Clinical, managerial and social audit of maternal & infant deaths occurring in health centres and hospitals

Measures to audit maternal and infant deaths occurring in hospitals would help managers to assess clinical, managerial as well as socio-economic (equity) factors influencing outcome. The results could be used locally, as well as for state level planning and policy making.

2.6.4 Negotiating health care

Marginalised community groups have high levels of illiteracy and lack exposure to the educated, professional world of formal health services. There is especially high social distance between providers an users in two situations of relevance to RCH:

a. Emergency obstetric or child care:

Families from poor communities tend to seek care late, when complications have become well established. In such a situation they have to directly interface with a higher, referral level of the health service -- the district, teaching or specialised private hospital, whose staff operate in a more medicalised way. The information and power imbalance is acute, when undereducated, impoverished families seek higher medical care in a state of desperation, from well-resourced and well-connected hospital establishments in unfriendly cities. Such a provider-patient relationship is prone to greater inequality and exploitation, and this in turn encourages several families to leave hospitals prematurely "against medical advice". To make the service more responsive requires action on two fronts – supply side action through attitudinal training to make providers and hospital administrators more responsive, and "demand-side" assistance to families to help them negotiate hospital care. We propose that the following measures be taken at large referral hospitals:

i. A 24-hour help counter staffed by social workers[23] and operated by a college of social work or NGO, outside the direct administrative control of the hospital establishment. The social workers would take rounds of parking and waiting areas, casualty and wards to identify and establish contact with indigent families. They would guide them through admission procedures and hospital rules (visiting hours, etc), help them access available subsidies (for BPL families, etc), help decide on blood donation and surgery, advise on inexpensive (co-operative) drug stores and arrange for family support, including available stay and food arrangements for attendants. While acting as a bridge between hospital staff and families, they would help patients deal with uncooperative staff and avoid paying informal charges if demanded.

ii. Crèche facilities for sibs of admitted children and mothers of sick newborns or infants. This could be managed in co-operation with a welfare organisation or NGO.

iii. Ongoing studies of experiences of hospital users after discharge or death, including costs and responsiveness of the system. This needs to be carried out by an organisation independent of the hospital and social support agencies.

b. Primary and secondary health services for adolescents:

Adolescents, especially girls living in interior areas endure a heightened state of vulnerability compared to older women, as a result of early marriage, change of residence, heavy work burden, and lack of autonomy and resources. This occurs at a time when they commence an active sexual life and have emerging reproductive health needs. Since adolescents' health needs could be met by existing services, we propose an intervention to help adolescent girls interface with the service systems and negotiate health care. These are again, intended to deal with the social distance and power imbalance between adolescents (especially girls) and service providers. A locally resident young or middle-aged woman, perhaps at the rate of one per gram panchayat, would be designated as adolescent health facilitator. Her roles would include identifying vulnerable adolescents through household surveys, establishing a friendly relationship with older family members and adolescents themselves, providing health education and information about available services. As a community based distributor, she could directly provide them with contraceptives, iron tablets, etc. Most important, she would, and accompany adolescents needing services to women paramedics, doctors and specialists as appropriate, and negotiate with them to her fulfil the girl's her needs while preserving her rights, dignity and confidentiality and also limiting costs and follow-up visits. Such a health facilitator will need intense training and confidence building, for her to be effective. While a similar arrangement could be considered for adolescent boys, it would be a lesser priority given their greater mobility and autonomy. A Social Work College or NGO may operate the intervention.

c. Contraception – reaching out to men

The role of men in adopting contraception has been negligible. The burden of responsibility for contraception consequently falls on women, especially those who are already socially and economically disadvantaged. Even if services for women were to be of high quality (which they rightfully should be), the burden would remain with them, in the form of the effort and endurance required to initiate and sustain contraception. We therefore view any open and transparent measure to

[23] it would help to have a substantial presence of women social workers

increase male contraceptive uptake, including increasing access to services and the use of financial incentives, as a valid and pragmatic way of balancing women's burden of responsibility. Recent attempts to offer men a financial incentive for adopting vasectomy may be up scaled, if found to be effective. As an extension of this approach, contextual studies of male attitudes, values and apprehensions regarding sexuality and contraception would help to re-design behaviour change interventions to promote male contraception. Our suggestions are based on the argument a programme that proactively encourages men to adopt contraception is in effect more responsive towards women.

2.6.5 Addressing gender-based violence through the health system

Women presenting with unwanted pregnancy, STDs or HIV are more likely to have suffered violence. Moreover, given that a large proportion of women in India suffer domestic and other violence, and that the health system might be their only contact with an external agency, health providers must be able to identify and guide women suffering violence in the following manner:

- Proactively inquire from women patients as to whether they have recently suffered physical or sexual violence. In some countries, inquiry about violence is a routine part of all health care to women. A few questions to screen women about violence can be included in routine checklists for maternal care and treating women with unwanted pregnancy, RTIs and STDs.

Refer women who have suffered violence to appropriate agencies in the district (groups working on violence, police stations, "*mahila thanas*" etc.). As with "assisted referral" for clinical emergencies, a proactive role by a health institution in helping women facing a social emergency would improve outcomes.

2.7 Creating a positive institutional environment

Mainstreaming gender equity concerns clearly implies that planners, policy makers, line-managers and service providers would need to own the decisions and processes required to make it happen. For building and sustaining that ownership, a series of steps may be undertaken -- these have been outlined in part 3 of this report. As part of the operational framework, we propose here, some key steps to build a positive institutional environment within the health system. We have centred these steps at the state level, where we see the issue of ownership as being the most critical

2.7.1 Designation of one institution per state for carrying out ongoing research, compilation and review of data on gender, social, economic and regional inequities affecting RCH

Issues of gender and related equity suffer from lack of visibility and evidence, and hence a lack of attention. Even if nationally commissioned studies do focus on them, the evidence is scattered and may not be contextualised to that state. It therefore becomes necessary to relate the evidence on the ground – from research studies, census, DHS surveys service records, etc to the mobilisation and deployment of health resources in the state. Hence a nodal institution may be commissioned by the state, to put together secondary and (where necessary) primary data on equity.

2.7.2 Establishment of a state advisory panel to annually review evidence and advise the government on mainstreaming equity[24], rights and quality concerns within health programmes

We propose that an advisory panel comprising experts from the field of public health, gender and rights, health policy and finance, etc be constituted, to assist the government in orienting the RCH programme towards equity, rights and quality concerns. Such a panel would need a capable secretariat to function effectively, however, the secretariat must from within the programme management unit of the RCH programme. The panel would use outputs of the nodal research institution to arrive at an understanding of the situation, and match it to progress by the RCH programme.

Box 9: WHO's Gender Advisory Panel

In 1996, the Department of Reproductive Health & Research (RHR), WHO, Geneva constituted a Gender Advisory Panel with a rotating membership of 12 persons from regions around the world, having expertise in reproductive health research and programmes, gender, human rights, law and policy. Panel members annually review the work of the RHR department, with the objective of "ensuring that considerations of gender equity and equality as well as the right to sexual and reproductive health be (are) brought into the Department's work". The chairperson of the Panel additionally participates in executive decision-making meetings of the department.

2.7.3 Introduction of Health Equity, Rights and Quality issues in pre-service training courses of doctors, nurses, public health managers and civil service officers

This would involve working with medical, nursing and public administration teachers to modify their pre-service curricula, and also perhaps conduct training of trainers.

Box 10: ***Mainstreaming gender within Medical Education***

A program to mainstream gender in medical education has been implemented onwards from mid-2003 in 6 states by Achutha Menon Centre for Health Science Studies, Sri Chitra Tirunal Institute, Thiruvanathapuram, in collaboration with World Health Organisation. A three-pronged approach has been adopted to achieve this. The first approach is to review medical texts from a gender perspective, and the second features a training course on gender and health for medical teachers followed by ongoing mentoring by NGO experts and project initiatives to address selected gender concerns within the medical college setting. The third is a larger advocacy effort that includes a workshop for Deans / Principals of Medical Colleges and MCI members on the need for gender in medical education.

2.7.4 Orientation of state political leaders, policy makers and managers

This may be carried out using workshops or keynote oration as appropriate, wherein the evidence on the need to address gender equity and rights is presented and debated.

[24] To cover equity based on gender, social and economic groups and regional disparity

Part 3: Changing mindsets

Moving from gender training to mainstreaming[25]:

In recent years, "*mainstreaming gender*" has gaining wider acceptability - because it suggests a process that is not limited to a training situation alone. This process involves beginning with training but has to go on to tackling planning, management, resource allocation, appointment procedures etc. In order to be effective, the process of internalisation of a different value system must go hand in hand with appropriate structural changes, a facilitating work environment and affirmation of the importance and relevance of such an exercise in their daily work.

Experience has shown that gender-training programmes that involve a group of people working together has greater potential for success than putting together a group of officials from different areas. Sharing a common experience and working together enables a group to learn from each other and prevents them from feeling isolated. A group of officers from different departments and from different parts of the county may go back with wonderful ideas. Most of them find it difficult to sustain their enthusiasm because their colleagues and superiors do not share it. Therefore, a training process must begin with careful selection of a group with a view to sustain the process.

At this stage, it is possible to identify stages through which such a process could be initiated, namely:

3.1 The training process

The first step in a training process involves creating an atmosphere where the trainees talk about their work, reflect on their experience and begin to feel confident to discuss without fear of censure or evaluation, thus creating a climate for genuine exploration. In conventional training programmes the trainer takes on the task of giving information. However, when we deal with attitudes, information transfer is not adequate and could lead to hostility. Information has to be gently encouraged from the group itself, giving the participants an opportunity to talk about their work, their family, and their community. The role of the facilitators (trainers) is to list the information, classify it, and involve the group in separating the "facts" from value loaded statements.

For example, statements such as women fetch water; fuel wood and forest would be classified as information. Statements like "women are always taking leave" would be classified as value loaded statement. This first step would have to done painstakingly, with the facilitator determined to keep his or her cool. He or she has to resist the temptation of quoting macro data on nutritional status, literacy, dowry deaths etc. It has been observed that macro data does not help at this stage. In most situations, eliciting information from the group throws up almost all the issues that need to be covered.

[25] This section is based on an unpublished mimeograph on Mainstreaming gender in the health sector, reflections on South Asian experience, Vimala Ramachandran (2000)

Once the information has been generated from the group, the next step is analysis. This prevents the most common reaction, i.e. "what you say does not apply to my region, my community, my work place". Such reactions invariably put the facilitators in a defensive position, and often lead to indifference or apathy in the group. Analysing the information generated by the group leads to a high degree of involvement.

At the end of this process, the facilitator could share available data, case studies and other information. The group could be asked to work in small teams to analyse the information and make a presentation. *At this stage, data assumes an entirely new meaning. It is not what the data says, but what the participants wish to say with the help of data, which leads to a qualitative difference in the use of information.*

Transaction of information can thus become a creative exercise, where the "trainees" knowledge base is tapped enhancing their sense of self worth. It also enables them to identify with the training process and feel that they have shaped it. In short, the facilitator has to draw upon the collective knowledge of the group, give it an opportunity to articulate its opinions, and build upon this in subsequent sessions.

An experiential learning process involves both the mind and the heart. When the heart is convinced, the information is internalised immediately. For the heart to be convinced, the information must not only be authentic in the eyes of the trainee, but must be like a mirror that reflects the "truth" as perceived by the trainees. This is important in training programmes that seek to bring about attitudinal change.

It is also important to reaffirm the value of common sense and relate daily experience as citizens to working life. People have the ability to critically reflect on social relationships, dominant prejudices, public face of the government from a lay person's perspective (as manifested in their daily interaction with officialdom). Training programmes that ask trainees not to mix a professional approach and common sense fragments the experiential reality. Building bridges between these two worlds invariably yields valuable insights.

Exposure to new ideas, a different vision of the world and encouragement to put new insights into practice, all need to go hand-in-hand with a conscious effort to unlearn. For example, sensitisation healthcare service providers to the lived experience of 'clients' who seek services necessarily involve a conscious effort to unlearn the conventional ways of dealing with people. Readiness to listen to problems and sensitivity to traumatised women cannot be reinforced without a conscious effort to understand and appreciate the shortcoming of the delivery system itself. For example, "safe motherhood" needs to address the role of the husband in ensuring the safety of his wife through timely intervention and responsible sexual behaviour to prevent frequent pregnancies.

Similarly, a change in the public image of the family planning programme, making it gender sensitive and responding to the needs of poor men and women has to include a conscious effort to unlearn, i.e. question the basic assumptions of the family planning programme. One of the underlying assumptions of the family planning programme is that population growth is the cause of poverty and that women are primarily responsible for high birth rates. Deep-rooted belief among service providers, administrators, policy makers, and development partners that population

growth can be arrested through birth control would have to be questioned. Without this, it will not be possible to en-gender population programmes.

A tight monitoring system for essential quality of care indicators (including privacy and dignity), service availability and service provision indicators could force some change in the way women and indeed the poor are treated in our health delivery system. Involving local women’s groups and other consumer protection groups in surprise inspection of quality of services, or village meetings to discuss quality and availability of services could make a dent. This may enhance accountability and in the process make service providers more cautious. Changing practice in health delivery points may – in the long run – change attitudes. There is indeed a window of opportunity in quality assurance standards and charter of patient rights in a clinic

3.2 From internalisation of information to conviction for action

The next step involves a giant leap. The training process may give us a wealth of new information and also a chance to rearrange some of the information we already have. Analysing this information and processing it in our minds and as a group is always a valuable exercise.

Internalisation of the information and shedding prejudices does not automatically lead to conviction for action. For instance, we may be aware of the effects of the dowry system or the horror of acid burns, we may actually be convinced that it is inhuman, but this does not automatically lead to readiness for action either in our personal lives, in our family or as a community. On the other hand, there are those who feel compelled to act on that information. What brings about this change?[26]

Institutions, government departments or international organisations operate within a given mandate, a work culture and systems of rewards and disincentives. Certain kind of pioneering work gets support and encouragement, while others may attract hostility. Mainstreaming gender evokes very strong reactions. It would therefore be important to acknowledge the need to consciously *create a supportive environment*. This invariably stimulates confidence to act on one's conviction.

Periodic reviews of progress, achievements, organisational targets could be done in a gender conscious way. For example, review of immunisation could be done using gender and socially disaggregated data to show difference between boys and girls and between the poorest quartile of the population and the top quartile. This could lead to a discussion on how poverty, social status and gender influences access to services and resources. If this were done systematically and at all levels by officials who are in important positions, over a few years gender analysis of services would be internalised by all functionaries. Almost all RCH goals could be monitored in this way. However, it is important to acknowledge the fact that gender sensitive monitoring by senior civil servants can happen only if they are given a clear directive to do so and given the opportunity to participate in orientation programmes that give the necessary tools and skill.

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[26] To recapture the three steps, namely:
- ~ Internalisation of the information;
- ~ Conviction to act on that information; and
- ~ Confidence to act on one's conviction.

It is important to recognise that movement from internalisation of information to conviction for action is not a linear process. It moves in a spiral fashion, where small steps taken by the organisation facilitate internalisation while creating a conducive environment for action. Creating supportive structure legitimises the process, which in turn internalises the process within the organisation. On the other hand, ability of the organisation to seize the right moment or make the right intervention is important. A group may be de-motivated to address a specific issue or problem, and it may not be possible for a programme to tackle the issue directly.

The long and the short of it are that one should be able to gauge the pulse of the organisation. Training and orientation programmes must be followed up with appropriate administrative interventions that create the climate for the conviction to be translated into action. In the absence of a supportive environment, training programmes will rarely go beyond tokenism.

3.3 Create structures that facilitate action

All through the eighties and nineties, government departments were encouraged identify gender focal points. These individuals were an add-on to the system. They were responsible for "gender mainstreaming" and they had to independently negotiate with each section, project or programme. Many of them did not have administrative authority. It was essentially a token to show the world that the organisation thought that women mattered. As a result, many of these consultants and units could not make a dent in the mainstream. They confined their work to organising training programme or providing a short module in existing training programmes. Over the years, it was recognised that such structures do not always facilitate action and it is therefore important to explore ways and means to make the system respond without marginalizing gender or converting it into a showpiece. On the other hand, without a focal point to push the organisation to act, nothing ever gets done. *It is therefore important to find a balance between marginalized gender focal points and marginalisation of the issue itself.* Each organisation has to devise ways and means to make gender a critical crosscutting issue in the very fabric of the organisation.

It is important to keep in mind that there is a danger of mechanical application of checklists, ignoring the spirit and the process to arrive at them. For example, in many states RCH I made gender training mandatory. As a result we went through the motions of a gender training – and in many areas they were squeezed it into a already crowded training schedule. What happens in such a case – the gender-training checklist is ticked off and everything went on as usual.

3.4 Ensure proper sequencing of implementation

There is a classic example that is often discussed in the health sector.

RCH programme provides for village health committees that provide for equal representation of different stakeholders, service providers, community representatives (women) and functionaries in supportive departments / programmes operating in the area. Creating demand and encouraging women to seek services is indeed necessary, especially in the EAG states.

However, demand generation is meaningless in the absence of a reliable services – primary care as well as referral. Equally, the skill and competence of providers, personnel and equipment in PHCs need to be in place before mobilisation activities.

What is the point of educating the community of the merits of institutional delivery or trained birth attendant when providers are not available or when referral services for obstetric emergencies are not functioning at the Block PHC or CHC?

3.5 Do not ignore finance and administration

Let us take the sequencing example discussed above. Let us assume that the activities are planned in proper sequence, but the sequence in which funds are allocated and released depends on the sensitivity of people in finance and administration. Funds for training Mahila Swasthya Sangh members to enhance their confidence to demand services and improving their knowledge base is often not given priority and may be released some where in the mid-point of the programme. On the other hand funds for construction, training of service providers and purchasing equipment may take precedence, without ensuring the posting of anaesthetist at the CHC to assist the gynaecologist with a obstetric emergency.

This may not be a "conscious" error, but often happens because people across the board do not have a shared vision / understanding of the programme.

3.6 Leadership is critical

Every new initiative gets its initial momentum from leaders. Within a group, there would always be those who break the path and make the journey less formidable for others. It is therefore important to identify such leaders, especially at the helm of the RCH II programme in every state and if possible every district. The aptitude and commitment of the leader to the goals of RCH II is of critical importance. Some organisations / states suddenly come alive with a change at the top, while some lose their creativity and vibrancy with a change of guard. It is therefore important to recognise the role of the leadership in creating and sustaining a climate for action. A sensitisation process should therefore involve the leadership in order to make the leap from conviction for action to the confidence to act.

3.7 Create a core to take the process forward

The leadership needs to be supported by a core team – drawn from within the system (Doctors, LHVs, ANMs) to carry the process forward. State Governments need to ensure a reasonably long tenure of this core group to steer the reform process.

Discussing allocation of responsibilities for mainstreaming, many practitioners in the region admitted that women were invariably chosen for the task. They also admit that an all women core group is not in a position to mainstream gender issues when they are themselves marginalized as a group. Experience has also demonstrated that the being a woman does not automatically make a person gender sensitive and that many dynamic and committed men have provided the leadership for mainstreaming

gender. Therefore, a core group should ideally have women and men across different levels. People working on civil works and logistics and supply of drugs have to be made part of the core. Creating a network among the core group is also necessary for experience sharing and mutual support and affirmation.

3.8 Identify doable tasks

The first sign of resistance surfaces through some predictable and common reactions, namely: "We have so many targets or goals to achieve this year. Mainstreaming gender will distract the staff and we will not be able to do justice to our primary responsibility – which is population stabilisation or universal immunisation."

This response must be addressed seriously. The overarching goal of the RCH programme must be broken up into short-term goals: reducing maternal mortality, reducing infant mortality and improving access to and use of contraception. Each doable goal must be linked to the overall goal – thereby communicating that maternal health and child health is not in competition with contraception or the pulse polio campaign – but that they all complement each other.

Equally, we must recognise and respect the specific responsibility and contribution of each level of professionals ANMs, doctors and surgeons. Identifying what they can do and how they can contribute to the larger goal is important.

3.9 Anticipate bottlenecks in order to overcome it

Most organisations have their share of people who act as gatekeepers and turf-guards. Some may do so because they feel insecure, having slipped into routine mediocrity; some fear change and the impact it could have on the work-culture, and in some organisations staff unions and associations play the role of maintaining status quo. Arguments for not doing something invariably revolve around workload, time, territories, externally determined agenda versus internally determined priorities etc. This kind of subtle pressure often wreaks havoc on any new initiatives. In many situations, bringing such tendencies upfront and placing them on the table could be the beginning of the process of reflection.

One of the major bottlenecks is the appointment of people without aptitude or interest into key posts. Many staff associations fight for promotion and growth avenues, without being sensitive to appropriateness of a given person for a particular post. Executive heads plead helplessness even when they are fully aware of an attitude problem among key officials. It will not be possible to initiate change unless such issues are addressed squarely. Is it possible to initiated dialogue with the staff union and negotiate appropriate staff selection for key posts?

3.10 Nurture affirmation and encouragement

Creating a nurturing environment, giving positive strokes at the right time, disseminating successful experiences, affirmation and friendly and constructive criticism - all these go into sustaining the process long enough for it to leave a lasting impact.

We are so used to time bound or one-shot training processes that a long drawn out process seems unnecessary. It is therefore important to repeat, over and over again, that changing attitudes, work-styles and redefining priorities cannot be achieved overnight. Therefore reinforcement and affirmation needs to be seen as an integral part of the process.

National, state or regional awards for PHC areas or Panchayats that have made significant strides in reducing maternal mortality, reducing infant and child mortality and ensuring a fully functional and popular cluster of PHC and Sub-centres could indeed turn the spotlight on caring, responsive and effective services being the key to achieving the goals of RCH II.

3.11 Are such process-oriented / 'cumbersome' processes possible?

The first reaction of civil servants is that such a cumbersome process cannot be initiated in the health and family welfare system. While appreciating the need for such a thorough exercise, many well-meaning officials plead helplessness. Some also argue that the forces that actively work towards protecting status quo resist any attempt to bring about systemic changes. However, there are examples where dynamic leaders have been able to make a beginning. It all depends on our ability to build a strong pressure group to force the leadership to acknowledge the need for change in order to *achieve the stated objectives of RCH II*. And it is also very important to break down the larger goals into specific objectives. Having a shared understanding of what we want to achieve is the starting point. *There are no magic bullets and no magic formula – mainstreaming is a cumbersome process of weaving in shared concerns into every activity and every single process.*

We can do it provided we do not go off the track and start chasing numbers again!

ANNEXURE OF TABLES

Table 1.1: OPERATIONAL FRAMEWORK FOR MAINSTREAMING GENDER WITH THE RCH PROGRAMME: ACTIONS BY LEVELS

Attributes >>>	***Enhancing availability of women health providers***	***Moving technology and skills closer to women***	***Reducing economic barriers***	***Making services responsive and accountable***
Service delivery	• Increase in functional health facilities • Women primary health providers available closer to home, especially for attending delivery and treating sick children • Regular, predictable visits by outreach providers • More locally resident providers	• Wider range of MCH, FP, safe abortion and RTI/STI services available at primary level Arrangements for assisted referral to secondary level Providers trained and equipped with appropriate technology to provide a range of services at primary and secondary levels	• Affordable services, flexible payment options • Imprest advance for emergency transport & care, available with primary care providers • Improving local availability of providers	• Humane and responsive provider behaviour • Privacy, confidentiality and amenities ensured for women's services • Women's right of consent respected • Village link persons help adolescent girls (and women) negotiate primary health care • Social workers at hospitals help families negotiate emergency care for women & children • Crèche for sibs and lodging for women accompanying hospitalised children
Family & Community	• Community support for improving living conditions and security of women-providers • Mechanisms for making providers accountable to local community	• Mapping of available transport, facilities, providers and their skills • Community education on danger signs for maternal, neonatal & child health • Building credibility of frontline providers • Community participation in ensuring quality at health facilities – health committees	• Linkage with women's micro-credit groups • Information and mobilisation for women's participation in health financing schemes • Surveillance of quality & cost of services covered by health finance schemes	• Community education on client's rights and responsibilities • User feedback studies on access, range, cost and responsiveness of services

Attributes >>>	***Enhancing availability of women health providers***	***Moving technology and skills closer to women***	***Reducing economic barriers***	***Making services responsive and accountable***
Programme management and oversight	• Distance-time & workload norms for locating facilities & providers • Norms for locating subcentres within the village and providing amenities • Pairing ANMs or providing them an assistant • Adequate numbers of women supervisors, with arrangements for their mobility • District Complaint Committee for sexual harassment at workplace • Appointment of a District Nursing-Midwifery Officer	• Performance appraisal of providers reflects RCH priorities • Introduction of appropriate technology[27] for increasing local access • Change in pre and in-service nursing and medical curricula and postings to invest more in practical clinical skills • Standards and protocols (standing orders) adapted and made available to health facilities	• Rational & cost-effective treatment protocols Women-centred health financing: 1. Health insurance to include women's needs 2. Health funds channelled through women's groups	• Orientation-training of line-managers on gender mainstreaming • Training of providers on gender issues and responsive care in the service context • Designation of team for carrying out maternal & infant death audit in health centres and hospitals
Policy & Planning	• Gendered human resource policy for frontline workers • Budget allocations for increasing availability of providers & supervisors	• Policy decision to provide a wider range of RCH services at primary level • Modify nursing council regulations • Establish state midwifery councils • License use of appropriate technology/ drugs by frontline providers • National service guidelines for adaptation by states • Budget allocations for training, equipment and supplies for a wider range of services at primary level	• Costing of essential RCH services • Guidelines on women-centred community health financing & insurance schemes • Budget allocations to finance RCH services	• Planners and policy makers hold annual review of results of clinical audit, user feedback studies, etc • Budget allocation for enabling adolescents & marginalized communities to negotiate health-care

[27] Examples: pelvic examination, oxytocics for active management of 3rd stage of labour, IMNCI case management protocols, medical abortion, MVA

Attributes >>>	***Enhancing availability of women health providers***	***Moving technology and skills closer to women***	***Reducing economic barriers***	***Making services responsive and accountable***
Building a positive institutional environment	Designation of one institution per state for carrying out ongoing research, compilation and review of data on gender, social, economic and regional inequities influencing health in the state Establishment of a state advisory panel to annually review evidence and advise the government on mainstreaming equity[28], rights and quality concerns within health programmes Introduction of Health Equity, Rights and Quality issues in pre-service training courses of doctors, nurses, public health managers and civil service officers; training of trainers Orientation of state political leaders, policy makers and managers			

[28] To cover equity based on gender, social and economic groups and regional disparity

Table 1.2: MOVING TECHNOLOGY & SKILLS CLOSER TO WOMEN: A LIST OF TASKS & SKILLS BY SERVICE LEVEL

<table>
<tr><th>Level>></th><th>Nurse-midwife at home / village clinic</th><th>Nurse-midwife at SC/ PHC</th><th>Graduate doctor / senior nurse-midwife at PHC/CHC</th><th>Trained graduate or specialist doctor at CHC/ hospital</th></tr>
<tr><td>Maternal health</td><td colspan="2">• Complete antenatal care [29],[30] (WHO model)
• Normal delivery using partograph, active mgt of 3rd stage of labour[31]
• Obstetric first aid (Inj Oxytocic + Intravenous fluids for PPH, IM antibiotic for puerperal / post-abortal sepsis, IM MagSulf for eclampsia) and referral
• Two postnatal visits[32] (within 24 hrs of delivery and on 3rd to 6th day)
• Accompaniment and care during transport

The nurse-midwife would more effectively perform these tasks in a health facility, but would also have to carry them out at home level where needed</td><td>• Complete ANC (WHO model) including blood group, VDRL/ RPR, urine test for UTI
• Normal delivery using partograph & active mgt of 3rd stage of labour
• Complicated deliveries (eg. twin & breech)
• Injectable iron for moderate/ severe anemia
• BEOC functions: managemt of PPH; manual removal of retained placenta; IV antibiotic for sepsis; management of eclampsia (IM/ IV Magsulf and delivery); suture of vaginal & cervical tears; early detection of obstructed labour; vacuum extraction, referral for caesarean or blood transfusion</td><td>All functions in previous level +
• Caesarean section,
• Blood transfusion,
• General / spinal anesthesia</td></tr>
<tr><td>Neonatal health</td><td colspan="2">• Immediate newborn care (warmth, support for early breast feeding)
• Bag & mask resuscitation
• Counseling on newborn care at home (exclusive breastfeeding, warmth, recognition of danger signs, cord-care)
• Early recognition of infections & management/ referral</td><td>• Care of sick newborn (level-II) -- oxygenation, IV fluids, temperature stabilization at all BEOC facilities</td><td>• Emergency neonatal care ((level-II/III)</td></tr>
</table>

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29 The new WHO antenatal care model recommends 4- visit schedule for low risk women, and consists of interventions that are of proven effectiveness to prevent or ameliorate adverse maternal outcomes: bleeding, anaemia, pre-eclampsia, sepsis and genitourinary infections, and obstructed labour, low birth weight infants. (Department of Reproductive Health & Research, Family and Community Health, World Health Organisation, Geneva, 2002. Antenatal Care: From Research to Action.

30 Antenatal care tends to be patchy at peripheral levels and would need to go beyond tetanus injections and iron tablets in order to become effective for improving maternal and foetal outcomes. It is feasible to provide most elements at home /village level except for blood group, VDRL/RPR and urine test for UTI.

31 Active management of third stage includes 3 actions to be carried out after birth of baby: early cord clamping, oxytocic injection, and controlled cord traction

32 World health Organization, Geneva. "Postpartum care of the mother and newborn: a practical guide: Report of a technical working group" WHO/RHT/MSM/98.3

Abortion	• Urine pregnancy test • Counseling and referral for women with unwanted pregnancy • Identification of incomplete abortion & first aid (digital removal of products) • Post MTP follow-up	• Pregnancy confirmation – pelvic exam. + urine test • Estimate gestational age • Counselling & referral of women with unwanted pregnancy • Identification of incomplete abortion & first aid (digital removal of products+ IV fluids if required) • Pre and post MTP instructions	• Medical abortion up to 63 days • MVA for 1st trimester • Uterine evacuation for incomplete abortion	• MVA, medical abortion • 2nd trimester abortion
Contraception	• Urine pregnancy test • Condoms, oral pills • Emergency contraception	• Confirmation of pregnancy status • Condoms, oral pills • Cu-T 200B • Cu-T 380A as a long-acting contraceptive • Emergency contraception	All services from previous level + • Vasectomy	All services from previous level + • Vasectomy • Tubectomy • X ray for detection of missing Cu-Ts • Difficult Copper-T removals
RTI/STI/HIV	• Identifying women with suspected RTI/STI • Counseling on STI prevention • Referral for HIV-testing	• Risk assessment • Clinical examination (including speculum and bimanual examination) • Counseling • Treatment of lower RTI • Single course treatment for upper RTI with referral • Counselling for HIV testing • Universal precautions	All services from previous level + • VDRL testing • Management of upper RTI • HIV testing, including pre-test and post-test counseling	All services from previous level + • Anti-retroviral therapy • Management of opportunistic infections • Management of chronic PID

Child health	• Counseling on child health and nutrition • Immunization • Micronutrient supplementation	• IMCI case management of sick children • Immunization	• 24 hr admission service for sick children[33] at facilities designated as BEOC including in-patient management of pneumonia, diarrhea, severe malnutrition, malaria, meningitis and measles.	• 24 hr admission service for sick children at facilities designated as CEOC including in-patient management of pneumonia, diarrhea, severe malnutrition, malaria, meningitis and measles.

[33] Management of the child with a serious infection or severe malnutrition: guidelines for care at the first referral level in developing countries: WHO, 2000