

1. Introduction

Gender Inequity

Gender disparity – inequality of status between men and women – is one of the most universal and persistent injustices in human society. It permeates every aspect of life, personal, social, economic and political. Many modern societies have recognised the existence of this injustice but hardly any have acknowledged its true extent. Countries have legislated for gender equality but practice falls far short of intent. Reluctance on the part of men to give up the power they have historically exercised over women and acceptance on the part of women who have, since time began, been brought up to believe in the traditions of patriarchy have perpetuated inequality. Religious faith and family ties are used to emotionally undermine the fight for equality.



Women working in the fields.

In India, the Constitution guarantees gender equality. Practice falls far short of ensuring it. For the majority of women, political and economic power remains out of reach. Income-earning opportunities as well as control over the income that they do earn are restricted, if not denied. They have little or no say in decision-making about personal and family-related matters like education, career, marriage, child-bearing and their own health. Their unpaid work in the family is taken for granted. Among the poor, women suffer in worse ways than men, usually having to bear the burden of nurturing the family. As in all systems of subjugation, mental and physical violence are not infrequently used to maintain the status quo and within certain limits are even seen as justified. Ruled as women are by oppressive and protective patriarchy, it is not surprising that those who oppose gender inequality have to deal with deep-rooted feelings of dependence and inferiority among women themselves, as well as more concrete obstacles.

Gender-related problems in health are legion. The over-arching problem is that most women have no control over their own health. From childhood their nutrition needs are neglected in favour of nurturing the males in the family. “Who eats last?” is a question that goes to the heart of the matter in attempts to raise awareness about the inferior position of women within the family. The unremitting burden of household work and the strains of child-bearing add to health problems. Women’s health problems are neglected by themselves and their families until they become too serious to ignore. Access to health services can be restricted both physically, in terms of distance and non-availability of transport, and by factors like denial of freedom of movement, lack of protective escort, reluctance to spend money on medical attention and transport, and sheer disregard for women’s needs. Added to these are a woman’s own reluctance to ‘push herself forward’ and traditions of self-denial. The dismissive and hectoring attitudes of health service providers, especially towards poor women and lack of privacy in medical examination are some of the factors that inhibit women from seeking medical aid.

When it comes to a disease like leprosy, the stigma attached to it adds to inhibit the health-seeking behaviour of women. While stigma in leprosy affects both men and women, the latter suffer in worse ways, economically and socially. Until its recent integration with the general health care service,

the 'vertical' leprosy elimination service in India was staffed almost exclusively by males and this made physical examination of women for signs and symptoms of the disease difficult. For years it was believed that women were less prone to get leprosy than men because statistics consistently showed that the ratio of male to female leprosy patients was 2:1. Increasing sensitivity among some health care providers led to the realisation that there may be many hidden cases among women because of all the inhibiting factors. When special efforts were made, both to fight stigma and to involve women in the process of detecting signs and symptoms of leprosy, the gender difference in incidence was dramatically reduced.

During the last three decades of the 20th Century, development concerns increasingly emphasised participation by the people in planning and implementation of projects designed to improve their lot. People were no longer to be passive beneficiaries in the development process. As community participation grew in both theory and application, its relevance to the health sector, as much as to other areas of development, was recognised. In the Seventies and Eighties, there was also realisation that leaving women out of the development process and ignoring their needs would render development efforts ineffective. The approach known as Women in Development (WID) grew out of this realisation. WID emphasised the crucial role of women in maintaining economic viability and nurturing health in the family. It saw the increasing of women's income-earning capacity as central to the development process.

Through the Eighties and into the Nineties, development theory began to acknowledge that income earning without control of income and decision-making power was ineffective. This inevitably led to recognition that wider issues of gender inequality, both economic and social, had to be addressed. By the mid-Nineties, a shift had been made in the world of development from WID to gender-related activity. While WID worked within the traditional perception of women's role and position in society towards the means of providing for their practical needs in education, health and income-earning capacity, the shift to gender activism recognised that the position of women as ruled by tradition is iniquitous and unjust; that only by spreading awareness of this injustice and empowering women to attain gender equity can true development take place.

In the area of health, however, gender was for a long time seen as relevant only to reproductive and child health care. And in a specialised vertical system like the leprosy elimination programme, gender needs did not impinge on the consciousness of those who planned and implemented it. To them, it appeared largely irrelevant. It is one of DANLEP's important contributions that it brought first WID, and then gender activities, into the leprosy programme in the three DANLEP-supported states of Madhya Pradesh, Orissa and Tamil Nadu, and by example influenced other institutions and individuals as well.



Women brushing teeth and bathing in a river.

The Danish Approach

A commitment to the improvement of women's position has been a constant factor of Danish aid to developing countries and is recognised as essential by all Danish agencies. In 1987 (at about the same time as the DANLEP project was begun), Danida appointed a WID Adviser in four programme countries, India being one of them. Later to be called Gender Adviser, this person's role was to ensure inclusion of gender sensitive policies in all projects. A decade later, a workshop for all project advisers was held to further ensure incorporation of gender issues in all projects. A Gender Core

Team with members from all Danida projects was formed. Reporting on gender initiatives and activities by all advisers became part of annual/bi-annual meetings.

In Phase I of the DANLEP project (1986-92), the WID approach was adopted from the beginning. A concern for women's development and inclusion was part of the community participation approach, particularly the camp method which characterised this approach. Women's involvement was actively sought in the areas of Information, Education and Communication (IEC) and in case-detection activity. This mobilisation of women was both an end in itself and a means to fight stigma through awareness and to bring to light hidden cases of leprosy among women. Getting women patients to come forward and openly display their patches or have their disabilities treated in public in prevention of disability (POD) camps was seen as a major step towards reducing stigma. Visual documentation of leprosy elimination work in the Phase I districts resulted in many sensitive photographs of women affected by leprosy and/or working to eliminate the disease. These were used in posters and booklets and formed part of the excellent IEC material produced by DANLEP.

Halfway into Phase II, the project's concern for women was limited to this 'women in leprosy' activity. The Phase II Mid-Term Review team in 1994 raised questions about the extent of gender activism in the project. This acted as a catalyst for the movement from WID to a wider gender-related activism and also for a shift from 'women in leprosy' to 'gender in health'. A Gender Core Team was formed, with representatives from the three DANLEP-supported states and from DANLEP New Delhi. In 1998, this was subsumed under the Gender Core Team formed by Danida with a single representative from each project. The DANLEP gender representative was then based in New Delhi.

While the Gender Core Team provided coordination and consultation on all gender-related activity, the project in each state, through a gender focal person, had the autonomy to plan and pursue gender-related activity based on her/his perceptions of the situation and needs in that state.¹ The ways

¹ This was, until 1998, the DANLEP Gender Core Team. From that year, guidance was provided by the Danida Gender Core Team in which DANLEP was represented.

each of the four DANLEP-supported states pursued gender-related activities is described in later chapters.²

Regardless of the extent and kind of gender-related activity, sensitivity to women's needs was evident among all those involved in policy making, planning and implementation in the DANLEP states. Factors which influenced the different approaches were:

- The perceptions of priorities by the state DANLEP team.
- The attitudes of the state government, particularly the health department.
- The progress of leprosy elimination in the state.
- The relationship between the general health system and the leprosy service, including the extent to which integration had been implemented.
- The involvement of other development institutions – government and semi-government (ICDS, literary mission), donor agencies, NGOs and women's groups – and the extent of DANLEP's interaction and cooperation with them.
- Long-term and intense commitment of an individual gender focal person to gender equity and gender-related activity and her networking with particular groups and individuals.

Partners in Gender-Related Activity

Like all Danida projects, DANLEP is a facilitating and not an implementing agency, working through other institutions, groups and individuals. DANLEP's strength in IEC and training has been particularly effective in promoting gender-related activity through its partners. Who are these partners and what is the extent of their interest and involvement in gender activities in the four DANLEP states?

² After the bifurcation of Madhya Pradesh and formation of Chhattisgarh, this new state was included in the DANLEP project along with Madhya Pradesh, Orissa and Tamil Nadu.

The State Health System, Including the NLEP

This partnership is strongest in Tamil Nadu where the need for gender training has been recognised at senior levels and DANLEP facilitation of the process has been welcomed. In Chhattisgarh and Orissa, female field health workers are included in groups of trainees undergoing gender sensitisation. Additionally, in Orissa, the gradual adoption of gender training in medical colleges and nursing schools is contributing to the presence of gender-sensitive workers in the health system.

The Integrated Child Development Services (ICDS)

Again, the formal partnership is in Tamil Nadu where the WB-ICDS III Project called upon the DANLEP adviser to plan and facilitate training of trainers (TOT) in gender for its staff. In the other three states, *anganwadi* workers have been included in groups undergoing gender training and have also taken part in activities facilitated by DANLEP relating to gender and women's empowerment.

Academic Institutions

In Orissa, gender training has become part of the regular curriculum in some medical colleges and schools for nurses and nursing assistants. The Women's Studies department of Utkal University and the St. Xavier's School of Management are other institutions involved in gender training and related activity. DANLEP has played a motivating and guiding role in the process.

The Literacy Movement and Other State-Promoted Organisations

The Literacy Mission in Durg has provided master trainers and worked closely with DANLEP on several aspects of training and IEC in gender-related activities, not just in Durg district but in other areas of Chhattisgarh as well. DANLEP, in turn, has provided the trainers with training modules and IEC material. In Tamil Nadu, the *Arivoli Iyakkam* (Literacy Movement) has been sending its trainers and workers to gender sensitisation workshops facilitated by DANLEP. Also in Tamil Nadu, DANLEP has worked closely with the State Resource Centre in facilitating gender-related activities, particularly through the Adolescent Task Force.

State and Regional Training Institutes

The State Health and Family Welfare Institute in Bhubaneswar has been motivated by DANLEP Orissa to undertake large-scale gender activities on

an extended scale. It produces much IEC material on gender for distribution to and use by various bodies. Regional Institutes of Health and Family Welfare, like that in Sambalpur, have had their staff undergo TOT for gender with DANLEP facilitation and conduct gender sensitisation courses for various categories of health workers as part of their training. The Regional Training Institutes in Tamil Nadu have had their trainers attend gender workshops facilitated by Danida and DANLEP. A select number of RTI trainers have also attended an advanced training course in gender. Such trainers form part of a strong network in the state which is extending gender awareness among various categories of health and development workers.

Women's Self Help Groups, NGOs and Volunteers

In all four states, DANLEP has built partnerships with a variety of SHGs, NGOs and other voluntary groups. In Chhattisgarh, SHGs which have entered the *Didi* Bank system of group savings and the *mithanin* (female community health volunteer) are developing a network of active women who are very responsive to gender training. Members of SHGs and NGOs working primarily with women have also been drawn into gender sensitisation workshops in Orissa and Tamil Nadu.

Student groups, Scouts and Guides, NCC, NSS

From the early stages, in Durg and Rajnandgaon in Phase I and in Gwalior in Phase II, DANLEP Madhya Pradesh mobilised school students and scouts and guides in leprosy elimination campaigns. In the training for these campaigns, there was strong emphasis on involving the women of the target communities. This emphasis continues in Madhya Pradesh. In Orissa, the NSS students of Utkal University receive gender training on a regular basis.

Members of Panchayati Raj Institutions

DANLEP Tamil Nadu planned and facilitated TOT in gender for staff of the World Bank Integrated Child Development Services (WB-ICDS) III project and they in turn have been providing gender training for women in *panchayati raj* institutions (PRIs). DANLEP has helped with training material and modules for this grassroots level training. In Chhattisgarh and Orissa, female and male *panchayati raj* representatives are regularly invited to participate in gender workshops.

Summing Up the Impact

In all these areas, women are waking up and taking on responsibilities of their own. Today, they increasingly have an independent identity and have made a space for themselves. Many, who had never dared to tread out of their homes, crossed the traditional barriers and moved into camps and other social welfare groups, not only to fight the stigma of leprosy, but to join hands in other areas of concern that affected their own lives. Some of these women have taken up responsible positions in NGOs, some have been elected and are serving as *sarpanches* and deputy *sarpanches*, while others provide support and participate in activities they consider to be worthwhile.

In the DANLEP-supported districts, the communities have been sensitised to accept women working not only for leprosy elimination but other welfare activities and no longer question their presence in what was earlier male dominated terrain.

Knowledge, empowerment, and a fundamental sense of worth and self-esteem have allowed them to be fully involved in leprosy work, which has also become the route to other positive changes.