

2. Orissa

Women to the Forefront

DANLEP Orissa's then newly-appointed health education and training adviser, having attended the community participation camp at Dongargarh, Madhya Pradesh, in 1987, took up the task in Orissa by organising a leprosy awareness camp with a difference: one which comprised exclusively of women from a rural community. That first women's camp was at Khankarpur village of Jagatsinghpur Leprosy Control Unit in Cuttack district. Thirty-six married, mostly illiterate women from different castes and economic groups, teachers and *anganwadi* workers spent three days in January 1988 in a residential camp with 15 leprosy patients (three female and 12 male) as well as staff from NLEP and DANLEP. Following the pattern set in Madhya Pradesh, the participants discussed facts and issues related to leprosy, listened to the experiences of leprosy affected persons, shared meals and played games and so arrived at knowledge, understanding and empathy. The experience was inspiring not only for the women, but also for NLEP and DANLEP staff. It was an exercise in confidence-building and discovery of women's potential for action, as well as in awareness raising about leprosy. When they heard of the event, women from neighbouring villages clamoured for similar camps and two more such camps for women were held in quick succession in villages in the area.

At these camps, women received training in leprosy issues, including ways to recognise the signs and symptoms, availability of MDT and methods of ulcer care. Such training was participatory and combined with a number of other camp activities of which the primary aims were to reduce the stigma attached to the disease and to bring the women to the forefront. Other camps for community participation followed, for both women and men. The fact that the process had begun so successfully with women's participation motivated project staff to ensure a strong female presence even in camps for mixed groups. Inevitably, women became aware of their own capacity for learning, understanding and decision-making.

While the main thrust of the camps was to raise awareness through training in leprosy, the first steps had been taken towards empowerment of women in these communities. The project extended its network over the next few years through efforts to enumerate women's organisations like *mahila mandals*, *mahila swasthya sangha* and women's cooperative groups. Such groups and organisations were mobilised to raise awareness about leprosy. By 1994, not only were more women being drawn into the process, but more issues that concerned them were being examined and discussed. 1994 saw a shift of focus in the project from women in leprosy to women in health. Women's organisations were encouraged to get involved in all issues regarding women's health rather than in the elimination of leprosy alone.

The project at this time continued to work in the Women-in-Development pattern. While a general awareness of inequity underlay all activity for women's development, there was no attempt to study concepts related to gender or analyse the causes of gender inequity and the need to confront and counter it. The 1994 Mid-Term Review team asked the question whether and how the project was dealing with gender concerns, and thereby acted as a catalyst for raising DANLEP in Orissa to a new level of consciousness and activity.

Articulating Gender-Related Concerns

The first step in this new direction was the state-level workshop held at Puri in July 1995 to sensitise policy makers on issues of gender in health and on gender equity in general. The possibility of incorporating gender in all health programmes in the state, and the problems to be faced in the process, were examined. Studies were presented on a number of socio-economic practices which placed women's health at risk – for example, a study on gender in nutrition practice in Ganjam district. Strategies for the future suggested at the workshop included strengthening basic services for health care delivery; increasing women's participation in health institutions, particularly at higher levels; bringing female healers and midwives into the health system and encouraging women's organisations to participate in primary health care activities in their localities. The workshop recommended that gender cells should be established at district level, training to sensitise district level officers should be arranged, and NGOs should be involved in planning and policy-making in areas related to women in health.

A year later, in 1996, the project facilitated a second gender workshop in Bhubaneswar to formulate a strategy. State government representatives, health and medical officers and faculty of the medical college and hospital in Cuttack, the Centre for Women's Studies of Utkal University, and the Regional Family Planning Training Centre participated. A number of NGOs, as well as WHO, UNICEF and ODA were also represented. Among the recommendations of the workshop was the taking up of action research programmes on subjects like increasing outreach to women in health care delivery, reducing female mortality due to TB, providing health information to rural populations, and strengthening the training curriculum of district health functionaries. However, while some studies were initiated the scheme did not progress much at that time.

By the turn of the century, many organisations in health services and related areas had been exposed to gender sensitisation. In 2000, the project facilitated a TOT for gender awareness at Konark which was attended by trainers from the health system, NGOs, and many of the other institutions which had become involved in promoting gender training.

Taking Gender into Nurses' Training

The first comprehensive gender training by the project in Orissa, which dealt with gender concepts, strategies and practical needs, was the two-day training of trainers (TOT) at the Berhampur College of Nursing in December 1996. This was followed by a similar workshop at the Burla Nursing College, Sambalpur, in July 1997. Participants on the second occasion included state regional training officers and representatives of the state health department. Official interest in gender training was in evidence.

At both workshops, trainers of field health workers, nurses and nursing assistants were sensitised to health issues relating to women and to the need to incorporate gender in all training plans and activities. The workshop at Sambalpur put together an action plan which included development of a training package for in-house training of multi-purpose workers (MPWs) with guidelines for inclusion of gender issues in the training, incorporation of gender issues in health in the nurses' training syllabus and increasing media activities to raise awareness on gender issues among health service beneficiaries. Since these two workshops were held, gender-related topics

have been included in the in-service training of health workers. Over the years, DANLEP, through its gender focal person, strongly advocated inclusion of gender issues in the nursing curriculum state-wide. The State Directorate, Nursing, drew upon her expertise while reshaping the nursing curriculum which has a strong gender component. When completed, it will be used all over the state. Meanwhile, a gender component has been introduced into the old curriculum in most nurses' training institutes in Orissa.



Gender awareness workshop in a college, Orissa.

Gender is also a part of the training of female health workers and/or multi-purpose workers. At the Daspalla training school for female health workers, several faculty members had attended gender training facilitated by DANLEP. Their students discussed gender issues with vigour and enacted a street theatre play, made lively with song and dance, which they had written and produced themselves. Entitled "How long must we wait?" it was about the various forms of discrimination suffered by a girl: denial of nutritious food and education because her brother needed them more; early marriage against her wishes; dowry demands and forced abortion because a sex determination test had indicated that she was bearing a girl child. The students were preparing to perform the play in the open in neighbouring villages. This, said the school principal, was revolutionary since it was a traditional

community which frowned upon girls getting themselves noticed in public places.

Sensitising Medical Students

The project was instrumental in introducing gender issues to the Berhampur Medical College. The faculty members of the Department of Community Medicine at the college were enthusiastic about gender training for medical students and welcomed input from DANLEP's gender focal person.

It is only recently that, in Orissa, both father and mother are being named when a child is registered for treatment. After all, a woman is, herself, not addressed by her personal name, she is always someone's daughter, wife or mother. She lives without a name and dies without a name. There is a need, in our society, for a woman's identity to be acknowledged. We now teach our students that when a woman's own name is used, rapport between doctor and patient is established.

Doctors can be very arrogant, particularly towards the poor and most of all towards women among the poor. Most medical officers will examine a female patient and then turn to her husband to explain the illness and give instructions about treatment. She, the patient, is ignored as a person. She should be able to discuss her own health. We have in-service gender sensitisation programmes here for medical officers. But it is preferable to make them sensitive to such issues when they are young.

Prof T. Sahu, HOD, Community Medicine, Berhampur Medical College, Orissa

From 2001, when official approval was obtained, a gender component was included in the study of Social and Preventive Medicine (SPM) for undergraduates. Gender-wise ratio of incidence was studied in the epidemiological analysis of several diseases and possible reasons for it discussed. Medical students were also sensitised on ways to approach female patients. Problems of attitudes to women's health needs within families, socio-economic reasons for nutritional deficiencies, difficulties in accessing health services, attitudes of health service personnel and other gender-related issues were dealt with.

Undergraduate students, in their seventh semester at Berhampur Medical College, are a little unsure about what they are in for when they gather for their first class on gender in health. Their teacher explains to them, clearly and succinctly, how gender biases and attitudes affect women's health, and why sensitivity to gender issues is important in the practice of community health. As he explains with diagrams there is understanding and acceptance. The visiting gender focal person from the project then takes over and the classroom atmosphere of logic and deduction is overturned.

"Who eats last in your family?" She raps out, pointing to a student. As she repeats the question in different directions, the answer is always the same. As aspiring doctors, have they thought about the health status of women in their families? And what about women in poor families? In their villages, have they seen women struggling to bring up children and make ends meet while the man spends his leisure with friends, drinking and smoking? And when she asks for money, what does he say? Suddenly, it is not question time any more. It is time for play-acting. Switching to Oriya, she imitates the arrogant stride and boorish voice of the husband declaring that he is a man and so cannot be questioned. The students break into laughter and sit forward eagerly as she takes them through situations that are familiar to all of them, each one an example of gender discrimination, and gets them to think about what they had taken for granted earlier. *"Will your father get more dowry for you because he has made a doctor of you?"* she asks a boy and he nods, shamefaced. She turns to a girl: *"And your father? Will he still give dowry after spending so much on your medical education?"*

How can such basic questions be new to them, one wonders. But they are, especially to the boys. She has their total attention as she rapidly covers several related topics. They laugh at her play-acting, respond eagerly to her questions and sometimes argue with her. And on some faces one sees a dawning awareness which is particularly sharp when she talks of a woman's workload and asks each of them to remember what their mothers do, each day, from dawn to dusk.

The last question is one they ask of her: When will she come back and talk to them again?

The department was also involved in providing training in community health to several nursing institutions in Berhampur and gender sensitisation became a part of this training as well. Having made a beginning in Berhampur, DANLEP initiated vigorous advocacy for inclusion of gender in the SPM course throughout the state. During the phasing-out period, there were indications that this would be taken up in Orissa and inclusion of gender in the curriculum was also being discussed by the Medical Council of India as a result of advocacy from several persons and institutions.



Studying DANLEP gender IEC material during a workshop, Orissa.

In Partnership with Training Institutes

One of DANLEP's earliest and most enduring partners in Orissa was the state IEC cell in Bhubaneswar, which was later upgraded to the State Institute of Health and Family Welfare (SIH&FW). The organisation's progress from an IEC cell to a state institute – to which level it was upgraded in 1994 – was largely the result of this partnership, which enabled its rapid growth through material aid and other facilitation.

The project introduced the IEC cell to new approaches in IEC and training. Strong bonds of cooperation and trust were already established when

People in the health services now recognise the need for gender training. But we need to work out some effective form of monitoring and evaluation. Group response to training is good, but are there changes in attitude? Even those who teach gender equity do not practise it in their personal lives. The real test lies there.

Dr B.C. Das, Director, SIH&FW

DANLEP raised gender issues with the Institute. The response was positive and, with the DANLEP gender focal person as facilitator, senior officials and persons in authority in the health system received gender training first. This was well-received and paved the way for acceptance of gender training for other health staff. The Institute had its master trainers undergo TOT in gender with DANLEP facilitation. It also worked with the project on production of IEC and training materials related to gender. Beginning with leprosy and then going on to reproductive and child health (RCH) and from there to other areas of health, the State Institute introduced a gender component into all its training programmes. The Institute's major gender training programme is in RCH, addressing three aspects. The first is TOT for district and block level officers, including MOs. The other two, for MOs, comprise integrated skill development and special skill development training.

It is unique to Orissa that IEC and training are integrated in the same Institute. Because of this, and because the gender focal person in DANLEP was also involved in both IEC and training, the two areas of action were

In Orissa, there is a very strong bias against girl children. In most families, the annaprasanna ceremony (first rice meal) when the child is ten months old is conducted only for boys. In the late Eighties, we made a film entitled "Let it be boy or girl" with nursing students. We were not aware then of the word 'gender' and what it stood for. Now we use it all the time.

In our society there is need for a lot of work to promote gender equity. We are making some progress, at least among health personnel. Earlier, medical officers were sceptical. Now they want material on gender and health. Most MOs now appreciate female health workers and treat them with respect.

Mr Parida, Consultant & former Deputy Director, SIH&FW, Bhubaneswar

coordinated and, when gender issues were raised, they were incorporated in both.

Apart from trainers at the Institute and in DANLEP, a group of state level trainers were identified for capacity building in gender training, so that they could in turn disseminate gender training at district and block level. This has been implemented in the two districts of Jharsuguda and Sambalpur.

In Sambalpur, the faculty of the Regional Family Welfare Training Centre had already become interested in gender issues because they had come across literature on the subject. When some of them attended a gender workshop facilitated by DANLEP in 1997, the experience helped them decide how to proceed and they included gender in all their programmes, for both basic and in-service training. Thus health staff at all levels received gender sensitisation, as did members of *panchayati raj* institutions. The institute maintained close ties with DANLEP and tried to get the DANLEP gender focal person to conduct their training of trainers as often as possible.

Extending the Network

The Utkal University Women's Studies Department in Bhubaneswar came into contact with DANLEP's gender focal person in the course of an evaluation study of an Integrated Child Development Services (ICDS) health training programme in 1996. Since then, there was much cooperation in gender activity, including training of staff and students. DANLEP provided facilitation in gender training for the University's National Social Service Scheme on a continuing basis.

Gender was a small little word when we started. She (the DANLEP gender focal person) was the first to speak out about it in public in Orissa.

Dr Asha Hans, HOD, Women's Studies, Utkal University, Bhubaneswar

The Xavier Institute of Management, which works with women's self-help groups through rural development projects, included a gender component in all its training programmes for all groups. For these, the DANLEP gender focal person was frequently the resource person. In training programmes on leprosy and TB, facilitated by DANLEP and DANTB for mixed groups of

anganwadi workers, NGO and *panchayat* members and community leaders, gender sensitisation was a component. Many NGOs working to empower women were strengthened by the gender training received through DANLEP. A typical pattern of contact would be that a woman's group member or leader would be a participant in a gender training programme where DANLEP provided the resource person. The latter would then be invited to initiate such training for the whole group. Later, group members would participate in leprosy and tuberculosis related activities followed by involvement in other health programmes.

Women in such groups were usually involved in several projects related to development. For example, in Angul district, 90% of community participation in the project for joint forest management in watershed areas comes from women. This kind of interlinking made for an extended network in the area. Invariably, the local *anganwadi* worker and woman *panchayat* member also belonged to such a group or worked closely with it. This carried the information about gender sensitisation further and often brought in more requests for training. In a programme specifically aimed at *panchayat* members, gender sensitisation for these elected representatives, both male and female, has been conducted in several blocks. The thrust of this training has been to make them understand how gender discrimination affects women's health and what they can do about it at the local level. Agencies which work in tribal areas have been contacted to further extend the scope of gender-related activity.

The *Nari Suraksha Samiti* is a federation of a 100 women's groups, each with a membership of about 20, spread over four blocks of Angul district. Formed in 1994, the group invited the DANLEP gender focal person to conduct a workshop on gender for members in 1997. Regular contact has been maintained since then. Many members have received training in leprosy and TB and participated in case-detection. The project has facilitated workshops for the *Samiti* on awareness and capacity building and gender inequality in health. There has been training in street theatre and gender has become a component in all its programmes. Groups from the *Samiti* have been involved in many activities related to women's empowerment. Their anti-liquor mass movement has had a major impact in the district. Through family counselling, a considerable reduction in domestic violence and the use of bad language by men has been achieved in their area.

Formation of self-help groups for income-earning activities is facilitated by the *Samiti*. Many members are active stakeholders in the watershed and social forestry programme. Nine of the *Samiti's* volunteers are elected *panchayati raj* members who try to spread awareness of gender issues among fellow members. A close relationship is maintained with *anganwadi* workers in the area.

The ICDS is part of this network, with *anganwadi* workers participating in gender training programmes and workshops in their areas. In most villages, the *anganwadi* worker is an important link in the development network. Usually referred to as *didi* (sister), she not only runs the *balwadi* (crèche), but is also involved in providing nutrition supplements for expectant and feeding mothers. She may be a provider of Directly Observed Treatment (DOT) in the TB programme, as well as drawn into other health and development programmes, and she is friend and counsellor to many families. As one of the few literate women in her area, she is also an active member of or adviser to women's groups.

Working with other Danida-Supported Institutions

DANTB, Danida Assistance to the Revised National Tuberculosis Control Programme (RNTCP) in Orissa, began in 1996 with the first phase being completed in 2003. DANLEP and DANTB shared office premises and facilities; the two organisations also had the same person as Associate State Coordinator handling IEC, training and gender issues. Inevitably, activities overlapped and influenced each other. In 2001-2002, RNTCP and DANTB conducted a study on the relative effectiveness of two different gender training strategies in terms of case-detection and cost. Over a specific period, health workers in one district were given training in gender sensitisation. In another district, both health workers and DOT providers were trained. A third district with no intervention acted as the control district. Findings on case-detection, especially hidden cases among women, showed that the greater the gender training input, the better the result in case-detection and in participation of women in the disease elimination programme. The increase in cost was small.³

³ *Effectiveness of Two Gender Sensitisation Strategies in RNTCP: A Comparative Study in Orissa*, IIMR, Jaipur & DANTB, 2002

In DANTB, gender inputs have been included in TOT and training of both medical officers and DOT providers. The training covers essential concepts such as the difference between sex and gender, social practices which obstruct diagnosis and treatment of female patients, and the kinds of interaction needed between health staff and the community.

We try to sensitise medical officers to the gender basis of infant mortality and maternal mortality rates. We have role plays illustrating male medical officers being dismissive with female patients. We train them in counselling family members so that they are able to say to husbands of female patients, 'Be a little sensitive; think a little.' That is what we try to put across.

Dr Meena, RNTCP

The Danida Assisted to Training and Extension for Women in Agriculture (DANTEWA) had been working for women's development and empowerment since its inception in 1987. In 1999, twenty master trainers from TEWA (ten women and ten men) were trained in gender sensitisation and this training was passed on downwards through district and block level trainers to field officers. The DANLEP gender focal person was actively involved in this training as one of the chief resource persons.

Gender in IEC

A major strength of the project in Orissa, from the beginning, was IEC. Throughout the project period, participation of women in case-detection and IEC for campaigns was an important thrust area. In SAPELs and MLECs, conscious efforts were made to include women in search teams for case-detection. This helped to substantially increase the number of leprosy-affected women detected during these campaigns. This approach was replicated in the urban strategy, to reach hitherto unreached pockets in urban slums, which was formulated and initiated during the project's phasing-out period. DANLEP provided gender sensitisation for officials who selected search team members to ensure that 50% of them would be women. In MLEC IV, too, there was a large presence of women among volunteers. With the introduction of a wider approach to gender, IEC methods and materials were produced and tested to meet new needs.

Training and IEC Materials

The SIH&FW and DANLEP have together produced a revised version of the curriculum for nurses' training, which is expected to be adopted throughout the state. Meanwhile, other material for gender training have also been produced. At workshops held in Konark and Bhubaneswar in 2001, teachers, administrators and nurses got together to develop a series of lesson plans on gender to be incorporated in nursing course manuals as reference material. Material is being produced to facilitate principals of all 21 training centres in the state to integrate gender in all their courses.

Among other initiatives undertaken in collaboration with the SIH&FW are production of an Oriya book on gender training and a training module and guide for training of peripheral health workers. A gender component has been included in the RNTCP training module. "Where Women Have No Doctor," has been translated into Oriya and distributed widely.⁴ The translation includes new chapters on leprosy and malaria.

Tribal women who had been exposed to gender sensitisation developed a series of pictures which depicted gender disparities existing in their society. The project put these together to be printed as a pictorial booklet in 2001.

At every workshop and discussion on gender, participants are encouraged to coin new slogans and couplets and many of these are included in IEC material, both orally, and on banners and posters.

In consultation with DANLEP Tamil Nadu, the project in Orissa has developed a gender kit that contains training and IEC material. Among these are posters emphasising gender issues in health, a pictorial flip book illustrating basic gender concepts, a quiz, a game of snakes and ladders based on adversities faced by women, and a set of reference materials for gender training. In addition, DANLEP Orissa has developed a gender logo combining a male and a female face, which identifies all training and IEC material related to gender. Recognition and use of the logo is increasing in the state.

⁴ *Where Women Have No Doctor*. Revised Ed. VHAI Press, New Delhi, 2001