

5. Summing Up

“Gender” in relation to health covers a wide range of perceptions and activities. Women’s participation, empowerment, gender sensitisation and gender training all refer to very specific and separate aspects of related processes; but they are also, sometimes, used loosely and interchangeably.

Content of Gender Training

Gender training aims to sensitise participants to personal and socio-economic factors which place women at a disadvantage in every aspect of their lives. The content of gender training facilitated by the DANLEP project in the states of Chhattisgarh, Orissa and Tamil Nadu – and for a short period in Madhya Pradesh – highlights major factors and beliefs which contribute to gender bias and injustice, such as those listed below.

The difference between sex and gender: Sex is biological and fixed while gender is a social construct that interprets sex in terms of gender roles within and outside the family, in relation to work, childrearing and many other aspects of life. The social construct of gender can be altered. Trainers illustrate this with a short lesson in anatomical differences and then go on to explain how external attributes like hairstyle, clothes and assigned occupations place men and women in different positions and how this is mistaken for unchangeable characteristics.

Biological determination of the child’s sex at conception: How do trainers explain X and Y chromosomes to an illiterate audience? In Tamil Nadu, it is done with lemons and tomatoes; in Orissa, they are called the cross and the half cross and writ large on flip charts. Either way, it is the skill of the trainer that brings about understanding. And when understanding does come, there is relief and joy among women who have suffered blame for bearing girl children. “*I shall tell my husband it is his fault!*” says a trainee. And that is followed by another lesson, that there is no ‘fault’, since the man has no control over the process either.

Easier lessons follow which all women can relate to their own experiences. The most striking is the comparison between a man's and a woman's workload. Participants make two lists, one of what a man does from waking up to going to bed every day, and the other, a comparable list for a woman. There is nothing that they do not already know in the lists, but it astonishes them because they had not realised the extent of the difference, and of the injustice in such difference. This is followed by the question of income-earning capacity, control over choice of work and over income and the right to education and decision-making in matters related to the family.

Gender in health takes up a major part of the training programme. Nutrition needs, often unmet, of girls in childhood and adolescence, and of pregnant and nursing mothers are neglected because it is more important to feed man-the-provider and because women are brought up in a tradition of self-sacrifice. The same applies to medical treatment, where there are further difficulties caused by problems of access, of cost and of indifference of medical service providers. Questions like "Who eats last in a family?", "Why does an ill woman not go to hospital?" also set participants thinking. They come up with several answers, all of them true and all contributing to the realisation of the existing neglect of women's health.

Finally, there is a session on leprosy awareness, which continues to be part of the gender training programmes in Orissa and Chhattisgarh where the disease is still one to be contended with. In Orissa, because of the involvement of DANTB, this is sometimes a session on gender in relation to TB, also a stigmatised disease. In Tamil Nadu, awareness about leprosy is not included in gender training. This is partly because the gender training programmes undertaken in the state were for specific objectives and in response to the needs of particular institutions; it is also because integration was implemented first in this state and followed by a large-scale programme of training in leprosy for health and *anganwadi* staff which made it redundant in the gender training programmes that followed soon after.

Over the 18 years of the project period, DANLEP moved from promotion of women's participation in leprosy elimination activities to gender training of women and men from a wide range of backgrounds. The extent of its involvement and of its success has varied between the four states in which the project has had a presence.

Common Threads and Different Weaves

What is common to the project's gender activities in all four states is the sensitivity and commitment to gender equity of project staff. In all four (earlier, three) states, there was a common beginning in the promotion of women's participation, particularly in training for case detection among women. Also in common was concern for the ways in which the stigma of leprosy affected women, as well as the attempts to fight stigma. Madhya Pradesh stayed with this model of women in leprosy and proceeded a little further into the women in health model after a few forays into training in gender sensitisation using theoretical gender concepts. The project's partnership in this area, as in others, remained largely with the community, with no involvement of government departments or institutions except for limited cooperation with some training institutes. The two factors which determined the extent of gender-related activity in Madhya Pradesh were the government's lack of interest and the perception of the state DANLEP team and NLEP staff that theoretical gender training was not a priority for the project. Gender workshops were considered useful only in so far as they contributed to the leprosy project in terms of improving case detection among women. Another factor that was probably important, though not vocalised by the project team, was that DANLEP Madhya Pradesh did not have as gender focal person a woman with the drive and commitment shown by the two in Orissa and Tamil Nadu.

Chhattisgarh, Orissa and Tamil Nadu moved from WID to gender, the former after its formation and the other two, from the mid-Nineties. In content, range and types of participants there were many similarities and a few differences between these states. In all three, participants included trainers from training institutes and other staff from the health system, SHG and *panchayat* members and *anganwadi* and health workers. In addition, each state had its own special constituency among participants in gender training. In Chhattisgarh, these were *mithanin*; also, from the beginning of gender training, Chhattisgarh did not at any time hold training programmes only for women as the other two states did on occasion. Orissa provided strong inputs in gender training to medical and nursing faculty and students, a special feature in the state arising from the background of the gender focal person and her strong ties with these professions. Certain groups of students

in Utkal University, Bhubaneswar were also exposed to gender training. In Tamil Nadu, the literacy movement, the State Resource Centre and the Adolescent Task Force all brought different groups into the ambit of TOT in gender sensitisation by the DANLEP gender focal person.

In terms of partnerships, particularly for the development of other trainers in anticipation of the project's phasing out, Chhattisgarh relied completely on the ZSS. In Orissa, the presence of another Danish aid project, DANTB, and the DANLEP gender focal person's involvement in that project, ensured that DANLEP and DANTB mostly acted in coordination. In addition, the state and regional training institutes, certain medical and nursing faculty members and the Women's Studies Department of Utkal University provided partnerships. In Tamil Nadu, the project's partners in gender training came from within the system and were all institutional: the health department, regional training institutes, the ICDS, the SRC and its Adolescent Task Force and the department of continuing education.

Anticipating Phasing-Out

Whether there will be a taking over by other groups and institutions of DANLEP's inputs in the area of gender sensitisation remains to be seen. Its funding and ready provision of other material support will no doubt be missed until replaced by other sources. What the project has done is to nurture expertise in training among several partners and so equip them with the means to continue the process, if there is commitment to do so from decision-makers.

In Orissa, DANTB has been a partner in all DANLEP's gender initiatives and the continuation of the gender focal person with DANTB ensures that the pace and intensity of gender activity will be maintained. Tamil Nadu, as always, worked within the institutional framework in gender-related activities. The project has provided TOT to the state and regional training institutes, to district training teams, to the State Resource Centre, to the general health system and the ICDS. Continuation of gender activity by these institutions after DANLEP's phasing out depends on their commitment and the resources available to them.



Mothers waiting for a check-up in a PHC, Tamil Nadu.

Contributions

It would be difficult to measure the contribution of the DANLEP project – or of any other agency – to the struggle for gender equity in quantitative terms. “Building Alliances for Empowerment”, which is a documentation of DANLEP’s gender-related activities up to 1998, provides a list of possible indicators for quantitative measurement of progress. These are broadly categorised as indicators related to process or inputs, those related to outputs and still others related to participation and empowerment.

Without cooperation, primarily from government departments, and also from various other agencies, collection and analysis of data required under these indicators would not be possible and no concerted effort to this end has yet been made. Commenting on gender indicators in 2000, the DANLEP representative on Danida’s Gender Core Team pointed out that projects could collect information on many indicators, but the prospect of incorporating them into the government reporting system is bleak. Late in Phase III, the project succeeded in having the NLEP provide gender-disaggregated data in leprosy.

It is encouraging that state health departments, training and other institutions have responded to advocacy for gender sensitisation and have incorporated gender training in their programme. Whether the attention and resources given to it in each state are enough is open to question. But several beginnings have been made as, for example, with medical and nursing curricula in Orissa. Many individuals have been enthused, converted, made to think and, sometimes, to act because of gender training facilitated by DANLEP. Men of sense and sensitivity have responded positively and women have been given courage to try to change their lives.

My wife and I both work but I did not think much about power relations or decision-making in the family until I was given gender training and then involved in organising training programmes which I also attended repeatedly. Then I began telling my wife about them and told her that she was earning a good income too and should assert herself, should use her own judgement and not wait for me to make the decision in every matter. We had invested a large amount from her income in some bonds and when I was away the agent came to tell her that it would mature in a few weeks and advised that she should renew it. She was convinced and signed for renewal. When she told me, I burst out, "What was the hurry to decide without waiting to ask me?" She became nervous at my anger and as I continued to scold she began to apologise. Suddenly, I realised what I was doing, that I was questioning her right to make a decision. But I was not able to admit my fault and apologise. Instead, I shouted at her for being a doormat and not standing up to me to defend her decision. She got thoroughly confused, shut herself up and wept. Several months later, she made a financial decision on her own, again, and I asked mildly why she could not have waited till we discussed it. She told me she thought it was time she took my advice!

Programme Officer, DANLEP, Orissa

For all that, it should be borne in mind that gender bias is deep-rooted in society and that change comes slowly, if at all, in such matters. In Tamil Nadu, during conversation with senior trainers who had undergone TOT in gender and themselves trained several batches of trainees, a woman trainer several times made hostile remarks about men in general; later, a male trainer burst into a diatribe about "women's liberation types who were out to grab power" – a sad commentary on the understanding and sensitivity of those who were training others.

The former Monitoring Coordinator of the Danida Health Care Project pointed out that, despite the enthusiasm of the Tamil Nadu health department for gender training, deep-rooted gender bias was reflected in the health administration's male-female distribution in terms of job profiles, roles, responsibilities and career opportunities. For example, taking the opportunities for promotion of a VHN (female) as compared to a HI (male), both of whom were supposedly of equal grade and rank, the latter can, on the basis of seniority only, move up to PA to the Deputy Director, Health,

which is a district level post. The VHN has to move up through three levels, qualifying through an examination for each level, before attaining an equivalent post.

In our work, there are no frustrations – only constraints. Where there's a problem, there's a solution to be found.

D.N. Sharma, Chief Director, ZSS, Durg

There is a long way to go for gender equity. The DANLEP contribution is the equivalent of a few steps forward. Unlike leprosy elimination in terms of prevalence rates, there can be no set targets in this. But in this, as in other aspects of people's daily lives and health, the project has touched the hearts and minds of many persons and helped set processes in motion that others will take further.