REPORT ON

POPULATION ISSUES AND WOMEN'S HEALTH
A NEW APPROACH

Population Issues and Women's Health: A New Approach

Report of the Health Watch Karnataka-Andhra Pradesh regional workshop

June 28 -29, 1996

Organized by VOICES, Bangalore & the Indian Institute of Health and Family Welfare, Hyderabad

Prepared by Suneeta Krishnan for Health Watch

Summary

This report describes the proceedings of the Andhra Pradesh-Karnataka workshop held at the Indian Institute of Health and Family Welfare, Hyderabad between June 28 and 29, 1996, the first in a series of regional workshops being organized by Health Watch to generate discussion on the Government of India's new health and family welfare program. The primary aim of the workshop was to examine and document NGO experiences in women's health in order to draw relevant lessons for the delivery of government health services. Participants included NGO representatives, government officials, and academics.

During the presentations and discussion, a number of key themes emerged. First, there was overwhelming agreement regarding the importance of the involvement of women's groups in the planning, implementation, monitoring, and evaluation of the new health and family welfare program. NGO experiences indicate that women's groups can play a critical role in ensuring the delivery of high quality services. However, careful attention must be paid to issues such as how these groups are formed; who will be responsible for their formation; and the groups' rights and responsibilities. Drawing upon the experiences of NGOs and the Government of Andhra Pradesh (which is conducting pilot projects of the new health and family welfare approach), strategies to form and activate women's groups, and to involve women's groups in the process of planning, implementation and evaluation were outlined. The need for documentation of these experiences was stressed. Second, participants emphasized the need to disseminate information on the new health and family welfare approach to all levels of the government and to the public. Channels of communication must be established, and should include mechanisms by which the perceptions of communities and government health functionaries will be recorded and taken into account. Third, the importance of formulating systematic implementation guidelines, and testing these guidelines through pilot projects during a defined time period was stressed. Evaluation and process documentation of these pilot projects are vital and can play a crucial role in tailoring programmes to local needs. Finally, it is hoped that the process of planning and implementation of the target-free approach will be open and responsive to feedback from advocates of women's health like the Health Watch.

Introduction

The International Conference on Population and Development (ICPD) marked a significant shift in the Government of India's (GOI) conceptualization of population issues and policies. GOI's official position paper at Cairo revealed a shift from a population control strategy to a more holistic, quality-driven reproductive health approach. As a first step in this direction, it decided to remove method-specific targets in its family planning programme in select districts across the country. Subsequently, it decided to eliminate targets completely on April 1, 1996. During the early months of 1996, GOI convened a task force to develop alternative performance indicators (in place of targets), and began developing a comprehensive health program in the spirit of the reproductive health approach (the Reproductive and Child Health programme).

In order to generate public discussion on the new health and family welfare program, GOI invited Health Watch to organize a series of regional workshops. Health Watch, an informal network of researchers, non-governmental organizations (NGOs), and policy analysts interested in health who came together during the pre-Cairo period, was formally launched in December 1994. *Its primary objective is to be an advocate for women's health, specifically, to try to ensure that government programmes are responsive to women's health needs and are accountable to women.* Health Watch has interfaced with GOI on the issue of the new reproductive health programme as a way of achieving its larger objective.

Focus of the regional workshops

Health Watch will be organizing eight regional workshops during the latter half of 1996; the Karnataka-Andhra Pradesh meeting is the first in this series. The focus of these workshops is as follows:

1. to examine & document NGO experiences in women's health in order to draw *relevant* lessons for the delivery of government health services; experiences on involving women in planning, implementing and monitoring programmes will be highlighted;
2. to study the ground-level implications of the "Target-free Approach" (TF) and the Reproductive and Child Health (RCH) programme from women's perspectives;
3. to examine & evaluate the new performance indicators developed by GOI, particularly those in the Manual on the Target-free Approach;
4. to develop a concrete response to the challenges, strengths and limitations posed by GOI's shift in population policy and health care delivery, particularly with regard to the process of planning, implementation, monitoring and ensuring accountability;
5. to expand & strengthen the Health Watch network, and formulate region-specific plans of action for advocacy at the state level.

Making the transition from target-centered to target-free programmes: experiences of Andhra Pradesh

Based on inaugural address by Ms. Rachel Chatterjee
Secretary, Health and Family Welfare, Andhra Pradesh

Introduction

Ms. Chatterjee's inaugural address focused on AP's experiences in implementing the Target-Free and RCH programmes. Her introductory remarks highlighted India's pioneering efforts in family planning (FP). India took the lead at the first International Population Conference in advocating an integrated approach to FP, one which involved a broad range of contraceptive methods, and was based on community participation. India had also linked FP to broader issues of poverty and gender discrimination. Thus, placing individuals at the center of FP activities, as was stressed at the Cairo conference, was consistent with GOI's efforts. Since the ICPD, there has been a marked shift in focus from FP to reproductive health; FP is now viewed as one intervention among many others through which women can fulfill their reproductive rights. The key policy implication of this shift is that programmes which were once based on demographic targets will now be based on clients' needs and desires. However, this does not imply that slowing population growth has ceased to be a goal; rather, it implies that the design and management of FP programmes will now be oriented towards satisfying clients.

According to Ms. Chatterjee, the TF/RCH Approach has four primary characteristics:

- it is client centered & moves away from targets;
- it expands choice by broadening the range of safe methods of contraception provided, and by introducing reproductive health services;
- it emphasizes quality of services and management of programmes;
- it builds partnerships with the community.

She went on to outline AP's experiences in implementing the above.

Need for a formal system of implementation and monitoring

The testing of TF in Tamil Nadu and Kerala revealed that eliminating targets does not compromise the goals of the FP programme. In fact, it has been observed that if the need for fertility control is met adequately, demand for such services increases. In Andhra Pradesh (AP), the National Family Health Survey indicated that there is considerable unmet need for fertility control. AP decided to initiate TF one year prior to its official launching in April 1996. A State FP Action Programme was formed, but its track record indicates that when a new approach is implemented in the field, a critical prerequisite is the presence of a formal implementation system which includes dissemination of the philosophy of the programme, training, advocacy for providers, and alternative performance indicators. In the absence of a formal system, it will revert either to the old "number-oriented" system or to a "work-free" system.

AP has attempted to develop a formal implementation system. A workshop attended by all health and family welfare functionaries was organized to outline an action plan and to discuss performance indicators. A second workshop was conducted to discuss objective methods of programme evaluation. These indicators and methods are currently being field-tested.

Need for broadening the range of services

In AP, 95% of contraceptive services provided are sterilizations; 95% of these are for women. The need for birth spacing methods is critical. Temporary methods such as hormonal contraceptives (implants), though controversial due to the potential for abuse and questionable safety when follow-up is inadequate, must be further investigated. AP is planning to introduce reproductive health services at the primary health center (PHC) and sub-centre levels.

Need for improving quality of services

A core issue facing TF/RCH programmes is the need to improve skills, knowledge, aptitude, and motivation levels of providers. If the quality of RCH services are improved, need for these services will decline (due to decreased morbidity); if quality of FP counseling improves, the demand for FP will increase. Thus, accountability of government health functionaries and programmes to clients is central. In AP, training programmes are underway for health providers, which include a module on attitudes and behaviour, and a module on RCH (including counseling, diagnostic and treatment skills).

Need for building partnerships with the community

Involvement of the community in planning, implementation, monitoring and evaluation is essential. The 73rd Amendment to the Constitution made this programme a people's programme. FP and RCH are linked to deep cultural and social issues, and are dependent upon community demand; in order to be successful, they must involve people.

Need to involve women

There is currently an enormous opportunity to involve women since they comprise a third of elected members of panchayats. AP has also witnessed strong women's movements. The government is building on these strengths to highlight the responsibility and authority of women, and to motivate women to take ownership of health programmes. Women's groups are the focal point of delivery of RCH, and women's leadership can be crucial in ensuring the delivery of quality services. A module for DWCRA groups has been developed to encourage them to be leaders in this social programme.

Involving women's groups in ensuring the accountability of field health workers such as auxiliary nurse midwives (ANMs) is currently being tested in two districts in AP over a one year period. At baseline, neither of the two pilot project areas had strong, functioning women's groups; the pilot projects had to develop them. In each village, women's groups will record ANMs' visits, and review them in monthly meetings. Based on this, they will decide the ANM's salary. In an ideal situation, health workers' salaries would be given by village groups/committees. However, this would depend on the existence of a sound partnership between the government and local groups.

Women's groups will also be trained to ensure that local health services meet women's needs. They will:

- maintain a register of services provided by ANMs and other health personnel;
- inform the District Medical Officer of problems;

- visit and observe the activities of Anganwadi workers and dais, and fill checklists once in six months;
- function as partners with government village workers such as ANMs and Anganwadi teachers;
- administer village referral funds for emergencies; the AP State government has sanctioned, on a pilot basis, a sum of Rs.5000 per village to be administered by village groups.

Problems with implementation

The AP pilot projects have just begun. Thus, results are not as yet available. However, one problem has been encountered thus far. It is clear that if women's groups are motivated, they can ensure accountability of government health services. The key question is how can women's groups be motivated? NGOs have to facilitate this process. In the Shamirpet pilot project, it was found that women's groups could not function on their own; a local NGO has been providing them training on managing their activities.

A key part of the pilot study experience is the documentation of the process and outcome of the projects. In order to guide the implementation of the TF/RCH programme in AP as well as in other parts of the country, process documentation and dissemination are critical.

Session I

New directions in Family Welfare

Presentation I: Women advocating change: lessons from experience[1]

Based on presentation by Vimala Ramachandran
Health Watch

Although GOI statements outside the country since the 1950s have been radical, there has been a significant gap between policy statements and ground level reality. The most visible gap has been in the family welfare sector: despite radical policy statements on the link between population and development, the FP programme in India has been anti-people. There have been many attempts to bridge the gap between policy and implementation. Efforts to make government programmes more sensitive to people's needs have been made by pressure groups such as women's organizations. There have been two kinds of experiences:

- the Development of Women and Children in Rural Areas (DWCRA) & Integrated Child Development Services (ICDS) experiences in which the programmes were conceptualized by individuals who were not involved in implementation;
- the Women's Development Programme (WDP), Rajasthan & Mahila Samakhya (MS) experiences in which the same actors were involved in the conceptualization and implementation of programmes.

In the latter case, there has been an emphasis on an organic link between those who develop and those who implement programmes.

Health Watch's activities are based on an understanding of the need for an organic link between the multiple stages of policy planning and implementation. In the context of GOI's TF/RCH programme, there are three potential functions that Health Watch can perform:

First, Health Watch may function as a sounding board for the government on the implementation of the TF approach. However, GOI will ultimately decide whether to incorporate or ignore its comments and recommendations. There have been primarily two reactions to this scenario. Some dismiss such efforts as being fruitless; others see this as an opportunity to keep informed about and to inform the process of implementation. Members of Health Watch subscribe to the latter view point. Health Watch workshops are intended to keep a dialogue open with the government; to keep pressure on the government to be cognizant of and responsive to women's needs; to communicate with those in the government, the medical establishment, and donor agencies who are also concerned with women's health.

Second, Health Watch may use the opportunity afforded by the RCH programme which has been introduced in select districts to promote a woman-centered focus in existing health services. There is a shortage of individuals to help the government design this programme at the district level which the government is aware of and wanting to address. However, as in the past, participation in the design stage may not be linked to participation in implementation.

Third, Health Watch may perform an advocacy role. Many politicians, and members of the media and the general public have not thought deeply about population issues; many advocate

---

[1] See also paper in Appendix.

FP and target-oriented programmes. There is considerable propaganda about the "population explosion" and its implications for development. Therefore, the overall mind-set must be changed. "Women advocating change" implies strategic planing: there is a need for radical protest as well as dialogue with representatives of the status quo. Individual women and women's groups need to realize their strategic roles in this spectrum of activities. Neither ends of the spectrum will be able to accomplish change on their own.

Presentation II: The "target-free" approach: potential and challenges

Dr. M. Prakashamma
IIHFW

Dr. Prakashamma's presentation discussed the potentials and challenges of the TF approach from several perspectives. She noted that, while the process of change in FP and health is a welcome one, it should not result in complacency given the long history of nomenclatural changes in government programmes without accompanying changes in the field. However, the current change has opened up a range of potentials and challenges for health personnel, women, NGOs and the government.

The position and role of health workers

Dr. Prakashamma highlighted the enormous unused potential of grassroots health workers in India. She lamented the transformation of the auxiliary nurse-midwife (ANM) from "one among women" in the 1950s to an "insipid character who can talk only about cases" in the 1990s. The "case" (a potential candidate for family planning) has come to dominate their thoughts, stories and dreams. *The challenge facing the ANM today is the transformation of this mind-set from a case-centered to a holistic, gender-sensitive, and quality-oriented one*. She must become an advocate for women and children. *The ANM's strength and potential is that she is a woman of the village*, she can identify with other women.

The IIHFW has been attempting to change ANMs' mind-sets from a case chaser to a counselor. However, there has been little time. The TF programme began on April 1, 1996; the past three months have been characterized by utter confusion for ANMs. Many are unaware of the changes that have and are happening. In one of AP's pilot projects, IIHFW staff spoke with village leaders and health workers about how the process of alienation experienced by ANMs can be reversed. Many health workers were pessimistic. One said:

"Our history is in their hands. All will collapse."

Many felt that the new programme was placing a great deal of responsibility on grassroots health workers, responsibility that no one else is willing to shoulder. Furthermore, attention has primarily focused on women health workers. The role of male workers is unclear. *Will the new programme further alienate male health workers?* Clearly, the role and accountability of all grassroots health workers need to be considered.

The role of women

Past experience indicates that merely renaming programmes as "target-free" and RCH will not impact women. The challenges facing women (and women's health activists) include:

- *recovering women's knowledge about women's health*. Many potentially beneficial traditional practices have been replaced by the biomedical system. Women's health centres need to be established to document women's knowledge and practices.
- *understanding women's health*. There has been extremely little research on women's health other than those aspects related to fertility and contraception.

The role of NGOs

Many NGOs have moved away from mainstream family welfare activities. Given the current changes in the government's approach, the potential and challenge facing them is whether they will be willing to contribute to the process of change.

The role of the government

The challenge facing the government is the realization and acceptance of the problems facing the current health and family welfare approach as well as the translation of these into appropriate action. The government needs to ensure that all its functionaries understand the philosophy of the new programme. An additional critical issue facing the government is the development of new quality and performance indicators.

Presentation III: Elements of a woman-sensitive and holistic health care system

Dr. S. P. Tekur
Community Health Cell, Bangalore

Dr. Tekur's presentation highlighted the elements underlying a "woman-sensitive" and "holistic" health care system. Holism, according to him, does not just comprise of a series of components (such as maternal and child health + child survival and safe motherhood + . . .); does not solely entail looking at an issue from a number of angles; is not just being open, unbiased, and pragmatic. Rather, *holism involves having a broad understanding of poverty, disadvantage, and well-being*.

Developing a woman-sensitive health care system does not have to be justified on philosophical, scientific or political grounds. *Being woman-sensitive is being practical*. Women have been neglected. The value systems they represent are eroding, and the health-carer in every family is being handicapped.

Women's health status is determined by a number of complex, intertwined factors: biological, social, economic, and cultural. It is known that women have better survival at birth, and have fewer manifestations of stress-related diseases. However, during their reproductive years, women suffer from anaemia, protein-energy malnutrition, damages to the reproductive tract, and depression. They are at higher risk per exposure to STDs such as HIV and HPV (which is a putative cause of cervical cancer. After menopause, women have higher morbidity due to stress than men of the same age. However, more data are required to truly understand women's health status. There have been few studies which have focused on women other than as mothers.

Women face social, economic and cultural disadvantages which also adversely affect their health. They get lower wages; are forced to do arduous work; have multiple roles and responsibilities; and face hazardous working conditions within the home and without.

Furthermore, many do not have control over decision-making (regarding education, marriage, children . . .). Many women are exposed to abuse and discrimination. Health care services are provided within the same ethos.

Functionaries of the government health care system may feel that they cannot tackle such a broad range of issues, and that tackling these issues is not their responsibility. However, if the government health system takes a life cycle approach, it has the potential to make a difference. Issues that need to be addressed include those during:

- infancy & childhood such as sex selection & discriminatory child care;
- adolescence such as family life education; prevention of early marriage, child bearing & discriminatory child care; prevention & treatment of anaemia & malnutrition;
- reproductive years such as address issues indicated above; focus on pregnancy-related & gynaecological problems;
- post-reproductive years such as address all health problems on top priority basis, particularly, malnutrition, osteoporosis, osteoarthritis, central vascular and central nervous diseases and gynaecological cancers.

Additional issues that the health care system can address are:

- gender-based violence during all phases of the life cycle;
- depression;
- disability;
- lack of decision-making power;
- hazards of work at home, in occupational settings, and in the environment.

Women can provide clues as to how these issues may be tackled. They have stressed the need for *education:* education of policy-makers, service providers, men and other women. There is a need for investment in women's education, specifically health education. Women's access to health services needs to be improved, and their needs must be addressed. Thus, provider competence, informed choice, continuity of care, and privacy must be ensured. During the entire process of building a holistic, woman-centered health care system, women must be consulted. Moreover, all members of the community need to be involved in this process in order to establish credence to women's needs.

Discussion Notes

Session I

Discussion at the close of the first session entitled, "New directions in family welfare," revealed a broad consensus on the importance of the involvement of women's groups in planning, implementation, monitoring, and evaluation of the TF/RCH programme, and the need for information dissemination and process documentation.

A participant suggested the use of participatory rural appraisal (PRA) techniques at the panchayat level to help formulate the programme in partnership with local leaders. Others stressed that women's groups should be actively involved.

The need for dissemination of information regarding the new programme to bureaucrats, health workers, and the public was raised by a number of participants. It was suggested that the development of a mechanism for the transfer of such information should be top priority since not even all senior government officials appeared to be aware of the new TF/RCH programme. A participant from AP noted that official meetings were underway with government functionaries at many levels.

There was also some discussion of the definition of "quality service" or "quality approach" in the government's Manual on the Target Free Approach. Mechanisms that may be employed to ensure high quality services as outlined in the Manual were critically evaluated. Participants noted that clarifications were required in two cases. First, the Manual's mechanisms for improving quality of equipment and infrastructure was found to be weak as they consist of ascertaining whether facilities are available rather than their quality. In addition to identifying whether equipment and infrastructure are available, it is felt that their quality should also be evaluated. Secondly, the Manual suggests that quality will be improved through the involvement of the community. While participants commended the fact that community involvement has been explicitly recognized, they felt that the nature of this involvement must be specified in more detail. In addition, it was felt that women's groups could play a key role.

Additional points raised during discussion included the importance of advocacy at the level of donor agencies (in order to ensure the appropriate allocation and disbursement of donor agency funds, they need to understand the ground reality); and the issue of "State culpability" (the greatest changes are called for at the level of grassroots workers and voluntary organizations while individuals at the top of the governmental hierarchy remain untouched). A number of questions regarding the nature of the role of women's groups, NGOs, and the government were identified for further discussion in working groups (see reports below).

Session II

Making government services accountable to women: lessons from the field

Presentation I: Mahila Samakhya, Karnataka

Representatives of field organizations involved with women presented their work, and its relevance to the implementation of the target-free approach. Ms. Gouri from the *Mahila Samakhya* (MS) programme in Karnataka was the first speaker. MS is active in five districts (approximately 250 villages) in Karnataka, and focuses on increasing women's literacy levels. The programme emphasizes development, health, and political issues. They have nearly 6000 women members, most of whom belong to the backward castes.

In order to encourage women to participate in MS, a number of methods were used. Street plays were conducted; anganwadi workers were recruited to help launch the total literacy campaign. Needs assessments were conducted among women to identify issues of concern to them. By focusing on these issues, women would be encouraged to participate.

Village leaders were identified, and given leadership training. These leaders and local women were made aware of government schemes and facilities. For example, the local primary health centre in one area was charging for its services. Women were told that these services should be free, and consequently they demanded that no fees should be collected. Thus, MS groups have been able to demand accountability of government health services.

Discussion Notes

Discussion of the presentation highlighted the use of role plays and dramas as methods to encourage participation and to provide information on issues such as the advantages of a small family and contraceptive choice. Ms. Gouri noted that members of MS were actively involved in the provision of FP services by, for example, helping ANMs and dais counsel women about contraceptive choice. As a result of the MS programme, substantial improvements in the quality of services delivered by ANMs and PHC doctors have been observed. Noted Ms. Gouri, "Five years ago there were no doctors at the PHC; now, at least the doctors are present." In addition, there has been an improvement in the quality of communication between ANMs and women.

Presentation II: Deccan Development Society, Hyderabad

Ms. Rukmini Rao, in her introduction to the work of the DDS, noted that women fail to utilize government health services not because of lack of demand for services, but because of their poor quality. In fact, poor women spend a considerable amount of resources on good quality care. Ms. Rao described the range of activities that NGOs have been involved in to promote health and to ensure the accountability of government health services. They include:

- raising awareness regarding prevention and treatment of diseases
- supplementing government services
- providing low cost drugs
- demanding reproductive rights

- highlighting problems with the government health infrastructure in local areas, and agitating for change along with local women.

The DDS is active in 70 villages in Karnataka; its health programme focuses on reproductive health. DDS works with women's sanghas (groups) and trained dais. They identify local practices, and assess their effectiveness. The most effective methods are promoted. *DDS' experiences indicates that, for successful health care delivery, the most crucial components are a strong grassroots health worker and a well functioning referral system.* DDS has accomplished this by, first, establishing links between ANMs, dais, and women's sanghas (woman to woman links), and second, establishing links between communities, primary health centres, and hospitals. The former ensures first level preventive and curative care, and the latter ensures higher levels of care.

Discussion Notes

Discussion focused on the potential of women's groups in implementation and evaluation of government health programmes, and on the need for male accountability. Ms. Rao pointed out many village-level women's groups which are supposed to be functioning in fact are not doing so. DDS has been successful by training and bringing together DWCRA leaders.

Dr. Prakashamma also echoed the fact that many village-level women's groups are not functional. She noted that making these groups functional is a long process; it requires continuous interaction. The AP government's Shamirpet pilot project has been able to create a functional sangha. This has involved using existing groups and strengthening them (by first focusing on members' most immediate interests - be it health or otherwise); this appears to be the most efficient strategy. The Shamirpet women's groups are now assessing health services by using an assessment form prepared by the Institute for Health and Family Welfare; these forms are discussed at monthly group meetings.

One participant (Ms. Prabeen Singh) raised the issue of male accountability:

> Why is it that only women have to help women? Why is it that the issue of male accountability (at the policy level or at the level of bureaucrats or NGOs...) is seldom raised? Women will not be able to make significant gains without male support; men must also become responsible for women's health.

Ms. Rao responded that DDS has realized the need for men to take responsibility. For example, when women in sanghas discussed various contraceptive options, they concluded that the Nirodh is the safest. DDS makes Nirodhs available to women, and women are demanding it. Thus, although men are not directly dealt with, they are being reached indirectly through women members.

Prof. Gita Sen noted that reproductive health has been part of a larger set of issues encompassed by "reproductive and sexual rights" which focus on changing *gender* relations. Thus, both men and women are involved. This has not been highlighted, largely because of the struggle to ensure that women's needs are met. In the case of government health services, we have been struggling to ensure that they are providing immunizations, diagnosing and treating reproductive tract infections, and so on. Making them address men, and involving men may be a secondary issue. However, we do need to focus on rights and responsibilities more clearly.

Presentation III: Gramya, Hyderabad

Ms. Jamuna, as a consultant, has visited over 70 NGOs implementing family welfare programmes. In her presentation, she summarized their experiences, and the results of her interactions with them.

Women's groups

The Andhra Pradesh Government was interested in forming women's health groups, Mahila Swasthya Sanghs (MSS). Rather than forming new groups, NGO experiences indicate that one can work with existing groups such as the DWCRA groups. In fact DWCRA groups could become MSS.

Strategy of implementation

The primary approach that NGOs have taken is intersectoral. NGO experiences suggest that programmes of the Departments of Rural Development, Health, and Education should be coordinated at the village level.

Training

In the initiative that Ms. Jamuna was involved in, NGOs did not have a training budget. Funds for training were provided by women's groups; they took up education activities (for adolescent girls, for health etc.). A training module has been developed for them which addresses issues of gender and development. The module attempts to give DWCRA leaders several methods which they can use to inform other women.

District level health educators have also been trained. The key is to provide a holistic picture of issues, and thus to enable women and men to easily incorporate them into their lives. One training session was held for policy officials and implementers. However, there was some resistance from these officials who claimed that the training material was "feminist." Also, while the ideological basis of programmes may be conveyed, translating them into action plans may be extremely difficult (or implementers may be resistant). Women's activism may be critical in these situations.

Lessons from AP

The importance of activism and its impact on policy implementation are manifest in two examples of people's mobilization in Andhra. The first is the anti-arrack movement in Nellur which was spearheaded by women. The second is the formation of mothers' school committees in Adilabad district in which mothers organized to demand that schools function.

The key lesson from the above two experiences is the need to politicize issues which may not initially be perceived as being political. Without political action, change will not occur.

The other key ingredient for implementing change is the dissemination of information. Information must be available with village-level government functionaries and with community members. This in turn is linked to the functioning of village institutions such as the primary health centre, and to the availability of information through mass media. Once information is available, demand for health services will increase.

Presentation IV: Vivekananda Girijana Kalyana Kendra, Karnataka

VGKK's experiences with working with a tribal community in Karnataka were presented by Dr. M. Roopa. Dr. Roopa noted that one of the strongest features of VGKK's work in this community was its exploration and use of traditional health practices. The NGO has conducted extensive research on traditional herbal medicines, and promotes their use. VGKK has now taken over two PHCs in their coverage area, and has hired staff from the community to run them. Thus, strong collaborations with the community are another key feature of the NGO's approach.

Drawing upon her experiences as a government physician and as an NGO activist, Dr. Roopa made the following recommendations for the implementation of the TF approach:

- family welfare and health need to be implemented in an integrated fashion;
- health problems such as cervical cancer and tuberculosis should not be neglected in favour of family planning;
- referral services, particularly for emergencies, should be ensured;
- a people-oriented approach needs to dominate; many women, for example, are unwilling to undergo an internal examination because of lack of information regarding what the process entails - information, informed consent, informed choices need to be central to health service delivery;
- gender-sensitive indicators of health need to be used in place of targets for programme monitoring and evaluation.

Discussion Notes

A major topic of discussion was the role of NGOs vis-à-vis the government. Questions that were raised included: should NGOs set up parallel structures as in health? what ends do these parallel structures serve? should NGOs limit themselves to monitor government activities or should they take over the government's responsibilities (such as by running PHCs)? There appeared to be a number of different opinions. Some felt that NGOs should in fact only act as people's advocates (monitoring activities and demanding change) while others felt that NGOs may be able to demonstrate how services can be provided to suit people's needs.

Prof. Gita Sen suggested that there may be two conditions in which NGO take-over of government services may be legitimate. The first is when an existing well established organization does so as a way of strengthening its own activities and as a way of taking services to a level that does not currently exist. The second is when NGOs can demonstrate how services can be provided to a community which hitherto had been underserved (or ignored). In the latter case, the NGO acts as a model for translation, and clear steps for translation need to be specified. This issue has not until now been framed in these terms by the government.

Ms. Vimala Ramachandran noted that the government sees NGOs primarily as service providers, not as partners or as pioneers of new approaches. NGOs will have to respond to this view. However, there is a "mixed wicket": many NGOs are willing to be service providers.

Ms. Rukmini Rao argued that NGOs have always been service providers. The difference now is that NGOs are now a means of "social privatization." They present an avenue by which the

government can abdicate its responsibilities. In this scenario, NGOs have to exercise extreme caution.

Session III

Summary review of the Ministry's "Manual on Target free Approach"

Dr. Gita Sen
IIM, Bangalore

Discussion Notes

A significant part of the discussion on the Manual centered on the AP government's experiences in implementing a number of TF/RCH pilot projects, valuable lessons have been learnt on the formation and training of women's groups and on the development of management information systems. Additional issues raised during discussion include the need to further develop the conceptualization of reproductive health within the RCH approach, and the need to put in place specific and direct links with women and communities to determine needs.

Experiences from Andhra Pradesh

Dr. Prakashamma described the process of forming women's groups in the AP TF/RCH pilot projects. At first, ANMs and male health workers were asked to form these groups. At a village meeting it became apparent that village members did not approve of the individuals identified by health worker. Thus, a grama darshan (village procession) was held to announce the formation of a women's group on health, followed by a grama sabha. At this village meeting, individuals volunteered to be a part of the committee. As a result of this process, a group which was locally acceptable was formed.

Ms. Chatterjee, Secretary of Health and Family Welfare, reported that the AP government was working with NGOs to train these women's groups on issues related to the TF/RCH approach; a module has been prepared for DWCRA members and ANMs on health issues. However, she stressed, the government system alone cannot conduct training programmes. NGOs will have to play a key role in training, motivating and sustaining women's groups during the initial period.

In response to participants' call for mechanisms of information dissemination and feedback, Ms. Chatterjee noted that the AP government was developing an information system to collect and analyze data from health programmes. Data will be analyzed at the district level, and relevant information will be intimated to the concerned personnel.

Echoing participants' views, Ms. Chatterjee stated that the Manual is a draft document whose performance will have to be tested. The Manual should be modified over time depending on its performance. In fact, the AP government has already made some changes to its Manual based on regional requirements. For example, the AP PHC plan is slightly different from the one recommended by GOI; it focuses on specifics such as electricity and water supply at the PHC etc. All levels of the health system have been informed of the new plan, and its experimental status.

Lacunae in the Training Manual

Participants felt that the RCH approach was based on a weak conceptualization of reproductive health. The components of reproductive and sexual health need to be more accurately conceptualized. In addition, the levels at which these issues need to be addressed (sub-centre, PHC etc.) must be meticulously outlined and addressed.

It was noted during the discussion that although in the preparation of the PHC, family welfare and health care plan meetings are to be organized with panchayat members, primary school teachers, etc., specific provisions for a direct dialogue with community members to assess perceived needs during planning and implementation is absent in the Manual. Participants agreed that this is a crucial part of the process of planning. Likewise, it was felt that the monitoring and evaluation components should include a mechanism for community feedback.

A key ingredient to the success of the new programme will be the level of motivation and skill of the staff of the government health infrastructure. Participants stressed the need to ensure quality of care by developing training materials for PHC staff which includes practical experience, motivational and attitude change sessions. One participant stated that "reproductive health and rights" should not be treated as mere vocabulary; communication of the concepts underlying the term is essential.

Session IV

Recommendations of working groups

Four working groups were formed on the second day of the workshop: one discussing the "Manual on the target-free approach"; one discussing the relationship between NGOs and the government; and two discussing the role of women's groups in ensuring accountability of government programmes. The following are some of their conclusions and recommendations.

Group I: Feedback on the "Manual on the target-free approach in family welfare programme"

Focus of Manual

A key component of the Manual is its introduction; it should contain the essence of the mission at hand. *First*, the group felt that a mission statement or preamble should be included which states the principles on which the TF approach is built. The statement should reflect the role of the Manual. For example, it may read as follows:

> Keeping in mind the change in approach, and keeping doors open for discussion and further change, this manual may be treated as guidelines which may need to be utilized and modified based on local conditions.

Second, the group felt that the Manual should be revised to highlight the centrality of women's health rights; thus, the focus should be shifted from one of achieving demographic goals to one of bettering the lives of women and men.

Implementation of Manual

Several steps need to be taken to implement the Manual. They include:

- awareness creation among government officials and the community about the nature and use of the Manual;
- widespread dissemination of the Manual;
- community-level workshops on the use of the Manual (and also to collect feedback);
- translation of the Manual into local languages;
- preparation of local models of components of implementation system (filled forms; clear instructions for activities involved; guidelines for the formation of community groups);
- concretization of community participation, and training of women's groups.
- outline of method for selection of community members who will be assessing health workers' activities and performance;
- outline of methods used to assess PHC activities (such as participatory rural appraisal);
- development of a feedback system on the Manual;
- formation of technical groups to formulate detailed formats for quality assessment.

In addition, it was felt that the manual should be made more user friendly.

Group II: The relationship between NGOs and the government

The aim of Group II was to critically examine the relationship between NGOs and the government, and their respective roles and responsibilities in the implementation of the TF programme. Group II began by exploring the history of NGOs. The group brought attention to the fact that the focus of voluntarism has shifted from charity to welfare to development; that historically NGOs acted as catalysts for change and worked for change as partners of the people. In more recent times, a split has occurred between NGOs and voluntary organizations in part due to the influx of funds to NGOs from the government and other external sources; the latter are thought to be more representative of the spirit of earlier times.

The group went on to discuss whether voluntary organizations can be partners of the government. It was felt that being partners with the government was made difficult by the rigidity and in-built inequalities that characterize the government bureaucracy. Furthermore there is now the danger that the government will use voluntary organizations as a means of privatizing their responsibilities.

What is the role of voluntary organizations? The group identified the following:

- as a catalyst for social change: one which brings the voice of the people to the government;
- as a partner of the people in the planning, implementation, monitoring, and evaluation of people-supported programmes;
- as a liaison between the people and the government to foster mutual understanding.

Finally, voluntary organizations are accountable to the people.

Groups III & IV: The role of women's groups in the TF approach

These groups discussed the role of women's groups in the TF approach. The overwhelming consensus of participants at the workshop was that, in order for women's needs to be recognized and met adequately, women's groups will have to play a key role in the target-free programme.

In this context, four key questions were identified:

1. How will women's groups be formed, and who will be responsible for their formation?
2. What are the pre-requisites for a well-functioning women's group?
3. What are the rights and responsibilities of these women's groups?
4. What sorts of linkages between women's groups , health workers and officials will have to be developed?

First, given that women's groups are integral to government health and family welfare policy formulation and implementation, a key question that policy makers will have to address is how these groups will be formed, and who will be responsible for their formation. It was

suggested that the group may be one which already exists in the community such as a DWCRA or MS group; Ms. Vimala Ramachandran suggested that an alternative was to form a village women's forum which came together specifically to address the TF/RCH programme. This would not be a group as such, but an issue-based forum consisting of interested individuals. This issue-based forum or group would be intimately involved in local-level planning, implementation, and monitoring of the programme.

Second, pre-requisites for a well-functioning women's group will have to be carefully identified. The group suggested that the following two issues would be important:

- conceptual understanding of issues which may be fostered through training sessions.
- availability of resources including a place to meet and funds for emergencies.

A third issue is the rights and responsibilities of this group/forum. What resources will they have at their disposal? How will they be involved in planning, implementation, monitoring, and evaluation? It is imperative that the government delineates their rights and responsibilities in detail, and *in consultation with women* themselves.

Fourth, the linkages between women's groups, health workers and officials in the health care delivery system need to be established. Will women's groups have some control over the salaries of health functionaries? Will village groups have recourse to higher officials such as the District Collector in the face of an unresponsive health worker? Lastly, what is the *locus standi* of the group? Participants felt that these issues must be resolved as soon as possible.

Conclusion

A number of vitally important issues related to the planning, implementation, and monitoring of the Target-free family welfare programme were raised during the two-day AP-Karnataka regional workshop. First, participants overwhelming agreed that women's groups must play a key role in the formulation and implementation process if the programme is indeed "client-centered". Questions that will have to be answered collectively, by the government and NGOs, include how women's groups will be formed and by whom; how the effective functioning of women's groups can be promoted and maintained; what the groups' rights and responsibilities are; and how the groups will be linked to health workers and government officials. Experiences of the AP government from its TF pilot projects and from NGOs such as the DDS offer answers to a number of these questions, and should be examined carefully. Second, participants also stressed the need to develop an effective communication system to ensure the dissemination of information to individuals at all levels of the government system as well as to the public; in addition, feedback loops need to established so that information does not travel unidirectionally. Third, it was felt that pilot projects need to be conducted over a defined time period (such as one year) in different areas in order to test the performance of the implementation manual under different conditions. It is critical that these pilots are extensively documented, and that the process documentation is widely distributed. Fourth, there was an overall consensus that the Manual be treated as a draft document, one which can evolve and be modified over time.

VOICES

POPULATION ISSUES AND WOMEN'S HEALTH : A NEW APPROACH

June 28 - 29, 1996 at Hyderabad

PROGRAMME

June 28

9:00 - 10:00	Welcome	
	Inauguration	Secretary Health and Family Welfare, Andhra Pradesh
	Moderators: Ms. Sucharita S Eashwar VOICES, Bangalore	
	Dr. M Prakashamma Indian Institute of Health and Family Welfare, Hyderabad	
10:00 - 10:30	**Coffee break**	
10:30 - 1-00	**New directions in family welfare** Moderator: Dr Gita Sen IIM Bangalore	
	The "target-free" approach: potential and challenges	Dr M Prakashamma
	Women advocating change: lessons from experience	Ms Vimala Ramachandran NFI, New Delhi
	Elements of a woman-sensitive and holistic healthcare system	Dr S P Tekur Community Health Cell Bangalore
	Discussion	
1:00 - 2:00	LUNCH	

VOICES

June 28

2:00 - 5:30 Making government health services accountable to women : Lessons from the field

Moderators: Dr. Dara Amar
St. John's Medical College
Bangalore

Dr. M Prakashamma

Ms. Gouri R
Mahila Samakhya, Karnataka

Ms. Rukmini Rao
Deccan Development Society
Hyderabad

Dr. M Roopa
Vivekananda Girijana
Kalyana Kendra, Karnataka

Ms. Jamuna
Gramya, Hyderabad

Discussion

June 29

9:00 - 10:00 Summary review of the Ministry's "Manual on Target Free Approach" Dr. Gita Sen

10:00 - 10:30 Formation of working groups on methods and mechanisms to make the government programme more accountable to women

Moderator: Dr. Shobha Raghuram
HIVOS, Bangalore

10:30 - 1:00 Working groups

1:00 - 02:00 LUNCH

2:00 - 5:00 Presentation and review of working group recommendations

Conclusion

Workshop on Population Issues and Women's Health : A New Approach
IIHFW, Hyderabad

List of participants

Name	Telephone No.	Fax No.
Dr. Gita Sen Indian Institute of Management Bannerghatta Road Bangalore 560 076	080-6632450	6644050
Ms. Sandhya Rao Parivar Seva Sanstha 2 and 2/1, AMM Towers DN No.53, Hosur Road Bangalore 560 027	080-2214270	080-2214270
Ms. Gangamma Mahila Samakhya Karnataka 3308, 13th Main, 8th Cross HAL II Stage Bangalore 560 008	080-5277471 5262988	
Ms. Subhadra Venkatappa Family Planning Association of India 375, 1st Cross, 9th Main Judges Colony, R T Nagar Bangalore 560032	080-3434818 3338755	
Ms. Neerajakshi Voluntary Health Association of India Rajani Nilaya, 60 R K Mutt Road 3rd Cross, Ulsoor, Bangalore 560 008	080-5546606	

Name	Telephone No	Fax No
DR. M Antony David Head-Dept. of Community Health Catholic Health Association of India P B 2126, Gunrock Enclave Secunderabad 500003, A.P.	040-848293 848457	811982
S.P. Doss Head-Dept. of Community Health Catholic Health Association of India P B 2126, Gunrock Enclave Secunderabad 500003, A.P.	040-848293 848457	811982
Dr. Nandini Gandhi President, Family planning Association Hyderabad.		
Mr. B. Nageswara Rao Sravanti Association 32-1-50 K V R Swamy Road Rajahmundry 533101, A.P.	0883-61139	
Mr. M. Subba Rao Director MASSES Velayanandapuram Gudur 524101, A.P.	51206	08624-51285
Mr. C H Sundera Rao President, Kamala Nehru Youth Association Nidubrolu 522124 Ponnur Mandal Guntur Dist., A.P.		

	Name	Telephone No	Fax No
	Ms. Sucharita S Eashwar Executive Director VOICES P B 4610, 59 Millers Road, Benson Town Bangalore 560 046	080-5546564 563017	569261
	Ms. Sangeeta Cavale Programme Executive VOICES P B 4610, 59 Miller Road, Benson Town Bangalore 560 046	080-5546564 563017	569261
20.	Mr. Azmathullah Manager VOICES P B 4610, 59 Miller Road, Benson Town Bangalore 560 046	080-5546564 563017	569261
21.	Ms. Suneeta Krishnan SFA Alpine Court 2-B Cross, 7th Main Koramangala 1st Block Bangalore 560034	5538205	
	Ms. Gouri R Mahila Samakhya Dist Implementation Unit Sangamesh Building, Viveknagar Near Ibrahimpur Basavana Bagewadi Road Bijapur 586 101	08352-22086	
	Dr. Dara Amar Professor and Head Dept. of Community Health St. John's Medical College Bangalore 560034	5530724, Ext 413,	5531786
	Ms. Mani Makalai Institute of Social Studies Trust 'Sreeshyla', No.42, 4th Temple Street 15th Cross, Malleswaram Bangalore 560003	3340315	

Name	Telephone No	Fax No
Mrs. Rachel Chatterjee Secretary Health and Family Welfare Andhra Pradesh		
Dr. V . Rukmini Rao Secretary, Deccan Development Society A-6, Meera Apartments Bashirbagh Hyderabad 560 029	040-231260 232867	231260
Dr. K. Rajashekhar HERSELF Society Shyam Nagar Nandyal Kurnool, A.P.	08514-44056	
Mr. D Srinivasu Regional Coordinator AWARE 5-9-24/78 Lake Hill Road Hyderabad 500463	040-236311	
Mrs. Sumabala, ASMITHA House No.45, Road No.2 West Maredpally, Secunderabad. 500 026 A.P.	803745	
G. Vijaya Lakshmi ASMITHA House No.45, Road No.2 West Maredpally, Secunderabad. 500 026 A.P.	803745	

Name	Telephone No	Fax No
Mrs Prabheen Singh A 10/3, Vasant Vihar New Delhi 110054	6874320	
Mr. Vinod Community health Worker Janadaya, Konapurpet, Mauvi Raichur, 584123, Karnataka	53534	
Mr. Avaji Sangamitra Service Society Vijayawada 520007, A. P.	554002 554374	
Mr. N. S. Chandrasekhar Creater's Charitable Organization 78-8-4 Gandhipuram - 3 Rajamandry 533 103, A.P.	76710	
Mrs J. Kausalya Villages on Partnership Teacher's Colony H-No 8-5-20B/1 Mahboobnagar, A.P.	42058	
Mrs N. Shanti Mahila abhyudaya Seva Samstha F-1, Shirdi Appartments, Rajabhavan road Somajiguda, Hyderabad	3325630	

Name	Telphone No	Fax No
Dr. J. C. Mahanty, Director IIHFW, Vengalraonagar Hyedrabad.	3810416	3812816
Dr. M. Prakasamma IIHFW, Vengalraonagar Hyderabad.		
Dr. V. Umadevi IIHFW, Vengalrao nagar		
Mr. T. Dass Women's Devolopment Society 6-88-34/1 Boregaon, Nizamabad, A.P.	43972	
Dr. S Balavenkataiah Kurnool Dist Rural Devlopment Society 13, Raghunath Complex Kallur, Kurnool, A.P.	26882	
Mr. K. Sivakumar MASS, Paddapalli Karimnagar, A.P.	08452-64353	
Mrs P. Jamuna Gramya 1-16-79/3 Sainagar Colony Alwal, Secunderabad	862007	

Name	Telephone No	Fax No
Mr. Gurudatt Prasad ACTION Krishna Sadam Dr. Med Ranga Prasada Rao Gardens Hukimpet Rajmundry 533103	0883-6~~1~~42	
Dr. V. Janardhan Rao Health Director WDT Hospital Kalyandurg 515761 Anathpur		
Ms. Mrudala State Programmer Andhra Pradesh Mahila Samitha Society Plot No. 8, Aparajitha Housing Colony Vidyadaya School Lane Ameerpet Hyderabad 500016, A.P.		
Mrs. Sarah Kamala Andhra Pradesh Academy of Rural Devolopment Govt of A.P. Rajendra Nagar, Hyderabad 500 030	245337 245959	257005
Mrs. Sushila Ramidamy President Academy for Nursing Studies, ~~6-1-630/2A~~, Nagarjuna Nagar Ameerpet,Hyderabad 6-1-630/2 A upper flat President Khairatabad, Hyd 500004(AP)	241228	
Mrs Vimala Ramachandran XC-1 Sah Vikas,68 I.P. Extn Delhi 110092	2432770 2432949	

Name	Telephone No.	Fax No
Dr. S P Tekur Community Health Cell 367, 1st Main, 1st Block J K Sandra Bangalore 560 034	080-5531518	
Dr. Pankaj Mehta 52, NGEF Layout, 1st Main Road Sanjaynagar Bangalore 560 094	080-3~~361615~~ ~~3365948~~ 3334896	080-3334896
Ms. K R Sreevidya Institute of Social Studies Trust Sreeshlya" No.42, 4th Temple Street 15th Cross, Malleswaram Bangalore 560 003	080-3340315	080-3311764
Dr. Shobha Raghuram HIVOS India Regional Office Flat No.402, Eden Park 20 Vittal Mallya Road Bangalore 560 001	080-2210514 2270367	080-2270367
Ms. C S Veeramatha Institute for Social and Economic Change Population Research Centre Nagarbhavi Post Bangalore 560 072	080-3355519	
Dr. Vijaylakshmi Hebbare Indian Society of Health Administrator 104 (15/37), Cambridge Road Cross Ulsoor, Bangalore 560 008	080-5574297	

Name	Telephone No	Fax No
Dr. R Radha Research Officer State Family Welfare Bureau Directorate of Health and Family Welfare Services Ananda Rao Circle Bangalore 560 009	080-2870224 2870205	080-2870224
Dr. M Roopa Consultant Vivekananda Girijana Kalyana Kendra B R Hills 571 441 Yelandur Taluk Mysore Dist., Karnataka.	08224-8425	
Ms. Dhanalakshmi MYRADA Post Box No.5 Challakere 577 522 Chitradurga Dist.	08195-2243	
Sr. Maria Rose 'Janodaya' Good Shepherd Sisters Manvi - 584 123 Raichur Dist., Karnataka.	08538-53534	
Ms. Poornima Health Coordinator ~~Samraksha~~ Samuha. Jalahalli, Deodurg Taluk Raichur 584 116, Karnataka	55223 56063	
Ms. Emelda Rani Family Planning Project Director Hope Foundation BangaloreP B 3828	080-5588819	5288819