WAH!-Women And Health Training Programme
India

The Expert Meeting on Building NGO Organisational Capacity For Women's Health

16 - 22 July 1993
Bangalore
India

WAH! Secretariat

CHETNA

In co-operation with

DSE

WAH!–Women And Health Training Programme India

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What is 'WAH'!

The 'Women and Health Training Programme' (WAH!) has its genesis in a consultation of NGOs representatives and experts from training institutes held at Surajkund, (Haryana) during November, 1992. The Surajkund consultation examined the health care scenario in India and women's access to the health care system. It was felt that women's experiences in health needed to be located both in the context of gender relations and macro level socio–political economic realities.

The 'WAH' group sees the need for synthesis of the following components within women's health care programmes :

* expanding the definition of women's health beyond just maternal and child health
* examining the gender relations within health rather than focusing on women in isolation
* an appreciation and commitment to build on local health traditions, self help and capacities
* organising gender–sensitive management training to help health managers especially, women to manage health programmes.

To promote this synthesis 'WAH!' is initiating a long term phased training programme on "Women and Health" for persons working in NGOs.

Membership in the group has been evolving, women and men who have been working in any (or many) of the above four areas or are concerned about them are part of this network.

(The Core Group formed at Surajkund completed its task of compiling the three modules and has now been reconstituted to take the task of organising the long term training programme ahead. The new core group members are mentioned in the report).

WAH!'s Aspiration/Aim/Expectation/Intention

"In five years, WAH! aims for multiple womens health programmes being implemented in various regions with feminist perspective and in which traditional practises are valued and used in programmes which are managed and even headed by women".

A REPORT OF THE EXPERT MEETING ON BUILDING NGO'S ORGANISATIONAL CAPACITIES FOR WOMEN'S HEALTH

JULY 16 – 22, 1993
INSTITUTE OF ADVANCED STUDIES
BANGALORE
INDIA

WITH

A REPORT OF THE SUBSEQUENT "WAH!" CORE GROUP MEETING AT BOMBAY AUGUST 17 – 18, 1993

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LIST OF ANNEXURES

ABBREVIATIONS USED

AIDS	– Acquired Immuno Deficiency Syndrome
ANC	– Ante Natal Care
ADS	– Academy of Development Science
AIKYA	– (Unity) Field Based Training Organisation
CINI	– Child In Need Institute
CHETNA	– Centre for Health Education, Training and Nutrition Awareness
DSE	– German Foundation for International Development
DDS	– Deccan Development Society
ERT	– Estrogen Replacement Therapy
IIHMR	– Indian Institute of Health Management and Research
IWID	– Initiatives: Women In Development
ISM	– Indigenous System of Medicines
JAGORI	– Training and Documentation Centre
LSPSS	– Lok Swasthya Parampara Samvarthan Samity
LHT	– Local Health Traditions
MASUM	– Mahila Sarvangi Utkarsh Mandal
MFC	– Medico Friend Circle
NGO	– Non Government Organisation
NIN	– National Institute of Nutrition
PNC	– Post Natal Care
PRIA	– Participatory Research in Asia
STD	– Sexually Transmitted Diseases
SEWA RURAL	– Society for Education Welfare And Action – Rural
SEARCH	– Society for Education, Action and Research in Community Health (Gadchiroli)
SHSD	– Society for Health and Social Development
SEWA	– Self Employed Women's Association
SNDT	– Smt. Nathiben Damodardas Thackersey University
SWDF	– Sadguru Water and Development Foundation
SWACH	– Sanitation Water and Community Health
SAHAJ	– Society for Health Alternatives
T.B.	– Tuberculosis
UTI	– Urinary Tract Infection
UNNATI	– Organisation for Development Education
WHODSIC	– Women Households Development Studies information Centre
ZG	– Public Health Promotion Centre of DSE

1. OVERVIEW OF THE PROGRAMME

1.1 Background of the Workshop (Concern of DSE/ZG and groups)

The German Foundation for International Development (DSE), Public Health Development Centre (ZG) regularly conducts dialogue and training programmes in Primary Health Care in many countries.

Since the important role of women in the development process and especially, in Primary Health Care Services has been more and more recognised, DSE also organised several events on behalf of "women in development".

In 1988, a conference, entitled "Towards Progress in Women's Rights and Social Status in Developing Countries" was organised and in 1989, another conference was held on "Women in the Development Process", which focused on three problems.

- strategies and programmes for women in the agricultural sector
- the effects of modernization process on women and the counter strategies developed by the women's movement and by government organisations and
- the impact of debt and crisis management on women with special reference to the subsistence work of women in the informal sector.

The main consequence for DSE was drawn out of the finding that there are urgent requirements for training of women the field of management and organisation building.

Subsequently at the end of 1989, in an expert meeting an analysis and assessment of training programmes for women was made, in order to develop programmes to strengthen the organisational and management capacities of women.

To specify the training needs of women in non–governmental organisations in India and Nepal, in 1990 a needs assessment was done by Ms. Asha Kachru to identify specific requirements.

In 1992, it was decided to develop a long term training programme for women in Non–Governmental Organisations (NGOs) linked with Primary Health Care (PHC). Though India has accepted the PHC–strategy as a guideline for health policy, the practical implementation has been hampered by a number of difficulties which are mainly the lack of political decision–making power at health infrastructure, insufficient education and training of health personnel being other responsible factors.

1.2 Surajkund Workshop ; November, 1992

Based on the needs assessment, a planning workshop on 'Management of Primary Health Care Programmes' was held at Surajkund, Haryana, during November 1992. The main objective of the workshop was to elaborate a framework for designing a comprehensive training programme aimed at strengthening the organisational and management capabilities of women in non–governmental organisations which are conducting Primary Health Care Programmes with a focus on women's health services and activities.

During the deliberations of this workshop, specific topics which should form the training programme were finalised, which were later incorporated into three training modules. These were :

- **Women's Health Concerns**
- **Building Women's Capacities to Preserve Health**
- **Management of Women's Health Programmes**

A broad outline of the framework for the above modules was discussed, in which specific objectives, perspectives and topics were suggested for each module separately. Strategies and methods for the training programme were also elaborated in general.

At the end of the workshop, a core–group was identified to build upon the process of module development, to keep contact and exchange information.

In addition, three task groups were also formed to develop the first draft of the detailed training module, identify participant NGO groups, collect relevant resource materials, and identify resource persons. Task group co–ordinators also collated the suggestions received by the participants/resource persons.

The core group was constituted by including the co–ordinators of the task groups and some other resource persons (for list see Annexure – I).

The task groups were co–ordinated by Ms. Mirai Chatterjee, SEWA (Women's Health Concerns), Vd. Gangadhran, LSPSS (Building Women's Capacities to Preserve Health) and Ms. Renu Khanna, SAHAJ (Management of Women's Health, programme). The overall co–ordination of the core group was done by Ms. Indu Capoor from CHETNA. The other task group members who contributed to writing the modules are given Annexure – IA).

The following decisions were also taken at Surajkund:

- After the first draft of the training module outlines was ready, a core group meeting would be convened by Ms. Indu Capoor at Ahmedabad, to discuss the module drafts.
- A second Core–group meeting would be organised with DSE in Bangalore immediately prior to an expert group meeting.
- An expert group meeting would be organised in Bangalore with DSE, comprising of persons with experience and background in the fields of women's health, management and traditional Indian medicine.

1.3 Core group meeting at Ahmedabad; April, 1993

The first core group, comprising of the task group co–ordinators, met on 26 – 28th April 1993 at Ahmedabad to discuss the draft of the module outlines, so that they could be prepared for the experts meeting.

CHETNA team members (Ms. Pallavi, Ms. Jyoti and Vd. Smita Bajpai) also joined the meeting. A tentative list of participants to be invited for the experts meeting at Bangalore was finalised. Along with the outline of refined modules, the list was shared with Ms. Erika Fink of DSE for inviting the experts.

The module outlines were shared with the various expert invitees and other core and task group members so that they could come prepared with comments and suggestions at the Bangalore workshop.

2. THE WORKSHOP AT BANGALORE; JULY, 1993

The Expert Meeting on Building NGO's Organisational Capacities for Womens Health was arranged at Bangalore in the form of a three day workshop bringing together about 36 persons of diverse experiences in the fields of health, education, womens development and management. This workshop was proceeded by a two day preparatory Core Group Meeting of the Women and Health Group (WAHI) and followed by a two day winding up session by core and task group members.

The objective of the whole three–part week–long experience was to continue and concretize a process initiated in November, 1992 at Surajkund, in co–operation with the (ZG) of Germany (German Foundation for International Development). The process launched is an initiative to develop a long term training programme for India and Nepal, involving NGO's in Management Training for Women in Womens Health.

The specific aim before the experts was to develop and substantiate three training module drafts prepared by three task groups in Surajkund and take up other logistics of the planned programme so it could begin by early 1994.

The basis principles and contents of the modules were discussed in the initial core group meeting. After incorporating their comments and suggestions, the enriched modules were presented to the larger forum of Experts. The participants discussed the content and implementation strategy of the modules in large and small groups which subsequently resulted in finalisation of the modules, the draft perspective paper and implementation strategy.

After exhaustive deliberations, discussions and debates, the comments were incorporated in the modules. The budget/finance could not be finalised in the expert meeting due to time constraints.

2.1 Core Group Meeting at Bangalore

This meeting was held on 16–17th July 1993, prior to the expert meeting. The objective of the meeting was to discuss the perspective and deliberate on the modules prepared, to be presented in the expert group meeting.

This meeting constituted mainly of the core members alongwith some experts on the subject. In the core group, the draft of the 'Perspective Paper' and the outlines of the modules on 'Women's Health Concerns', 'Building Capacities to Preserve Health' and 'Management of Women's Health' programmes were discussed at length and enriched for the presentation in the expert group meeting.

2.2 Expert Group Meeting

In this meeting, 36 experts representing the areas of health, nutrition, women's development and management participated. It was a mixed group of men and women (see Annexure – II).

Ms. Erika Fink, who had been involved as a representative of DSE from the initial planning stages of programme warmly welcomed the participants and explained the aims, objectives and activities of the German Foundation for

International Development (DSE). Ms. Indu Capoor, co–ordinator, presented the detailed background information on the process since the workshop in November 1992 at Surajkund and, the objectives of the present Experts Meeting.

Objectives of the Experts Meeting

The main objective of the expert meeting was to discuss the draft of the perspective paper and enrich the three modules on Women's Health. The specific objectives were :

- To develop the three training modules
- To shape the long term dialogue and training programmes
- To identify NGO participant group for different programmes.

2.3 Task Group Follow–up Meeting

The objectives of the task/core follow–up meeting was :

- To identify resource persons for the training.
- To suggest methods of monitoring and evaluation.
- To elaborate on the time schedule.
- To plan financial requirement for the programme.

To set the tone for the meeting and to know each other, participants introduced themselves, their background and work experience.

3. COMMENTS/SUGGESTIONS ON "PERSPECTIVE AND MODULE" OUTLINES" :

The suggestions/comments given by the core group as well as the experts group are as follows, based on which, the small groups worked to further enrich the perspective and modules.

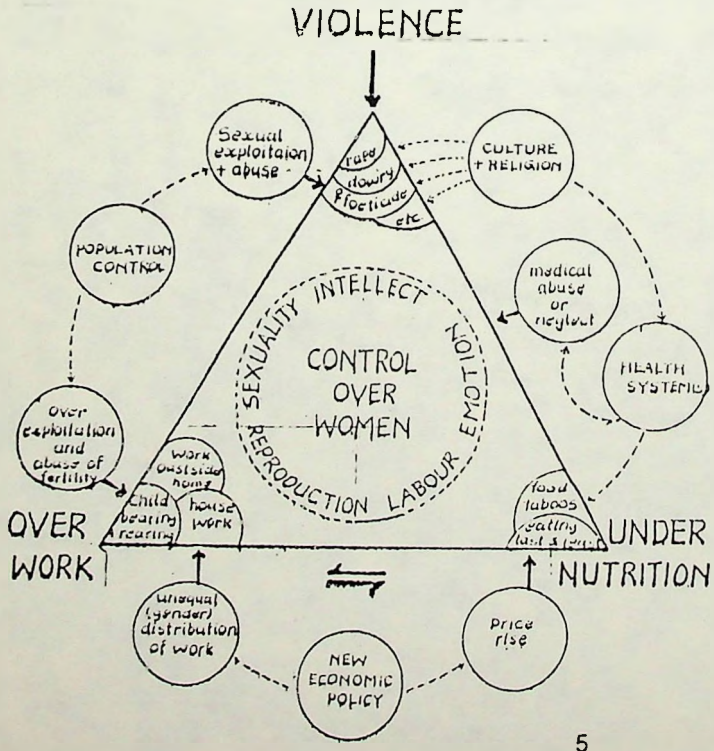
3.1 The Feminist Perspective on Women's Health :

Dr. Mira Shiva and Ms. Asha Kachru had prepared a draft perspective paper which was discussed in the core group prior to the Expert Meeting.

Suggestions of the core group

- The perspective paper was seen as a connecting thread between all three modules to guide the development of the training programme.
- The perspective was expected to focus on the broader scenario of health situation and then narrow down to specific aspects.
- Health perspective should be seen within the dynamics of class, caste, gender, patriarchy, division of labour and ecological aspect.
- More additions to the content such as the feminist definition of health, militarism, violence, effect of family and education, sexuality were suggested.
- Appropriate reorganising and sequencing of the perspective content was suggested.

Suggested Diagramatic Representation of the Perspective on Women's Health



Based on the above comments from the core and expert group the perspective was enriched (See Annexure-III).

3.2 The Module on Women's Health Concerns :

Suggestions of the Core Group

- Many topics were suggested by the members so as to develop/enrich the content of the module.
- It was felt that the module should begin with the presentation of a conceptual understanding of gender and patriarchy and its impact on health.
- The "Girl Child" phase was sub–divided according to age and socio–health issues were dealt with accordingly. It was suggested that health and nutrition related factors such as public distribution system, water politics, women and workload, environmental factors (such as pesticides) emotional stress, medico legal aspects, traditional food practices, taboos, should also be included.
- The topic of "reproductive" health and sexuality was discussed at length. Its multiple facets, such as population politics, population control, contraception. MTP, fertility awareness, sexual abuse, sexual assault, control of womens sexuality and sex practices were incorporated. That women are aware of their right to demand, initiate and assert their rights in the area of sexuality was also debated.

A sequence for the framework of working on the perspective was suggested as follows :

* Problems – present status of women's health
* Analysis – causes, concerns
* Perspective – definition
* Issues of women's health in development theories (analysis)
* Feminist perspective of women's health
* Approach to address the causes (issues)

Dr. Mira Sadgopal and Ms. Abha Bhaiya volunteered to work on the Feminist Perspective and present the same to the larger group of experts.

Suggestions/Comments of the Expert Group

The experts provided more insights to ensure a complete picture of the perspective on women's health. The entire experts group together, went through the refined perspective presented by the core group members and they discussed and debated on various issues. The following was the outcome.

General

- The perspective highlighted a macro picture of the problems. There was a need felt by the participants to "flesh it out" so as to make it useful for policy analysis. e.g. In the policy of Child Survival and Safe Motherhood (CSSM), some policies meant for women, sometimes worked against women, e.g. contraceptives usage was encouraged only for women rather than male, though they are more safe. These were considered crucial concerns to be addressed.

Specific

- In addition, inclusion of few more topics was suggested :
  a. Details of feminist strategies, research, process, women's struggle for various causes
  b. Micro level case studies and its analysis
  c. Regional case studies, highlighting realistic situations
  d. Assertion and image building
  e. Psychological process
  f. Economic and social marginilisation
  g. Politics of health
- Legal aspects related to maternity rights and benefits and division of labour were incorporated.
- Negative portrayal of women by media, unnecessary surgical interventions, Hormonal replacement Therapy (HRT) were some of the topics suggested by the core group members.

The module enriched by the core group ensured an inclusion of an overall comprehensive picture of all the issues related to women's health. The suggestions made by the core group members were related with content, ideology, social conditions, legal aspects, violence – especially family violence, ecological destruction and demystification of medicine. This module was later presented in the expert meeting to receive more inputs in the larger group.

Comments/Suggestions of Expert Group

- It was felt that the module must identify research areas where enough knowledge does not exist. it was also felt that it should also provide a feminist critique of the health policy and health delivery systems.
- Other topics suggested to be included in the module were, addressing emotional health during adolescence and aging, endometriosis and tuberculosis and their link with fertility and other diseases, child abuse and battering. Women and disability, women and work were suggested for inclusion by the group.

This was further enriched in the small group which met to discuss the strategy. The enriched module is enclosed (see Annexure –IV).

3.3 The Module on Building Women's Capacities to Preserve Health

Suggestions/Comments of Core Group

This module focused on the traditional methods of preserving health and strengthening of women's self help potentials. Water and sanitation was also included as it was considered an important aspect of health preservation. The other comments on the module were as follows :

- In order to make the objectives of the module more clear, it was suggested

to include a brief background on the importance and rationale of using traditional systems of health care. In this context it was agreed that the role of indigenous health practises are viewed in perspective in terms of training and focusing on aspects which are beneficial and rejecting the sexist, superstitious practises.

Since alternative health care system included a range of healing approaches which are region and culture specific, the module needed to be flexible to incorporate this diversity and drawing upon these varied sources be it homeopathy, herbal medicine, accupressure, Marma Vidya, meditation etc. It is necessary to have a holistic approach. This does not mean having an aggregrate of healing components. It involves diagnosis and work with global perspective of the person as a total being situated in her/his specific socio–economic physical and psychological context.

It was also felt that the module needed integration of :

a. Allopathic practices with Ayurvedic & Traditional practices

b. Areas that are overlapping, with the module on women's health concerns.

Dr Shanti Ghosh cautioned the group to also keep in view the limitations of traditional medicine in acute and emergency cases and not get carried away by its usefulness. Dr Veena Shatrughna expressed her doubt regarding the integration.

Comments/Suggestions of the Expert Group

A general consensus was that, knowledge of traditional sciences expower women to look after their own health and that of their families and communities. Based on this view, the following was suggested.

- The module focused on curative aspects as, it was organ based. It was suggested that, an attempt should be made to integrate preventive concepts like self help approach and useful local health traditions.
- The perspective should clearly highlight, that the reason for promoting traditional practices was not because of its alternative status but because it led to the empowerment of women.
- Anatomy & physiology should be described as 'body structure & function' & should be based on the "chatras" & "meridian" approach to understand traditional practices like reflexiology, accupressure etc.
- Apart from the use of traditional medicine, folk dancing, body awareness, rhythm & meditation, yoga, spiritual health, humour should be encouraged.
- It was cautioned that it is necessary to evolve a decision making criteria so as to be able to appreciate the limitations of traditional and allopathic systems.
- The module must also focus on the harmony of themind & body, specifically evolving a healthy healer–healee relationship and prevention of commercialisation of indigenous systems.

These comments were incorporated and the modified module is in (see Annexure – V).

3.4 The Management Module

It was felt that values of the feminist perspective of Management should be reflected throughout the training programme. The group discussed the feminist management principles at length and some outcomes expected in a women's health programme were accountability, demystification, value of shared decision making and, mutual respect for everyone concerned. Other criteria were listed as follows :

* Collective functioning
* Shared leadership
* Shared responsibility
* Decentralized (a) Decision making
  (b) Control of Assets
* Opportunity for development of human potential
* Empowerment of women
* Non–gender division of labour
* Connection/Harmony with nature

In addition there was a need to address/change the duality of masculine and feminine principles to bring about an equilibrium between :

Mind	_____	Body
Rationality	_____	Emotion
Competition	_____	Harmony
Profit and Production	_____	Qualitative change
Target	_____	Process

There was a strong plea by the experts present that these values must be incorporated in the :

* Design and delivery of the module

  Process of selection of NGOs to minimize the conflict and duality that could arise out of differences between organisation and programme management, when women become articulate.

Suggestions/Comments of the Core Group

Due to time constraints, this module could not be discussed in detail. However, the core group felt that the module has to be viewed from a feminist perspective which appeared to be lacking.

The members worked on the module based on the suggestions and then it was presented during the experts group meeting.

Comments/Suggestions of the Expert Group

Managing women's health programme was identified as one of the crucial areas for which women's capacities had to be developed. The design and the layout

of the module needed to be altered. It was suggested that the design of the module should begin with understanding self and others, managing group processes and proceed to project and programme management. The management of external environment should be taken up last.

Specific comments were as follows :

- Each concept should be redefined and analyzed from a feminist perspective.
- Experiences of women's groups as managers needs to be included.
- There should be an appropriate balance between idealistic and realistic vision.
- The module must also address the conflicts between the women's health programmes and organisation and, their interfacing with the government health system.
- It should be kept in mind that as women are more comfortable with the oral form of communication, for which appropriate documentation should be ensured.
- Gender issues in all areas of management should be clearly focused.
- A planning of the follow–up activities should also be included.
- An attempt has been made to incorporate in the module should be addressed both to men and women.

An attempt has been made to incorporate all the above suggestions in the module. (see Annexure – VI)

3.5 Integration of Modules

It was felt that several content/concepts in the three modules were overlapping with each other. A need was expressed to integrate them so as to avoid repetition.

The members suggested the integration of the module on health concerns with that of building capacities and later on, with some parts also with the module on management. Common areas identified were, anatomy and physiology of the human body and its function, socio–cultural factors, nutrition, maternal health, reproductive health and sexuality, misuse of modern medicines, etc. It was felt that this would avoid repetition and reduce the time–period required for the training.

4. FINALISATION OF THE MODULE :

The participants were divided into four groups based on their expertise and preference. These groups worked at length on the guidelines given to them and the following was the outcome :

a. Finalisation of the Content :

The groups scrutinized the content of the module in detail and made appropriate additions to the content.

b. Sequencing :

The members organised the topics of the module ensuring continuity and inter–linkages.

c. Prioritisation :

The essential areas to be covered on a priority basis were also identified.

d. Time estimation :

The time required to cover the content of each module, topic wise, was estimated.

e. Integration :

Areas overlapping amongst modules on Women's Health Concerns and Preserving Women's Health were identified for integration. e.g. Nutrition, Maternal Health and Reproductive health concerns.

5. IMPLEMENTATION STRATEGY :

The participants felt that the programme should be implemented in a phased manner. It was suggested that the phases could include:

*	Phase I	– Feminist Perspective/ Approach Process	Understanding of self & Others (Co–operation) Overview of Programme.
*	Phase II	– Women's Health Content	(Women's Health Concerns & Building Women's capacities to preserve health).
*	Phase III	– Management Skills	Management/organisation of women's health programme.

However, it was stressed that there should not be a gap of more than three months between each of the phases. Regularity of participants in each phase was essential. It was suggested to divide the training programme into three phases. The integration of the women's health perspective was considered important in each phase.

There was a lot of debate and discussion on the implementation of the training programme' whether to start at the National level or at the Regional level. Majority of the participants felt that as the expected trainees from the NGOs participants would be more familiar with the local language it would be more effective to start the training at the Regional level. The experiences of the regions could be later shared at the National level.

The participants also debated on whether to mention the word "feminist perspective" in the title of the programme and it was decided not to do so strategically, as it may keep away individuals/organisations who do not have a clear idea of feminism.

It was suggested that NGO participants must be contacted individually to enquire whether they would like participate in the programme. Based on individual needs, the course could also be condensed into smaller modules.

6. SELECTION OF COLLABORATING NGOs

Since the effective implementation of any programme depends on the organisation implementing it, it was suggested that a careful selection of collaborating NGOs is essential.

6.1 Suggested Criteria for selection of collaborating NGOs

To ensure that women's health programme is implemented with the correct perspective at the grass–root level, it is important that appropriate selection of the participant NGOs is done. To facilitate the regional groups to be able to do this selection objectively and effectively, a list of criteria were suggested by the experts.

The suggested criteria based the order of priority/rank are as follows :

- Should have an experience in women's issues
- Should have an experience in women's health
- Should be committed to women's health and empowerment
- Should have credibility
- Should have an experience in community health
- Should have an experience in implementing socio–economic education programme.
- Should have training and organising capacities
- Support organisations with field based experience should be given preferance.
- Grass–root level groups should have been formed.

7. ORGANISATIONAL DETAILS

A core group was formed as a central body to assess the progress of the activities of the programme. Regional core groups were also formed, headed by co–ordinators, who would carry out the implementation at the regional level. Resource task groups were formed who would work on the content of the modules, identify areas which could be integrated and suggest resource persons.

7.1 Core Group

Expected task of the core group

- Co–ordinate/take the process ahead at the National level and Nepal region.
- Review and finalise a design based on suggestions made by the regional/ resource groups.
- Develop and suggest integrated training designs
- Create and provide pre/post training design support
- Conduct on going review of the implementation of the regional courses.
- Prepare a time frame and an action plan for the training courses.
- Suggest Budget implications/financial planning for the implementation of the courses.

It was suggested that the core group co–ordinator would co–ordinate/ interact with :

- Relating with DSE (Erika Fink)
- Relating with Regional/Resource Groups (including Nepal)
- Relating with core group members

7.2 Core group composition

Co–ordinator
Ms Indu Capoor, CHETNA, Ahmedabad

Members
Ms Ranjani IWID, Madras
Mr Gangadharan LSPSS, Coimbatore
Ms Anu Wakhlu, Pragati Foundation, Pune
Ms Renu Khanna, SAHAJ, Baroda
Ms Philomena Vincent, SHSD/AIKYA, Bangalore
Dr Mira Shiva, VHAI, New Delhi
Dr Sharad Onta, Nepal
Dr Mira Sadgopal, Pune

Since the Expert Meeting completed, the core group met on August 17/18 at Bombay (for details see Annexure – VIII)

7.3 Regional Group : Role/Need

As it was expressed that initially the programme should be implemented at the regional level it was decided to form a regional group that would have the following responsibilities.

Responsibilities

- Identification of NGOs in their region
- Integration /modification of the module based on regional requirement.
- Choosing and adapting of design based on the need of selected NGOs.
- Meet regularly to assess the progress of implementation at the regional level. (atleast once in three months)

1. **Maharashtra Region**

   Co–ordinator
   Ms Anu Wakhlu

   Members
   Dr Mira Sadgopal
   Ms Manisha Gupte
   Ms Marie D'Souza

2. **Western Region (Gujarat/Rajasthan**

   Co–ordination : CHETNA, Ahmedabad

   Members
   Dr Pal, IIHMR, Jaipur
   Mrs Chandra Bhandari, Sewa Mandir, Udaipur
   Mr Binoy, UNNATI, Ahmedabad
   Ms Renu Khanna, SAHAJ, Vadodara

3. **Southern Region (Tamil Nadu, Kerala, Karnataka)**

   Co–ordinator : Ms Philomena Vincent, AIKYA, Bangalore

   Members
   Ms Ranjani K Murthy, IWID, Madras
   Vd Gangadharan, LSPSS, Coimbatore

4. **Eastern Region (Orissa, Bihar)**

   Co–ordinator : Ms Soma Parthasarty, New Delhi

   Member
   Ms Ranjani K Murthy, IWID, Madras

5. **Nepal Co–ordinator : Dr Sharad Onta**

7.4 Resource Group

It was felt that apart from the regional groups, formation of resource groups was essential to finalise and integrate the modules and, to identify additional resources.

Responsibilities

- To suggest priorities in the content and the methodologies
- To suggest and finalise a tentative design for the modules
- To finalise the content and to integrate the modules
- To identify and collect appropriate resource material
- To identify resource persons and get their commitment
- To identify NGOs and assess their specific needs

It was suggested that the resource groups complete the following tasks by December, 1993.

- Identification of resource persons
- Identification of NGOs
- Identification/collection of training material

Composition of Resource group for 'Management Module'

Co–ordinator : Ms Philomena Vincent, SHSD/AIKYA, Bangalore

Members
Ms Soma K P – Responsible for material collection
Dr Nirmala Murthy
Anu/Arun, Pragati Foundation
Mr Stephen, SEARCH
Ms Renu Khanna, SAHAJ

Composition of Resource group for Integration and finalisation of the Modules on "Women's Health Concerns and Women's Capacities to preserve Health"

Co–ordinator : Vd Gangadharan, LSPSS, Coimbatore

Members
Vd Smita/Ms Pallavi, CHETNA
Dr Mira Shiva, VHAI
Ms Manisha Gupte
Ms Renu Khanna, SAHAJ, Baroda
Ms Philomena Vincent, SHSD/AIKYA, Bangalore
Dr Mira Sadgopal, Pune
Sarojini/Abha Jagori

(This group met at Ahmedabad on September 29 – 30th, 1993 and apart from outlining the principles of intregration of modules also prepared the tentative training design for the Ist phase of the training programme).

8. FINANCE

DSE Budget

DSE has planned until end of 1994 ,a budget for implementing three training programmes on women's health. After the pilot phase, DSE plans for an implementation for decentralised courses for the following years. However, since it has a limited budget (enough for one training in 1993 and for two trainings in 1994), the following was suggested.

- to transfer the funds available for the year 1993 to 1994 as it seemed difficult to conduct a training programme during 1993.
- to start with training programmes in a phased manner, region wise, so that there is no gap in–between training programmes.
- to use the training budget economically so that instead of only one training in a region, several trainings can be organised for different regions.

Organisations like CHETNA and AIKYA also showed willingness to subsidize/ support partial training costs from within their organisation's funds for organising workshops, including sensitization workshops for heads of NGOs.

For the implementation of the training programme to take place smoothly, it is important that DSE maintains the flow of funds on a timely basis.

9. FEEDBACK AT BANGALORE THE EXPERT MEETING

The workshop was fruitful as it fulfilled its objectives. Assistance from local organisations enabled its smooth functioning. The venue and the physical arrangements were appreciated by the participants as they provided an ideal environment for sharing of experiences both, formally and informally.

Suggestions made for improvement in future

- It was felt that the core group should lay down and follow more clear norms for managing the roles and responsibilities of the various groups involved as core and expert enabling the process to be more effective.
- Due to diversity of the experiences of participants, sometime was wasted in unnecessary arguments.
- For the successful outcome of the workshop, the role of participants and that of resource persons should be clearly communicated, prior to the workshop.
- Invitation letter to the resource persons and participants should be sent atleast 3 months prior to the workshop to enable them to plan and confirm their participation. A reminder should be sent atleast one month prior to the workshop.
- Role of the resource persons and participants should be clarified in the invitation letter itself.
- Networking between organisations andindividuals was considered essential.
- A name for the above network of organisations was suggested as WAH! (meaning–Women & Health). WAH! is an expression of appreciation in several Indian languages.
- The workshop co–ordination could be better in terms of providing direction to the proceedings and managing group dynamics and group processes.
- The core group should meet on a daily basis to provide feedback.
- Report writing should be a collective responsibility to be shared amongst the participants.
- Cultural programme should be held on the first day itself.
- Core group should know about all the related information sent to the participants.

10. CONCLUSION/FUTURE DIRECTIONS

The meeting was fruitful in achieving its objectives of developing and enriching the draft perspective and finalising the modules on women's health concerns, capacity building to preserve women's health and, management of women's health programme from a feminist ideology.

It also succeeded in exploring the possibilities of integration of the three modules. The formation of the core groups at the national and regional level and, resource groups would further ensure the integration and finalisation of the modules.

The decision of initially starting with trainings at a regional level, instead of national level was also taken unanimously, by the experts.

The tentative plan for 1993 is :

August/September,1993 : Finalising report of the experts meeting, sharing of responsibilities and role clarification of/among resource and regional groups.

October/December, 1993 : Integration of the modules into a long term training programme including design, details of content and identification of probable participants & resource/ resource persons.

11. AFTER THE BANGALORE WORKSHOP....

In continuation to the tasks completed at the Bangalore workshop, the urgent need expressed by DSE to start the initial training workshop during 1993; was considered during a National level core group meeting held at Bombay during 17/18th August, 1993 (see Annexure – VIII) and it has been decided to launch the first training programme in the Southern region from 6 – 16th December, 1993 which would be co–ordinated by Ms Philomena Vincent of AIKYA/ SHODHINI/SHSD. The financial requirements for the programme were worked out after the Bangalore workshop.

PROCESS OF BANGALORE WORKSHOP

The workshop brought together different people with different expertise and lengths of experience. Some had experience in gender issues while others had experience in indigenous healing systems or health care management. Quite a significant section of the gathering consisted of women who had been associated with the women's movement in India, at sometime or the other.

Out of the thirty six participants, only six were men. Some of the participants had been associated with this (WAH!) effort since the beginning, while majority of the people present were joining for the first time.

This diversity was both enriching as well as problematic. For instance in the first core group meeting comprising of about 12 persons, there could be genuine dialogue between the feminists and others from disciplines of management and traditional medicine. Many of the latter expressed that their understanding of feminist perspective on health was strengthened significantly. However, this same understanding could not be satisfactorily promoted in the larger expert group perhaps because of the size of the group. This communication gap manifested itself in statements like "the NGOs with whom we are working will reject this philosophy!" or "we are being too radical".

Despite these limitations, the group did proceed to effectively evolve the three modules. However, after the work on the modules, the group found it difficult to reach a consensus about how to proceed further and operationalise these modules.

For instance, in a classic chicken or the egg situation, the discussion kept going on round on whether to first select the collaborating NGOs and finalise the design of the training programme or whether to design the training programme first and use this to initiate dialogue with the NGOs. Another point where a long discussion took place was whether to launch the training programme at the national level or at the regional level.

These frustrating moments were, by and large overcome by the seriousness and commitment of the persons present. At various times, individuals articulated their personal vision, and this was inspiring.

A large group has its own dynamics depending on the background and the history of their relations due to different background and experience.

And lastly, a factor which seriously impaired the proceedings of the workshop was the lack of clarity on roles and responsibilities. For instance, as mentioned

earlier, the entire meeting was divided into three parts; the core group, expert group and task group. The boundaries between these three groups overlapped leading to some problems.

Rather than using the expert group as a sounding board for ideas and basing the decisions on these by the core group, there was a tendency to expect the expert group to take certain decisions. Another problem caused by overlapping boundaries between the three groups, was a lack of continuity in distinct participation and changing discussions to a natural closure.

(The purpose of documenting the process of the Bangalore meeting was not just self flagellation but to draw out lessons for the future).

Heterogeneity of the group made it at times difficult to reach a common understanding. In the process it had to be cleared and decided upon how and in which institutional frame work the curriculum would be implemented.

Annexure – I

SURAJKUND CORE GROUP COMPOSITION

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} Co-ordinators of Module Writing task groups

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Annexure – IA

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   – Dr. Mira Shiva

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   Ms.. Jyoti Gade CHETNA Team, Ahmedabad
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Annexure – II

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Annexure – III

A FEMINIST PERSPECTIVE ON WOMEN'S HEALTH

A feminist perspective implies an alternative outlook originating from the experience of women living in a society dominated by sets of values and institutions which are "male–structured". It was felt relevant and necessary to develop a feminist perspective on women's health to guide the DSE–supported "WAH!" (Women and Health!) Programme for training of women in management skills relating to women's health.

The perspective presented in this paper was elaborated during the DSE–organised Expert Consultation at Bangalore in June 1993, through a group process. The whole group of approximately forty persons was mixed, including those who had never before internalised the meaning and significance of feminism. Therefore, several sessions were devoted to the process of exploration and elaboration. This resultant paper* is intended to guide the development of the training programme with inclusive regard to aims, approach, methodology and materials. It is presented in three parts:

1. The first part outlines the status of women's health in Indian society, including the impact of so–called development" on women.
2. The second presents a critique of present health care systems in India from a feminist perspective. It introduces a theoretical framework of patriarchally–structured gender relations, and analyzes the interlocking of gender with other oppressive relations.
3. The third part highlights the contributions of women to health, and their struggles for health, in order to convert the distorted image of women as only victims and to help find positive strategies.

I. STATUS OF WOMEN'S HEALTH

Women's health status in general is abysmally poor. This is directly related to their low status in society as opposed to men. It is reflected in overt statistical trends like

- falling sex ratio (currently 929 females per 1000 males) and – persisting high maternal mortality (estimates ranging from 300 to 900 deaths per 100,000 births, compared to low two digit figures in developed countries),
- 278 per cent increase in rapes of minor girls in the city of Delhi alone in the last year,and in daily newspaper reports of domestic violence, murder and suicide. Even so, most harassment and violence against women remains invisible to society and is even hidden from other women. Studies now show that roughly seventy percent of violence against women including persons who are not strangers.

In fact, the combined result of sex pre–selection technology, use of amniocentesis leading to female foetus abortion, rising female infanticide, nutritional and medical neglect of girl children, severe sexual and physical assault of girls and women, reproductive over–exploitation, hazardous contraceptives and sterilization abuse, dowry and domestic murders, overwork of underfed women, all aggravated by the

effects of the price rise spiral, amounts to a picture of no less than genocide of the female sex.

Leaving aside mortality, morbidity (debility and illness) is even more pervasive. Most Indian women are semi–starved and anemic, making them prone to various infections including tuberculosis. Gynecological illnesses are silently rampant, notably sexually transmitted infections, contraceptive–induced disorders, and cancers. Particularly, the incidence of cancer of the cervix in Indian women is the highest in the world. Post–tubectomy syndrome (PTS) is now a medically recognised term, validating women's long reported ailments following sterilization opera tions. Widely experienced menstrual bleeding disorders add to previously existing anemia. In turn, in pregnancy anemia puts women at higher risk for developing fatal toxemic eclampsia (fits) and hemorrhage. Childhood undernutrition can leave a girl to grow up with an undetected contracted pelvis, resulting in obstructed child–birth and tragedy.

Among the poorest, high birth rates (40–50 births per 1000 population per year) are always a sign of people waging (through their women's bodies) desperate struggles to survive and grasp control of life in the absence of food, employment, old age and other social securities. In all social strata infertility of couples (approximately 30% man–related, 40% woman–related, 30% both or undetermined) causes untold suffering, cruelty and desertion, as the entire blame gets thrust on women. To ensure biological offspring as heirs, new reproductive technologies (NRTs) like in vitro fertilization (IVF or test–tube baby) flourish. Amniocentesis and ultrasonography is widely used to determine sex and enable selective female foeticide by abortion.

Adding to this unhealthy picture, the Government Health Services have become blatant vehicles for population control aimed mostly at the rural and urban poor. Despite women's constant, long standing demand for safe contraceptive methods which they themselves can control, the government is accelerating its policy of introducing invasive, systemic, long–acting, provider dependent methods of so–called "family planning", namely injectable and surgically implanted contraceptive hormones and anti–fertility vaccine (AFV).

Promoted with jargon of women's empowerment and reproductive rights, these methods further remove the control of reproduction from women. Not only that, through enhancing men's free sexual access, women report that such methods often doubly aggravate their subjugation.

Behind this global intervention into women's lives are the multinational commercial interests. These fortify pressures by rich Northern governments and global agencies upon third world countries to adopt stricter and stricter measures to control population (read women). Complications which women face include a sevenfold rise in incidence of pelvic inflammatory disease (PID) due to IUD insertions and and to mass sterilizations (Bangladesh study, 1989), and involvement of women without informed consent in large field–based trials of methods like NETEN, NORPLANT and AFV.

The economic context of these stresses upon women's health is the global and national trend towards privatisation and structural adjustments. In the Government health care system, whatever supports for women existed are being undermined and dismantled. What had begun happening even since the sixties is now

accelerating under the "New Economic Policy" (NEP). Pressures on Government to take stricter population control measures are knit into the NEP, as can be seen by the proposal to limit access to the public distribution system (PDS) through ration cards to families with two or fewer children.

Women suffer the worst effects of the NEP. Their burden of work in the family increases. Middle class women depend on procuring cheaper food in rawest and crudest form and home-processing it for consumption, whereas poor women forego even essential nutritious food to help ensure that men and children do not suffer or starve. Increasingly marginalised from the organised and unorganised labour sector by unemployment, women are being pushed back into exploitative home-based piece-work or into fulltime unpaid domestic labour.

At home, women as wives, mothers, sisters and daughters carry actual responsibility for holding the family physically and emotionally together, including keeping up in-law relations and religious rituals. The stress of double burden on women who also work outside the home can result in breakdown. Women who become ill receive resentment more often than sympathy. For instance, if a woman falls sick with tuberculosis, she does not receive the care and attention that a man does. Hence, for her, having the same disease as a man is not at all the same experience. Additionally, women at home are occupationally prone to suffer certain ailments besides anemia such as backache, headache, tiredness or exhaustion, stomach acidity pain, eye complaints due to cooking smoke, pain during intercourse, etc., and from emotional states of depression, anxiety, loneliness, irritability, restlessness or heartache which can't be expressed.

Sexuality is a severely distorted and abused area of women's lives. The middle class woman bears the most distortion, beginning from her childhood upbringing which instills a sense of shame, distaste for and separation from her own body and which discounts her intellect, too. At puberty she may be literally contained in the home until marriage can be arranged and carried out. As a rule, no information is conveyed to her in advance to help her understand and cope with menstruation and with sexual relations in marriage, not to speak of knowing her rights to say yes or no to sex. While poor and dalit women may be freer to express sexuality, they are more prone to sustain blunt male violence. For a single woman, never married, abandoned, widowed or divorced, sexuality is unspeakably taboo, at the cost of being switched or dismissed into the category of "prostitute" where she becomes free game for men.

Sexual abuse is ubiquitous – at home, on the street, at the workplace. Needless to say, it never gets the warranted attention from civic bodies and labour unions. At home, it is indulged in by male relatives and acquaintances on vulnerable children and women, blind to their categories, especially when men are confident that those they abuse won't or can't speak about it. Molestation and rape of mentally and physically disabled women is virtually expected.

While women suffer all forms of emotional stress and illness, they often get labelled or parcelled away as mentally sick simply because they are reacting to injustices and cruelty. Field investigation now suggests that hysteria in young unmarried and married women is almost always an unacknowledged response to sexual abuse. The phenomenon of possession by a female deity is a sanctified means for temporary physical and sexual liberation, and a safety valve to help

maintain a woman's sanity intact. Devaluation of aging and aged women, including the misunderstand ing of menopause, is growing.

It explains the failure to address the specific health problems of older women, such as arthritis, osteoporosis, cancers, malnutrition and loneliness. Sexuality of older people is discounted along with other positive aspects of aging such as wisdom and freedom from reproduction. Further, the devotion of women's whole lives to maintaining and preserving society and culture is simply taken for granted.

AIDS (Acquired Immuno–Deficiency Syndrome) has emerged as a global public health threat. Its profound socio–economic impact could be especially destructive in our country because of the various factors affecting health status already laid out. Preventive strategies are women–focussed, particularly on women sex workers (prostitutes). While sexual contact is the major route of HIV (Human Immuno–deficiency Virus) transmission, it is not acknowledged that it is the men, not the women, who are the main vectors of transmission. That is, among persons involved in the practice of prostitution, men (as clients) are far more numerous and mobile than women. Rather than being labeled the most "high risk" group, sex workers are the most "at risk". Biologically, uninfected women are ten to thirty times more prone to AIDS infection at any given contact, because the vagina is a large exposed surface of virus penetrable membrane, and because condom leakage still protects a man but not a woman. Prior STD infection like gonorrhea or syphilis further increases the risk factor to three hundred times.

Legislation at present provides little relief for women in terms of general health protection. Much legislation still views women as exploitable and discountable in both production and reproduction spheres. Some legislation is grossly out–dated and inhumane, such as a clause permitting a man divorce of a woman who has epilepsy, leprosy or mental derangement. Divorce, maintainance, child custody, inheritance and land property rights are in the domain of personal law of the various religious communities. While not being uniform, all the codes subject women to forms of patriarchal injustice adversely affecting women's status and health. Rape Law contains many lacunae and injustices, such as requiring semen presence to establish rape. Domestic violence is often not recognised, unless it results in death, and even then it is often covered up. Legislation to contain harrassment and punish murder connected with dowry is a victory for women's organised struggle, but has not resulted in reduction and such deaths continue. Employment service guarantees, including paid leave, child–care creches and maternity benefits are unavailable to most women. Maternity benefit is never sanctioned in case of child adoption.

The MTP Act (Abortion Law) passed in 1975 made medical abortion legal but has not succeeded in making it available for most women. There are five to six million unsafe pregnancy terminations per year according to official estimate. No legislation protects the sexual and reproductive rights of women. The legal right to abortion is secure only on account of population control interests. Accordingly, the health budget allocation to 'family welfare' has increased significantly, in absence of legal protections for women in case of contraceptive abuse and complications.

The dynamics of patriarchal control over women resulting in their poor status of health can be conceptualised as in the diagram of triangular force accompanying this paper. (Refer Page 5)

II. CRITIQUE OF HEALTH CARE IN INDIA

Actually speaking, in India a number of health care systems operate at the same time, occasionally side by side, sometimes vastly separated. Let us take stock of these systems:

1. The western medical system (allopathy) which was introduced through British colonial rule, forms the basis for the post– independence Government health services and the bulk of lucrative private practice.

2. Culturally more pervasive and much older are the indigenous health systems. These are further divided into two streams:

   a. the widespread Folk (or Local) Health Traditions (alsoknown as LHTs, or Lok Swasthya Paramparas), characterised best by their diversity and spirit of self–reliance, and

   b. the classical (shastriya) systems known as Indigenous Systems of Medicine (ISMs),including Ayurveda, Siddha, Tibbia and Unani. In their development, the ISMs have drawn much from the LHTs, and vice–versa, over one to three thousand years or so.

3. Originally developed in Germany, Homeopathy has taken deep root in India over the last century. We have the largest number of homeopathic practitioners in the world.

Although widely prevalent, the indigenous systems and homeopathy are virtually ignored by the dominant western system.

THE DYNAMICS OF PATRIARCHAL CONTROL OVER WOMEN RESULTING IN THEIR POOR STATUS OF HEALTH

Triangular Force Diagram developed by WAHI (Refer Page 5)

(Women and Health!) Training Programme, 1993 .

Hence, the Government has established a western–oriented programme of primary health care to treat emergencies, prevent and control communicable diseases, extend supplementary care to mothers and children, and promote "family planning". In addi tion, institutions have been set up to render specialised cura tive care which are usually urban–based.

Inherant in each system of health care is a specific attitude towards people and their bodies. The allopathic system tends to view people as composed of distinct mechanistic organ systems like the gastro--intestinal tract, the cardio–respiratory system, the uro–genital tract, the nervous system. etc. The Indian indigenous and homeopathic systems, in contrast, see human health more in terms of balances and flows of vital humours* and energies. They are less concerned with the physical boundaries and connections of organs. The allopathic approach to medical treatment is characterised by attempts to fight, remove or eradi cate causative agents (germs, allergens, defective parts) and to suppress symptoms. On the other hand, the indigenous and homeo pathic systems, aim towards

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* The word 'humour' is not a satisfactory translation of the ayurvedic term 'dosha', but only an approximation.

restoring balances and flows in the person without considering the parts separately. The latter approach is called holistic. Realistically speaking, each approach has certain strengths and weaknesses.

Whatever the particular health system, the healer (doctor, vaidya, hakim, vaidu) can exploit his (or rarely her) power over the sick person (patient) and relatives, and often does. Even when benevolent, the relationship is usually patronising. It is doubly so with women who are sick. In this respect, there is little difference between practitioners of the holistic and non– holistic systems. Women sometimes tend to prefer the holistic approaches, perhaps because allopathy is understood to be too "strong" and invasive. However, this comparable gentleness is no guard against patriarchal attitudes which have become embedded even in holistic health systems.

Patriarchal values and behaviour in society exert control over women's labour, reproduction and sexuality. The basic social unit of patriarchal control is the family through mar riage. Inheritance is patrilineal through father to male off spring, and hence biological motherhood is necessary. Most existing religions are patriarchal and reinforce the patriarchal bias in the health systems.

The Dominant Health System's Stance towards Women

Patriarchy is a fundamental undercurrent in the dominant health system. Women themselves are seen as problematic They are considered ignorant, irrational, emotional, dependent, superstitious, unhygienic, etc., rather than as resources who are intelligent, practical and knowledgeable. Women are generally allocated identity and social worth in relation to the notion of motherhood rather than womanhood. Medical treatment first takes stock of a woman's relationship with family and childbearing.

Hence, single women's gynaecological problems have little sanctioned place in health care. Problems during other parts of women's life–cycles, like osteoporosis in older age, are neglected.

Hence, the system does not locate the health problems of women in the real context of oppressive man–woman relations. Treatment ignores the need to change these relations. Ill– effects to women's health arising out of such relations, such as reproductive tract infections or injury and mental trauma, are not treated seriously enough. The effect of gender division of labour on women's health is unrecognized, including the health costs of invisible work at home and in the informal sector.

Under sanction from patriarchy, medicalisation of health has occurred at women's expense. Whereas pregnancy was viewed as a part of life, it is now treated as a disease. Thus, people are led to believe that doctors, hospitals, medicines and high technology are necessities for achieving healthy birth. Infer tility has also become a disease to be cured at any cost.

New reproductive technologies flourish pandering to the craving for biological offspring, despite the more sensible path of child adoption. Health and reproduction are becoming like market commodities which one can buy if one has money. In the commodit isation process, the pharmaceutical industry has played the greatest role. There seems to be no end to its tampering with women's

bodies, as in the promotion of ERT (estrogen replacement therapy) to postpone menopause indefinitely. In case of hormones used for oral, injectible and implantable contraception, never before have so many women been given potent medicine continuously to suppress a condition (fertility) that is not a disease.

In this process, women's indigenous knowledge of health care has been marginalised or lost, and their continuing role in maintaining the health of their families and communities has been devalued. Self-help measures and remedies that address women's ailments, passed down through generations, are being replaced by mystified pharmaceutical and high-tech paraphernalia. Not sur prisingly, this leaves women with a sense of separation from their own bodies.

The dominant health care system virtually revolves around statistics. This introduces certain automatic biases. For instance, statistics give importance to rates rather than reasons. Hence, they give legitimacy to population control in place of development of health services. People are looked at as numbers and targets rather than as persons.

The Government Health Care System

States by nature are always more or less patriarchal. The patriarchal nature of the Indian State is reflected through all its institutions including the Government health care system. As everywhere else, patriarchy does not operate in isolation, but interlocks with all other oppressive and discriminating systems such as class, caste, ethnicity, religion, race, etc.

Within the health care system operated by the Government, o:_6 there is a peculiar dichotomy of attitude towards two types of women. Women patients receive benefits only as mothers or repro ducers, and the nurses (ANMs) who provide care are treated as sex objects, lowest in the health service heirarchy. Higher up, women doctors are pressured to operate within a male–structured value system which devalues and abuses women and people from oppressed caste and class. Further, women are viewed by the family planning programme as either targets or traitors to the national cause if they do not accept contraception.

In another variant of relationships, the patriarchal role pattern of the family gets replicated within medical institutions, with the doctor (typically but not always a man) playing the role of father, the nurse (usually a woman) acting as wife and the women patient playing the child.

Government Health Policy and Population Control

It is important to identify who decides what is important in health, and how health expenditure gets allocated. Multi–lateral aid agencies, the Indian government, large pharmaceutical indus tries, health administrators and doctors determine the priori ties. Today, these inevitably represent the interests and per ception of western society, the rich, the powerful, the Indian upper class and caste, and the male.

Population control in the dishonest guise of a family planning programme receives priority, neglecting development of the health care system and other social necessities and supports for women. The programme is technology–based, placing no faith in the resources of people to control their own fertility, given adequate

education, safe contraceptive options, and support through assuring survival of themselves and their children. It selectively targets the poor and women. Rather than guaranteeing women's freedom from oppression, it accepts and accommodates unequal man–woman relations. Rather than rendering support to women, incentives and disincentives undermine relations between the people and the health services.

International Aid and Population Control Agencies

International agencies construct gender in several ways. For example, the W.H.O. considers women to be "vulnerable". Looking at what vulnerability really means and at what makes women vulnerable is generally avoided. Women's health is sub sumed in the term "safe motherhood".

Fear is expressed that population growth of the poor and in third world countries threatens the future of all on our planet. In reality at present, the rate of resource consumption and toxic pollution is much higher in the rich developed countries than in the poor developing countries. The problems of improving general health status in the third world and of curtailing consumption levels of the first world are intertwined with and in no way less important than fertility control. Yet the rich countries are seeking to force population control upon the poor who have no guarantee of health, without curtailment of their own wasteful lifestyle and consumption levels.

This has led to a sophisticated culture of deceipt. International aid agencies seek to legitimise blunt population control programmes under guise of slogans like safe motherhood, reproductive rights, right to abortion (as in Nepal, where abortion is illegal), environmental awareness, etc. The massive scale of funding and publicity given for AIDS prevention undoubt ably belies the ulterior motive of controlling population through universalisation of "safe sex" (condoms).

The Non–Allopathic Systems

A feminist critique of these systems has not been evolved by women health activists. Neither has it been possible for us to make much headway while preparing this perspective paper. One problem is the confusion from assuming that holistic systems are kinder to people in general and to women in particular. This may be true in many instances, but it is not necessarily so in practice. Another reason is that few women well educated in these systems have identified with the modern women's liberation movement, initially inspired by western feminists. Hence, at present we offer a few superficial and tentative observations as experienced so far by women among us.

As noted before, patriarchal biases exist in these systems as they do in allopathy. In the LHTs the authority of patriarchy tends to be less, but is apparently still there, as in tribal communities and in the matrilineal Nayar community of Kerala. Patriarchal attitudes can appear when considering white discharge, menstrual disorders, and food restrictions. Classical ISM physicians are usually male, and rarely if ever perform internal physical examinations, but reportedly can diagnose gynaecoiogical disorders by pulse alone. This may be hard to fathom and accept for some women health activists oriented by the western system and committed to demystification and self–exam.

It has been suggested to us that, particularly in ayurvedic tradition, there are certain specific "women–strengthening" features. We would like to know more about this possibility, and whether these are not cryptic ways of again accommodating to and strenghthening women's subjugation under patriarchy.

In the ISMs, it is said that there are areas of misinterpretation and superstition overlaid upon the original pure teachings of the ancient physicians. Until these areas are cleared up by vaidyas and hakims themselves according to common agreements, it will not be possible for lay people to know the difference. In addition, modern indigenous practitioners have the task of addressing new phenomena, such as air pollution, pesticide poisoning and AIDS, never imagined by the original physicians.

The ISMs have arisen from non–commercial tradition where looking after the health of fellow beings was considered the duty of learned persons. The ayurvedic text Vagbhata warns a physician that he should better swallow molten iron than take a fee from a suffering person. Today, the ISMs are prone to mimickry of allopathic form and co–option into the western commercial mode. As this process continues, much stands to be lost further. Still the majority of our people think and believe in terms of the ISMs and LHTs, even though they often spend and depend on dramatic allopathic cures.

We realise the importance of the holistic essence in these systems, which in general do not split the human mind and body from itself or from surrounding nature and universe, in contrast to allopathy's (and western culture's) tendency to do this. Feminists concerned with health must focus more attention on compre hending the strengths and limitations of the non–allopathic systems.

III. WOMEN'S CONTRIBUTIONS, STRUGGLES AND STRATEGIES

Focussing so acutely upon the low status of women's health may send us into a state of numbness and pessimism. Women are victimised, yes, but women are not only victims. In this section, the intention is to demonstrate that not only can women be victors, but they are also characteristically creators and sustainers of life, bounty, beauty, peace and joy. Even when sick themselves, they continue to contribute fundamentally to the health and preservation of society and the environment.

Women's contribution to health is traditional as well as innovative. Traditionally, they have been healers (herbalists, massage experts, midwives, counsellors for emotional problems), nurturers (food–processing, feeding, comforting, sympathising), and health educators (training eachother and the next generation). They have carried the brunt of reproducing the next generation. They have traditionally played a large role in farming, invisible to patriarchy, particularly in the production of food. Maintaining a clean and fresh home environment through fetching water, fuel and fodder and carrying out daily tidying and repairs provides the necessary background for their families' health. In rural areas, while pursuing these functions they preserve and maintain the forests and fields which provide the sources of life support. As part of work and life they create music, art and dance to lift the spirits of themselves and others. Their personal faith and religious observances tend to link holistically with all of women's functions.

In contrast to men, women's names are few in the recorded history of health, and one has to search for them. Despite Indian women's direct and crucial involvement in health, the reasons for their namelessness could be :

Women's oral culture, ignored by literate brahminical tradition, their less competitive, more participatory nature, being relatively unconcerned about being named and famous, and their marginalisation and devaluation as healers and as persons, with expropriation of their healing authority under patriarchy.

From western medical tradition, one only thinks of Florence Nightengale and Marie Curie amongst hundreds of men of medicine, although the women's movement in the west has unearthed other women's names and histories. It is an uncompleted task to raise up the names of women who have contributed outstandingly in Indian health tradition.

However, we can think of some very current names of women who have suffered specifically for their role in struggles for health and the right to healthy life. The following three women were gang–raped in different incidents within the last one year:

Bhanwari, a saathin of the Women's Development Programme, Rajasthan, in retaliation for her work against child mar riage (September 22, 1992), Satto, a sakhi of the Mahila Samakhya Programme, Saharanpur, U.P. (May 1993), and Budiben, an activist of the Narmada Bachao Andolan, at Antras village in Madhya Pradesh, for opposing the dam and for refusing to leave her village (April 4, 1993).

These women have not given up their struggles. In commemoration of their bravery and in attempt to call attention to the viola tion of women's human rights 22 September 1993 was observed all over India as National Protest Day against Violence on Women.

Still, as we write these words, we see before us the expressive faces of countless women healers of today, working constantly to reduce suffering and impart strength – women like Balnagam ma in Andhra Pradesh, Sukhabai from Gujarat, Siddamma of Karnata ka and Bhagwati of Madhya Pradesh.

As part of the women's liberation movement, women's groups in Government programmes, in NGOs, in mass movements and mass organisations, party–affiliated and non–party, are struggling for health rights and trying to build new alternatives for health care. From Madurai to Manipur, Arrakkonam to Ajmer, Dalli–Rajhara to Delhi, Goa to Gadchiroli, Tehri to Tirupati, women are taking steps to paint a new picture of health over the old background of exploitation, abuse and servitude. Many of these initiatives include anti–alcoholism struggles, targetting the liquor contractors and merchants who benefit, pulling men in line, and pressurising the Government. In health care, women are reclaiming authority and knowledge through self–help ap proaches, using new scientific information and validating old indigenous remedies and herbal medicines, as in the Shodhini Network.

In the cities like Delhi, Calcutta, Madras and Bombay, with the spectre of AIDS growing, health activists working among sex workers (a new name replacing "prostitute") have enabled these women to convert their imposed self–image of being "highest risk" to "most at risk" from men infected with HIV and other sexually transmitted diseases. With life and death at stake, and stereotypes to

break, health care initiatives among sex workers in the major cities may well form a cutting edge of the new women's health movement in the coming decade.

On another front is the struggle against coercive Government population control policies and programmes, particularly against the pushing of "long-acting, invasive and systemic" contraceptive methods at the cost of women's health and undermining the functioning of the government health care system. Despite stiff resistance from women's groups, but with heavy international pressure and funding from population control agencies, the Government is going ahead with its programmes to launch NORPLANT (below–skin hormonal contraceptive implant) and AFV (anti–fertility vaccine) at mass level. At the same time, expansion of facilities for IUD insertion and for the terminal method of laparascopic sterilisation continues.

Slower to start but soon to accelerate is the initiative of local women's organisations and networks to teach the use of "barrier contraceptive methods", which are safe. Particularly interesting are those controlled by women (unlike the male condom, or Nirodh) such as the diaphragm, cervical cap, vaginal spermicidal sponge, and female condom. Since the Government has so far resisted including these methods in the "family planning" programme, channels of supply may have to be opened up from elsewhere, and indigenous manufacture tested for feasibility. These developments are linked with the sharing of information about reproductive biology and training of fertility awareness skills. The initiative squarely questions men's rights over women's bodies and challenges men to participate equally in the

CONCLUSION

The sphere of health management in NGOs as well as in Government is largely dominated by men and by male–structured thinking and relationships. Management itself carries with it an ideological history which has not always been kind to people's or to women's interests, intuitions, and capabilities. Successful women managers, like women doctors, have always been forced to adopt male styles to succeed. New trends in management acknowledge this, and much has begun to change. The challenge to women is not only to enter into management of health successfully, but to do so in solidarity with the interests of women. Additionally, they may identify and explore management forms and techniques known to our people traditionally, attempting to correct the biases of western style management as it dominates today.

Self–Help and Self Reliance are passwords of a new wave in the women's health movement. In this evolving context, training in women's health management skills assumes great importance. We look forward to collaboration with friends and the fruitful implementation of the WAHI Programme with excitement and hope.

Members of the Perspective Task Group: Abha Bhaiya, Asha Kachru, Sharad Onta, Veena Shatrughna, Ranjani Murthy, Mira Sadgopal, G. G. Gangadharan, Smita Bajpai, Philomena Vincent.

Annexure - IV

MODULE - WOMEN'S HEALTH CONCERNS

Introductory Note :

The outline of this module was discussed and it was felt that the contents of the perspective paper should be integrated throughout the module and four sets of factors

Technology, social/cultural, legislation and self-help approach should form the basis of the discussion on each concept.

I. Role, Status and Contribution of Women

Objective :

To understand and appreciate the role, status and contribution of women in our society.

Expected Outcome :

To understand how "patriarchal structures" and systems influence the status and health of women.

Concept/Content :

1. Social reality in terms of the present health situation and trends in society (rise of fundamentalism, new economic policy, population and health policy).
2. Women's contribution and women's place in health care system.
3. Concept of patriarchy and gender.
4. Life cycle approach to women's health.
5. Critic of health system from feminist perspective, western approach of health.
6. International network on Reproductive Rights and National level on Women & Health

Methods

- Lecture/handouts
- Discussion
- Small group discussion
- Structured exercises

Resource Material

- Film "ARMAAN/PRATIKSHA (UNICEF)
- 'Sasuraal - Piyar' "Trilogy" (Meena Diwan's)
- Something like a war (JAGORI)

Resource/Resource Persons

- Abha/Sarojini, Jagori
- Ms.Nandita Gandhi
- Ms.Nandita Shah
- Dr. Mira Shiva
- Ms.Asha Kachru
- CHETNA
- Ms.Renu Khanna
- Ms.Maitri Krishna Rao – SNDT
- Dr.Mira Sadgopal
- Dr.Meera Chatterjee, Ms.Ranjani, IWID
- Sabla, Kranti

Estimated Time Required : 3 days

II. Conception : Birth and Infancy

Objective :

To understand and recognise the beginning of discrimination against girls from birth and before.

Expected Outcome :

Should be able to understand and recognise discrimination against girl child from birth and before.

Concept/Content :

1. Sex Ratio
2. Determinants of gender
3. Role of modern technology
4. Discrimination of girl babies despite biological superiority, high mortality of girl child–infanticide /neglect
5. Discrimination in nutrition (breast feeding, feeding practices).
6. Social, cultural supports for mothers, for child care, maternity benefits, creches at work place.
7. Adoption issues, rights of adopted child/law for adoption of child.

Method

- Lecture/handouts
- Discussion
- Reading
- Action Research for feeding pattern of child/rest of mother, baby food (Girl and boy)

Resource/Resource Persons

- Dr. Meera Chatterjee
- Dr. Mira Shiva
- Dr. Shanti Ghosh
- VHAI
- CHETNA
- JAGORI
- Vimochana Women's Centre
- Janet Chawla

Reference Material

- Books
- You and your child, Dr. Shanti Ghosh
- Adoption – Dr. Mira Shiva
- Pakistani Video Serial "Ahaat"

Estimated Time Required : 2 days

III. The Girl Child and Adolescent

Objective :

To understand and recognise the specially disadvantaged status of the girl child in our society.

Expected Outcome

- Should be able to understand and recognise the discrimination faced by girl children in all spheres of their lives like education, nutrition, health.
- Should be able to understand how girls are socialized into stereotypical roles.
- To be able to identify signs of sexual abuses and how to prevent it.

Concepts/Concerns

(1 – 5 years)

- To understand and reorganise social, cultural factors influencing high mortality rate in girl child.
- Understand how girls are socialised in stereo–typical roles.

(6 – 10 years)

- Discrimination of girl child in education, self esteem, physical and sexual abuses, emotional health (factors affecting under–nutrition).

(11 – 15 years)

1. Understanding their own body
2. Understanding and preparing for marriage or its options
3. Sexual abuse

Methods

- Lecture/handouts
- Discussion
- Reading

Resource Material

- Pakistani Serial 'Ahaat' (Video film)
- Ghanashyam and Punki
- Armaan

Resource Persons

- Ms.Manisha Gupte
- Dr. Shanti Ghosh
- VHAI
- CHETNA
- JAGORI
- Dr.Meera Chatterjee
- Dr.Mira Shiva
- Vimochana – Women's Centre
- PRERNA
- Ms.Shalini, ISI, New Delhi
- VHAI
- Kamala Bhasin
- Sarah Chanda

Estimated Time Required : 3 days

IV. Adult Women's Health

Objective :

To know and understand the different integrated elements of women's health and their interaction.

a. Nutrition

Expected Outcome :

- Should be able to identify critical areas of women's health concerns.
- Should be able to identify critical areas of women's nutrition and on its nutritional status.

Concept/Content :

- Food and politics of food within the family and society – Public Distribution System (PDS)
- Water, politics of water
- Gender division of work and its effect on women's health.
- Women's work Vs. Calorie intake.
- Anaemia/Feeling tired.
- Food during pregnancy and lactation.
- Deficiency (nutritional), Vitamin A/Calcium/Iodine.
- Food taboos and food taboos related to control of sexuality.
- Toxic adulteration and contamination including pesticides, colouring agents and preservatives.

Method :

- Lecture/handouts
- Discussion
- Reading
- Lecture/handouts
- Videos
- Role Plays
- Survey in the field

Resource/Resource Persons :

- CHETNA
- Dr. Shanti Ghosh
- Dr. Veena Shatrughna
- Dr. Mira Shiva
- Dr. Mira Sadgopal
- Ms. Vanaja Ramprasad, LSPSS
- Sabla Sangh/Action India

Estimated Time Required : 1 – 1/2 day

b. Occupational Health

Objective :

To know and understand the different integrated elements of women's health and their interaction.

Expected Outcome :

- Should be able to understand the "impact of work" on women's health

Concept/Content :

- Contribution of women in organised and unorganised sector
- Working environment and condition of women workers at home and outside the home
- Legislation (equal wages for equal work)
- Occupational health problems of women
- Working postures
- Repetitive strain
- Injury (RSI)
- Gynaecological problems
- Stress
- Exposures to toxic and irritants
- Effect on foetus
- Effects of technology on women's work
- History of resistance and strength against occupational health hazards
- Focus on large occupation groups
- CSW (Commercial Sex Workers)
- Women health workers (ANMs)

Methods

- Discussion
- Reading
- Lecture/handouts
- Videos
- Role–plays
- Survey in field

Resource/Resource Persons

- Dr. Mirai Chatterjee, SEWA
- Ms. Suneeta Dhar
- Dr. Mira Sadgopal
- Ms. Veena Shatrughna
- Ms. Vanaja Ramprasad, LSPSS
- Mr. Binoy Acharya, UNNATI

- Ms. Sujatha Gothesker
- Ms.Elina Sen
- VHAI
- Dr. Shyama Narang

c. Emotional Health

Objective

To know and understand the emotional health concerns of women and towards equality/balance.

Expected Outcomes

1. Discuss the role of family in precipitating stress and violence.
2. Debate the assumption that home is a safe environment for women.
3. Recognise and encourage positive family support to women
4. Discuss alternatives of support for women e.g. encouraging other forms of living eg. community living other than marriage and family.

Concept/Content

- Sexual harassment at home, at work and community
- Family rape, incest and history of sexual abuse
- Marital Rape.
- Social pressures e.g. Dowry).
- Multiple roles.
- Overwork.
- Discrimination at home and work place.
- Battering and other violence
- Suicides, murders
- Accidents and stove bursts
- Women as witches
- Depressions (Schizophrenia and other psychological disorders)
- New structures and spaces
- Concealing
- Women and spiritually

methods

- Lecture/handouts
- Discussion
- Videos
- Profiles of women
- Films

Resource/Resource Persons

- Ms. Manisha Gupte
- Ms. Renu Khanna, SAHAJ
- Ms. Abha/Sarojini, JAGORI
- Vimochana Women's Centre
- Dr. Mira Sadgopal
- Ms. Gita Thadani
- Eyes of Stone (Film)
- Ms. Flavia, FAOW

d. Other Health Problem of Women

Objective :

To recognise other health concerns of women not covered specifically under earlier sub–themes.

Expected Outcomes

- To realise, the importance of those problems which worsen women's overall status.
- To question the medicalization of women's condition for profit.

Concept/Content :

- T.B. including its relation to infertility and ecotopic pregnancy
- Cervical and breast cancer
- Aids
- Headache
- Lower backache
- UTIS
- Acidity, restlessness
- Unnecessary medical intervention
- Cosmetic surgery
- Hormone therapy

method

- Lecture/handouts
- Discussions
- Self–help
- Group discussions
- Slides
- Videos
- Pictures

Resource/Resource Persons

- SEWA
- Dr. Rani Bang, SEARCH
- Dr. Mira Shiva, VHAI

Estimated Time Required : 2 days

V. Sexual Health and Sexuality :

Objective :

To understand women's sexuality and sexual energies

Expected Outcome

- To understand women's (and men's) sexuality
- To discuss the construction of sexuality and sexual roles of men and women
- To assert women's right in the expression of their sexuality/sexual preference
- To understand and initiate self help as a way to learning and training
- Challenge myths regarding sexual behaviour

Concept/Content

1. Question stereotypes of masculine/feminine.
2. Right to say yes/no.
3. Right to abstinence and sexual activity.
4. Sexual labels like frigidity (Is it a form of showing disinterest or resistance).
5. Right to sexual preference and reject heterosexuality.
6. Myths related to masturbation/other socially unaccepted sexual behaviour.

Methods

- Use of speculum
- Body awareness
- Self examination of breasts, cervix, menstrual charting, etc.
- Small group discussion
- Personal sharing
- Role–play
- Demonstration
- Body mapping

Resource Material :

- AVEHI, Bombay – Video
- NIROG, Gujarat
- CHETNA – Child Birth Picture Book and Slides

Resource/Resource Persons

- Ms. Manisha Gupte
- Abha/Sarojini, JAGORI
- Ms. Kamala Bhasin
- Dr Mira Sadgopal
- Ms.Kranti, Sabala
- Ms. Mallika
- Dr. Shyama Narang

Estimated Time Required : 3 days

VI. Gynaecological Health

Objective :

To know and understand the gynaecological concerns of sexually active and celibate women.

Expected Outcome :

- Should know and understand the range of GTI concerns of women including STDs
- To understand the social implications on women's gynaecological disorders (e.g. Painful intercourse, infertility, related to desertion and violence, etc.)
- To encourage self help approach in identifying gynaecological disorders

Concept/Content

1. Care during menstrual period
2. Menstrual problems
3. White discharge
4. Upper and lower genital tract infections
5. Painful intercourse – how to prevent it, frigidity
6. Sexually Transmitted Diseases (STDs)
7. Accquired Immuno Deficiency (AIDS)
8. Problems precipitated by Contraceptives
9. Prolapsed uterus
10. Endometriosis/fibroids/cysts
11. Cervical, uterine and breast cancer

Method

- Lecture/handouts
- Use of speculum, home remedies
- Discussion
- Demonstration
- Body mapping
- Action Research

Resource Material

- SHODHINI Report

Resource/Resource Persons

- Dr Rani Bang
- Dr Daxa Patel (ARCH)
- Dr Mira Shiva
- Dr Mira Sadgopal
- Dr Veena Shatrughana
- Ms. Manisha Gupte
- Sarojini/Smita Bajpai/Philomena, (SHODHINI Network)
- Dr. Shyama Narang

Estimated Time Required : 4 days

VII. Reproductive Health :

Objective :

To know and understand the politics of reproduction and its effect on women's health.

Expected outcomes

1. To understand conception and reproduction.
2. To encourage fertility awareness.
3. To discuss women's reproductive rights (Choice, Control).
4. Problems related to reproduction.
5. To meet women's need to make safe and effective contraceptives available to women and to resist the testing and peddling of harmful contraceptives.
6. To create options to invasive reproductive technologies

Concept/Content

1. Menstrual charting and knowledge of conception
2. Contraception and rational contraceptivechoices and after care.
3. Targets in family planning
4. Coping with infertility
5. Abortion and law related to it
6. Lower Reproductive Tract Infection (RTI)
7. Ectopic pregnancy
8. Unnecessary medical and Pharmaceutical interventions
9. Adoption as reproductive choice
10. Low access to medical technology
11. Post tubectomal problems

Method

- Lecture/handouts
- Case studies
- Data collection and documentation
- Action research
- Demonstration
- Films
- Videos

Resource/Resource Persons

- Dr Rani Bang
- Dr Veena Shatrhghna/Dr. Shyama Narang
- Dr Mira Shiva
- Dr Mira Sadgopal
- Dr Daxa Patel
- Manisha Gupte
- Kalpana/Lakshmi, SAHELI
- Abha/Sarojini, JAGORI

Estimated Time Required : 3 days

VIII. Maternal Health

Objective :

To know, recognise and understand the elements of maternal health.

Expected Outcomes

- To facilitate access of women to health care during and after pregnancy.
- To facilitate access of women to nutrition during and after pregnancy.
- To facilitate access to care and rest during and after pregnancy.
- To increase men's participation in child care and during pregnancy.
- To increase women's access to Maternity Benefits

Concept/Content

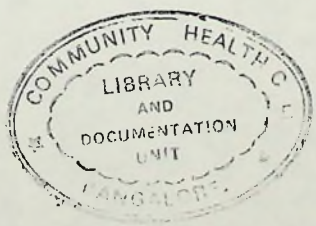
1. Maternal Morbidity
2. Mortality (Extent and rates by region)
3. Maternal Nutrition during pregnancy, lactation
4. Anaemia
5. Calcium/Iodine, Vitamin A, under–nutrition (Nutritional Deficiencies)
6. Toxemia
7. Eclampsia
8. Unattended Child Birth
9. Need for Ante Natal Care/Post Natal Care (ANC/PNC)
10. Lactation failure
11. Overwork, need for rest
12. Multiple burden
13. Sharing household work
14. Paternity leave
15. Looking after children
16. Creche facilities
17. Maternity leave (even after adoption)

Resource Material

Poster –'Meri Bibi Kaam Nahi Karti'

Methods

- Lecture/handouts
- Role play
- Simulation
- Posters
- Charts
- Videos
- Films
- Discussions
- Case Studies



Resource/Resource Persons

- Dr Shanti Ghosh
- Dr Pal
- Dr Rani Bang
- Dr Veena Shatrhghana/Dr. Shyama Narang
- Dr Mira Shiva
- Dr Daxa Patel
- CHETNA/Ahmedabad
- SEWA Rural, Gujarat
- CINI, Calcutta
- CHETNA, Ahmedabad

Estimated Time Required : 3 days

IX. Older Women

Objective :

To understand and recognise the concerns of older women.

Expected Outcomes

- To understand the health concerns of older women
- To question the denial of basic rights to older women.
- To question over–intervention or underutilization of medical technology.
- To create and promote networks/support groups of older women.

Concept/Content :

- Menopause
- Sexuality
- Nutritional Deficiencies
- Poverty and neglect
- Oesteoprosis
- Freedom from reproduction
- Backache
- Postural problems
- Arthritis
- Loneliness (Widowed and within family single women)
- Legal protection (property rights)
- Exploitation and abuse
- Lack of social and cultural support
- Lack of health care
- Estrogen Replacement Therapy (ERT)
- Increase social interaction
- Spirituality and faith

Methods

- Lecture/handouts
- Discussion groups
- Sharing of experiences

Resources/Resource Persons

- Ms. Abha Bhaiya, JAGORI
- Ms. Asha Kachru
- Dr. Shanti Ghosh
- Dr. Veena Shatrughana
- Dr. Mira Sadgopal
- Ms. Chandra Bhandari

X. Organising for Women's Health

Objective

To learn and facilitate the discussion about possible solutions/action programmes for addressing women's health concerns.

Expected Outcome

- Should know about different approaches to solving women's health problems (actual programmes from the field).

Concept/Content

- Different approaches to women's health (examples of action oriented, grass–root and other intiatives options/strategies available from real experiences).
- Use of media
- Formation of resource groups, lobbying, networking.
- Creating spaces and alternatives : self–help, services network/structure systems
- Initiatives
- Other experiences of women organising around issues like water, politics of water etc

Methods

- Lecture/handouts
- Action research to generate needed data
- Case studies
- Reading
- Video
- Discussion
- Workshop

Resource/Resource Persons

Ms. Abha/Sarojini, JAGORI
Dr. Mira Sadgopal, MFC
Ms. Nirmalben, SARTHI
Ms. Renu Khanna, SAHAJ
Dr. Rani Bang, SEARCH, Wardha
Ms. Sabla and Kranti
Ms. Manisha, MASUM Mahila Samaj Utkarsh Mandal
Ms. Fatima Bernad
Dr. Veena Shatrugna, ANVESHI
Ms. Uma Maheshwari, DDS

SEWA
Sadguru Water and Development Foundation

CHETNA

SUTRA

URMUL
Ms.Srilata Batliwala

SAHELI
Sabla Sangh/Action India

Estimated Time Required : 3 days.

Annexure – IV (a)

TIME FRAME – MODULE ON WOMEN'S HEALTH CONCERNS

I.	1.	Role, status and contribution of women	:	3 days
	2.	Conception, birth, infancy	:	2 days
	3.	Girl child and adolescent	:	3 days
		Total days	:	8 days
II.	1.	Sexual Health	:	3 days
	2.	Reproductive Health	:	3 days
	3.	Gynaecological Health	:	4 days
	4.	Maternal Health		
		Total days	:	13 days
III.	1.	Adult women – (a) nutrition (b) occupational	:	3 days
	2.	Other health problems	:	2 days
		(c) Emotional health	:	4 days
		(d) Older women	:	2 days
		Total days	:	11 days
IV.	1.	Doubly disadvantaged women	:	3 days
	2	Policies and registration related to women's health	:	3 days
	3.	Organising women	:	3 days
		Total days	:	9 days

Total days : 41 days

Annexure - V

MODULE : BUILDING WOMEN'S CAPACITIES TO PRESERVE HEALTH

Introduction :

This module is designed for training of Managers and Supervisors of women's health programmes. This module was discussed amongst the experts and in small groups of specialists.

It was felt that the feminist perspective should be the connecting thread common to all the objectives. At many places

it was felt that the module can be integrated with that of women's health concerns and management. This could be discussed at later stage.

It was felt that the module may not limit itself to ayurvedic systems but should also incorporate other systems like homeopathy, siddha, unani, reflexology, yoga, meditation, accupressure, etc. Most important of all, it should be based on people's knowledge, system of traditional practices and, culture.

It was also thought necessary to organise a meeting with resource persons who would conduct the sessions. The group also felt that before undergoing this training the participants should be familiar with the local traditions, culture, food habits, crops, medicinal plants, etc. Hence a "home work" sheet will have to be duly filled by them before coming to the course which couldbe discussed under relevant topics during the training.

Participatory methodology shall be used to impart the training.

Overall Objectives of the Module :

a) Understanding, accepting and building a positive attitude towards self as a woman.

b) To sensitise women on the current social, political, economic, environmental and "developmental" impact on health.

c) To build the capacities of co-ordinators and promoters of women's health programmes using traditional knowledge systems as a tool for empowerment.

d) To recognise, preserve and strengthen traditional knowledge systems and skills.

I. General

Objectives :

To sensitise individuals on the role and importance of traditional knowledge systems.

Expected Outcome :

Should be able to understand, recognise, preserve, strengthen and communicate traditional knowledge of community medicine and skills.

Subject/Content

- Introduction to Local Health Traditions (LHT) and Indigenous System of Medicines (ISM).
- Health care system, gender perspective, traditional technology.
- Orientation in traditional health care.
- The philosophy, approaches, concepts and methodologies.

Categories in Traditional Medicine.

- Community medicine, preventive and promotive health.
- Role of multiple healing systems like yoga, folk medicine, accupressure, dance, meditation, etc.

Methodology/Teaching Aids

- Home work done by the Participants, sharing of LHT
- Group exercises
- Role play
- Photo language
- Lectures
- Notes
- Books
- Simulation exercises
- Slides
- Video

Resource/Resource Persons

- Mr Darshan Shankar, ADS
- Vd G.G. Gangadharan, LSPSS
- Vd Smita Bajpai, CHETNA
- Dr Mira Sadgopal, MFC
- Mr Balasubramaniam, Sree Chakra Foundation
- Mr MM Kumarswamy, SHSD, Pune

Estimated Time Required : 2 days

II. Body Structure and Function

Objectives :

To provide an understanding on body structure and function

Expected Outcome :

Should know the basic structure and function of human body (male and female).

Subject/Content

- Personal perceptions
- Basic structure and function of human body
- Digestive, respiratory, excretory, nervous, cardio- vascular and reproductive systems, the five senses
- Mind and emotion in relation to well being
- Broad understanding of Prakriti (constitutional type)

Methodology/Teaching Aids

- Body marking, drawings, pictures
- Self help
- Models
- Charts
- Books - (Pictures)
- Phad/exhibition
- Games
- Video, slides

Resource/Resource Persons

- Philomena, Sarojini, Renu Khanna - SHODHINI Network
- Vd S. Koppikar
- Vd Varsha Walavalkar
- Vd Smita Bajpai, CHETNA
- Vd Surabhi Adbe
- Vd Radhika
- Sabla//Kranti

Estimated Time Required : 2 days

III. Nutrition

Objectives :

- Tc understand the gender discriminatory practices related to food.
- To understand, preserve and encourage the utilisation of positive local food practices.
- To encourage the regeneration and utilisation of local food crops.
- To develop an understanding of a balanced diet, locally available foods.

Expected Outcome :

- Should be able to identify and know the nutritional locally available plants and crops.
- Should know about sound food preservation and processing techniques.
- Should know about need of seasonal variation infood habits.
- About personal constitution (Prakriti) and its relation to food and health and also compatible food combinations,its hazardous effect on health.

Subject/Content

- Sharing of knowledge of local food practices and acknowledgment of positive practices and, exposure to distorted practices.
- Seasonal variation in food practices.
- Concept of hot and cold, incompatible food combinations.
- Social aspects of nutrition including Public distribution System.
- Encourage growing of nutritional plants adapted to specific area.

Methodology/Teaching Aids

- Lecture/handouts
- Module on Nutrition in life cycle developed by CHETNA
- Demonstration
  Practicals
- Herbarium
- Charts
- Colour photographs
- Audio visuals
- Reference books from
- VHAI
- CHETNA
- LSPSS
- ASTHA
- Vd Ramesh Nanal
- Pathyapathya
- Calendar

Resource/Resource Persons

- LSPSS
- Prof Tara Mehta, M.S. University, Baroda
- SHODHINI Network
- Dr Veena Shatrughna, NIN
- Uma Maheshwari, DDS
- Pallavi/Smita, CHETNA
- Ms Vanaja Ramprasad
- Ms. Sarojini, JAGORI
- Ms. Padmasuri, Asuri,Bangalore

Estimated Time Required : 3 days

IV. Promotion of Health

Objectives:

To provide information on factors helping to maintain and preserve positive health.

Expected Outcome

- Should know how to prevent communicable diseases, promote positive health
- Should also know the traditional practices of Rasayana which improves resistance to diseases
- Should be aware of environmental pollution

Subject/Content

- Knowledge of rational and irrational products in the market
- Preventive
- Positive health
- Rasayana
- Harmful effects of pesticides, chemical fertilisers, pollutants, etc.
- Greening of environment
- Meditation

Methodology/Teaching Aids

- Lecture/handouts
- Demonstration
- Video film
- Audio visuals

Resource/Resource Persons

- Ms Chandralekha
- Dr. Mira Shiva
- Ms Asha Kachru
- Vd H.B. Singh
- Vd Pathod
- Mr M.M. Kumarswamy, SHSD
- Mr Vasudevan
- Vd. G. G. Gangadharan
- Vd. Tathed

Estimated Time Required : 2 days

V. Simple Skills for Diagnosis

Objectives :

To make the woman self-reliant in a holistic approach to diagnosing illness.

Expected Outcome

- To incuicate a compassionate, intuitive and holistic approach towards individuals.
- Should be able to diagnose common ailments using simple techniques and should be able to refer cases wherever necessary.
- Should be able to diagnose PHC components like
    - Gynaecological health and ailments
    - Maternal health
    - Antenatal Care
    - Postnatal Care
    - Child Care
    - Emotional disturbances

Subject/Content

- Socio-economic cultural factors affecting health
- Understanding stress, strain
- Basic principles, Dosha, Dhatu, Roga marga
- Simple methods of diagnosing common ailments
- Traditional Medicine and Primary Health Care and Women's health
- Good healer - patient relationship i.e. listening, touching, counseling, etc.

Methodology/Teaching Aids

- Sessions
- Video slides
- Notes, charts
- Demonstration
- Clinical exposure
- Practicals
- Exchange of views
- Traditional Birth Attendant (dais's)
- Folk practitioners

Resource/Resource Persons :

- Vd. Gangadharan - LSPSS
- Vd. Smita Bajpai, CHETNA
- Vd. Ramesh Nanal
- Vd. S. Vilas Nanal
- Vd. S. Koppikar
- Dr. Marie D'souza
- Dr. Rani Bang
- Ms. Janet Chawla/Shyama Narag

Estimated Time Required : 4 days

VI Disease Management

Objective

To provide information and knowledge of managing different common ailments using local resources and alternative healing systems such as yoga, reflexology, meditation, etc.

Expected Outcome

Should be made aware of harmful beliefs and practices

Subject/Content

Practical demonstration of alternative healing practices

Methodology/Teaching Aids

- Clinical sitting
- Practical Demonstration of alternative healing practices
- Notes
- Manuals and classes

Resource/Resource Persons

- Dr Shyama Narang
- Vd Sanjay Dakhore
- Vd Varsha Walavalkar
- Vd Vanita Rage
- Vd Vanelana Vaidya
- Vd Illa Deshpande
- Vd Shubada Velankar
- Vd Usha Deshmukh
- Ms Asha Kachru

Estimated Time Required : 5 days

VII. Maternal Health

Objective

To provide information regarding various aspects of maternal health.

Expected Outcome

- Should know the needs of a pregnant mother
- Should know of sound delivery practices
- Should know to diagnose a complicated presentation
- Should know safe abortion techniques, contraceptive methods and hazardous reproductive technologies
- Should be able to refer cases at appropriate time
- Should know the components of ANC PNC, diet, regimen
- Should know about the food and plants useful in improving/increasing lactation

Subject/Content

- Maternal Health
- Diet
- Massages
- Herbs
- Regimen in pregnancy and lactation
- Drugs and technologies used in contraception

Methodology/Teaching Aids

- Sessions
- Clinical presentation
- Demonstration
- Audio-visuals
- Manuals
- Exhibition
- Homework on collection of local practices

Resource/Resource Persons

- Vd Varsha Walavalkar
- Vd S Koppikar
- Vd Smita Bajpai/CHETNA
- Vd Durga Paranjpe
- Vd Ila Deshpande
- Vd Mahashabde
- Vd Usha Deshmukh
- Vd Manda Bahulkar
- Vd Mrs Mhaiskar
- Dr Rani Bang, SEARCH
- Sabla and Kranti
- Dr Shyama Narang
- Ms Janet Chawla

Estimated Time Required : 3 days

VIII. Child Health

Objectives

To provide information on various aspects of child care.

Expected Outcome

- Should be able to manage low birth weight babies
- Should be able to understand different aspects of child health like breast-feeding, weaning, nutrition, common ailments, etc.
- Normal stages of child development and how to identify abnormalities.
- Improving immunity and understanding emotional needs of the child.

Subject/Content

- Infant care
- Needs and importance of breast feeding
- Massage
- Bal-ghutti and other types of immunisation
- Traditional toys
- Traditional story telling
- Identification of risk symptoms
- Child labour, legislation and linked diseases

Methodology/Teaching Aids

- Lectures/handouts
- Manuals and Audio-visual aids
- Practicals
- Picture books
- Charts
- Posters

Resource/Resource Persons

- Vd Durga Paranjpe
- Dr Shashi Vani
- Vd B.V. Sathye
- Dr Shanti Ghosh
- Ms Tripta Batra
- Vd Koppikar
- Dr Bhangale
- Ms Nandana Reddy, Lawyer (Bangalore)
- Ms Manjari Dingvani (Delhi)
- Ms. Uma Kulkarni, MSK, Bangalore

Estimated Time Required : 2 days

IX. Water and Sanitation

Objectives :

1. To sensitise individuals on the traditional methods of water harvesting, recharging and conservation methods
2. To provide skills in organising women to improve access to drinking water
3. To provide knowledge on techniques to make drinking water clean and safe
4. To understand and act upon women's needs for sanitation according to local conditions
5. To provide knowledge about links between illnesses, women and, water and sanitation

Expected Outcomes

- Should be able to plan, decide and take action for easy accessibility to potable water
- Should be able to appreciate the need for traditional water harvesting methods and organise people
- Know the methods of water purification at home and community level
- Be able to identify water borne and water related diseases and its linkages to impure water

Subject/Content

- Traditional water harvesting, conservation and purification techniques for utilisation and skills of repair hand-pumps.
- Plants used in water purification, effects of herbs in water
- Methods for physical purification and its limitations
- Herbs that can be used to give cooling effect to the water
- Herbs used for aromatic carminative and digestive properties
- Water for regular drinking
- Boiling water, reasons for its advice
- Different types of water, well-water, the difference and physiological effect
- Drudgery saving devices
- Illnesses associated with water-borne diseases and with carrying water

Methodology/Teaching Aids

- Lectures/handouts
- Practicals
- Demonstrations
- Coloured photographs of plants
- Manuals

Resource/Resource Persons

- Ms. Alka Shrimali, SWACH, Udaipur
  CEE, Ahmedabad
- Ms. Rima Nanavati, SEWA
- Ms. Madhavi and Arti - U.P. Mahila Samakhya
- Ms. Madhu Sarin
- Aga Khan Rural Support Programme, Gujarat
- Sewa Mandir, Udaipur

Estimated Time Required : 3 days

X. Identification of Medicinal Plants

Objective :

To provide an understanding of varieties, identification methods and uses of local medicinal plants

Expected Outcome

- Should know the list of medicinal plants used commonly in the country/state/ local level.
- Should know how to identify the local species used in the particular area.
- Should know about the medicinal plants useful in Primary Health care.
- Should know about the plants that are rare and endangered species and be able to protect the existing plants and linkage with environment (deforestation)
- Should know how to make on herbarium sheet for identification purpose.
- Should be able to protect the existing plants and linkage with environment (deforestation).

Subject/Content

Identification of medicinal plants :

a. Local or area specific

b. National scenario

Methodology/Teaching Aids

- Assessing the home-work on list of plants available in one's own area.
- Field visit to the nearby forest area with Vadus
- Folk practitioner
- Local Vaidyas
- Botanists
- Video
- Slides on medicinal plants
- Practicals
- Demonstration
- Lecture/handouts

Resource/Resource Persons

- Ms Indira Balachandran, Kottakal
- Ms Gangamma, Mahila Samakhya, Karnataka
- Ms Bhanvar Dhavai, Jagran Janvikas Samiti
- Vd Unniyal, CCRAS, Ranikhet
- Mr Chavda, Government Ayurvedic College, Gujarat- Mr Abdul Karim, LSPSS
- Dr Mrs.Ghate MACS, Pune
- Ms. Uma Maheshwari, DDS, Bangalore

Estimated Time Required : 2 days

XI. Propagation of Medicinal Plants

Objectives

To provide knowledge and skill on plant propagation techniques.

Expected Outcome

- Should have adequate knowledge propagation techniques of medical plants.
- How to plan a home garden
- Should know the different aspects of propagation of locally available species
- How to plan a community herbal garden, nursery and seed bank
- Should be able to be aware of dangers related to commercialisation of medicinal plants

Subject/Content

- Plant Propagation Nursery
- Seed-bank

Methodology/Teaching Aids

- Lecture/handouts
- Field visit to herbal garden
- Demonstration of kitchen garden
- Community garden
- Classes on different aspects of Nursery

Resource/Resource Persons

- LSPSS
- Dr Pushpangadan (TBGRI)
- Prof Panikar
- Mr Arumukam
- Mr Abdul Karim
- Shree Ram, LSPSS
- Dr Marie D'Souza
- Philomena Vincent, SHODHINI, AIKYA
- Ms Vandana Shiva
- Mr Venkat, DDS, Hyderabad
- TBGRI (Tropical Botanical Research Institute)

Estimated Time Required : 2 days

XII. Processing of Medicinal Plants

Objective :

To provide knowledge and skills on various self-help techniques in processing plants.

Expected Outcome

Should know how to prepare medicine using self-help techniques.

Subject/Content

Self-help technique to prepare medicine like Kwath, Choorna, Kalka, etc. (See Appendix I for details).

Methodology/Teaching Aids

- Lecture/methods
- Demonstration
- Manuals
- Practicals

Resource/Resource Persons

- Vd Sanjay Dakhore
- Dr Manjunath, VHAI
- Ms Gangamma, Mahila Samakhya, Karnataka
- Ms Halamma, Mahila Samakhya, Karnataka
- Ms Savitri with Philomena Vincent, AIKYA
- Ms Nirmalben, SARTHI, Gujarat
- LSPSS Network
- Uma Maheshwari, DDS, Bangaore

Estimated Time Required : 1 day

Annexure - Va

TIME FRAME - MODULE ON BUILDING WOMEN'S CAPACITIES TO PRESERVE HEALTH

A.	General Introduction	:	2 days
B.	Human Body Structure and Functions	:	2 days
C.	Nutrition	:	3 days
D.	Promotion of Health	:	2 days
E.	Simple Skills for Diagnosis	:	4 days
F.	Disease Management	:	5 days
G.	Maternal Health	:	3 days
H.	Child Health	:	2 days
I.	Water and Sanitation	:	3 days
J.	Medicinal Plant Identification	:	2 days
K.	Propagation of Medicinal Plants	:	2 days
L.	Processing of Medicinal Plants	:	1 day
	Total	:	31 days

Annexure - VI

MODULE : MANAGEMENT OF WOMEN'S HEALTH

A. An Alternative Perspective on Management

Expected Outcomes

Should be able to understand:

- The processes, roles, tasks and functions of Management
- Values and practices of management for development or social action including that of women's groups

Content/Concept

- Management Processes
- Values : equity, justice, democracy, participatory functioning
- Concepts of Patriarchy, Power and Subjectivity
- An organisational framework, from the feminist perspective
- Overview of the module

Methodology

- Lecture/handouts
- Exercises on understanding values, value classification, and sexual biases
- Roleplays
- Diads, Triads, Groups

Emphasis : Manager

Resources

- IWID, Madras
- PRIA, New Delhi
- SEARCH, Bangalore
- AIKYA, Bangalcre
- JAGORI, Delhi
- Mahila Samkhya Programme

Estimated Time Required : 2/3 days.

B. I. Understanding Self and Others

Expected Outcome

- Should be able to analyse and understand self in terms of needs, wants, values, attitudes, aspirations, motivations and thinking patterns.
- Should be able to distinguish between her various roles compatible in the gender relations framework.
- Should be able to analyse and improve own communication patterns with colleagues at different levels and with peers.
- Should be able to analyse dynamics of interpersonal relationship between men and women.

Content/Concept

- Personality
- Transactional Analysis
- Creativity
- JOHARI window
- Erik Erikson's Eight Stages (Gender Perspective)
- Roles and role conflicts
- Sub personalities + Psychosynthesis
- Communication theory
- Patterns of women's communication : Oral Vs. Written
- Active listening, Articulation
- Assertiveness training (with reference to gender and cultural aspects)
- Stress Management

Methodology

a. Sociocultural Content

- Analysis of women's lack of self worth in the historical context of class, caste and gender and in relation to Who am I?
- Sources of power, strength and selfimage

b. Emotional Content

- Creativity
- JOHARI window
- Erik Erikson's Eight Stages

Managing Self

Simulation, exercise, roleplays, small groups, meditation, songs, dance, drama

Emphasis : Manager/Supervisor

Resource

- SHAKTI
- SEARCH
- AIKYA/SHSD

Estimated Time Required : 4 days.

B. II Small Group Processes

Expected Outcomes

- Should be able to analyse group dynamics and develop skills to manage them
- Should be able to apply all the above principles to developing a good, well functioning team
- Should be able to develop flexible leadership styles to match individuals in team
- Should be able to resolve conflicts within the team
- Should be able to appreciate the importance of counselling in management of women's team
- Should be able to build skills of effective counselling for women team members

Content/Concept

- Theory of group dynamics
- What motivates women?
- Teams and team building (with reference to gender and expowerment perspective)
- Enhancing capacities of team members
- Leadership theory
- Shared and collective leadership
- Conflict resolution
- Giving and receiving feedback
- Counselling frameworks

Methodology

- Lecture/Handout
- Exercises : case study, role plays, journal/diary writing
- Games, reflection
- Exercise to identify own leadership style

Small group processes

Simulation, exercise, roleplay, small groups, meditation, songs, dance, drama, group exercises

Emphasis : Manager, Supervisor

Resource

- SHAKTI
- SEARCH
- AIKYA

Estimated Time Required : 2 days.

C. Project Management

Expected Outcomes

- Should be able to apply principles of management to plan out the objectives, staffing, sequence of activities required for women's health programme.
- Should be able to apply all the above to developing a good, well functioning team.
- Should be able to develop flexible leadership styles to match the individuals in team.
- Should be able to resolve conflicts within the team.
- Should be able to apply principles of problem solving and decision making.
- Should be ale to prepare a budget for the women's health programme.
- Should be able to prepare a project proposal.

Content/Concept

- Participatory planning processes based on community & community participation , women's priorities related to objectives, staff, activities, resources, time
- Teams and team building (reference to gender andempowerment perspectives)
- Enhancing capacities of team members.
- Conflict resolution
- Giving and receiving feedback
- Building : fixed/variable cost analysis
- Use and preparation of budget

Methodology

- Lecture/handouts
- Exercises : case study, role plays, journal/diary writing
- Games
- Handout on budgeting
- Case studies incorporating gender sensitive ways of managing
- Field visits

Emphasis : Manager

Resources

- SEARCH, Bangalore
- PRIA
- VHAI
- Dr. R.K. Pal
- AIKYA/SHSD
- "Management Process in Health Care" Book by VHAI
- IWID

Estimated Time Required : 5 days.

D. External Environment

Expected Outcomes

- Should be able to relate effectively with the external environment
- Should become an effective community organiser manager
- Should become an effective resource mobiliser and manager
- Should become an effective women's health advocate

Content/Concept

- Role as a boundary manager (define boundary manager)
- Gender aspects of becoming an effective boundary manager
- Community participation
- Organising and mobilising
- GO and NGO relations, Value of Government infrastructure
- Role vis-a-vis Government infrastructure
- How to do intersectoral coordination
- Relationship with funding agencies
- Ways of mobilising funds
- Advocacy on women's health issues
- Networking with women's groups
- Networks, coalitions, federations
- Framework for policy formulation and planning from a gender perspective

Methodology

- Exercise on mapping significant others
- Exercise on listing methodologies for relating with community and identifying skills required
- Roleplays, case study
- Handout on Advocacy for women's health

External Environment

Developing cognitive level skills Field visits, Interviews, AVs of case studies, role play, practise sessions, role model and simulation.

Emphasis : Manager

Resources

- PRIA
- SEARCH
- Advocacy Network
- AIKYA/SHSD
- IWID

Estimated Time Required : 2 days.

E. Programme Management

Expected Outcomes

- Should be able to apply principles of management to plan out objectives, staffing, sequencing of the activities, resources required for women's health programme and manage time.
- Should be able to understand and practise humane, empowering personnel management (support, collaboration, sexual division of labour).
- Should be able to understand,
  - the difference between monitoring and evaluation
  - the philosophy and concepts of self and participatory evaluation
  - develop indicators to evaluate
- Should be able to facilitate the collection and analysis and, use data
- Should be able to document the process and outcome of work

Content/Concepts

- Overview of management process
- Planning : How to state and prioritize objectives, plan for staff required, schedule activities, resources required.
- Staffing : What kind of staff, how many, job descriptions roles, reporting relationships, delegation (risk taking)
- Statutory aspects of personnel management
- Monitoring : According to schedule of activities, quality of work, process of work to uphold values outlined in section-I, costs and expenses
- Evaluation : Why evaluate, What to evaluate, How to evaluate, Participatory evaluation, Quality of care indicators as applied to women's health
- Quantitative indicators
- Data Management :

  Why (including dangers of collecting unnecessary data), what kind (including social) and gender aspects of women's health), Participatory methods of data collection and analysis

Methodology

- Handouts on : Planning, staffing with exercises on developing their own job descriptions, monitoring and evaluation, quantitative indicators, data management.
- Game on planned and unplanned activity in 2 groups.
- Exercises on : Planning a programme for women's health, staffing, developing indicators, reports and records, data management.
- Case study, Tentative formats of records and reports.
- Field visits

Emphasis : Managers

Resources

- SEARCH, Bangalore
- PRIA, New Delhi
- VHAI, New Delhi
- Dr. R.K. Pal
- CEDPA materials
- WHAC (M.S. University, Vadodara)
- Ford Foundation
- IIMA, Pachod
- AIKYA,SHSD
- IWID

Estimated Time Required : 5 days.

Examine all tools, materials, methods, values to be applied from a feminist perspective.

*** Methodology**

- Process Oriented
- Experiential, Participant Centred
- Participatory
- Collective responsibility for learning programme non- gendered, division of labour
- Action focus
- Informal, Flexible (space for reflection)
- Balanced (mind/body, emotion/rationality)
- Integrated
- Joyous/fun
- Nonjudgemental
- Respect for self and others

Annexure - VIa

TIME FRAME - MODULE ON MANAGEMENT OF WOMEN'S HEALTH

A.	Management Perspective	:	2/3 days
B.	Understanding		
	i. Self and Others	:	4 days
	ii. Small group processes	:	2 days
C.	Project Management	:	5 days
D.	Managing External Environment	:	2 days
E.	Programme Management	:	5 days
		Total	21 days

Annexure - VII

Programme Schedule

Expert meeting to finalise training programmes for "Building NGOs organisational Capacities for Women's Health"

16/17 July 1993 in Bangalore - Core Group Meeting

Prior to the expert meeting

16th July 1993	Morning	Arrival of core group members
	Afternoon	Report of activities after Surajkund workshop (Indu Capoor) Activities from DSE (Erika Fink) Discussion/modifications on feminist Perspective of Women's Health
17 th July 1993	Morning	Strategies for the finalising of three modules Summarizing, feed back
	Afternoon	Strategies and perspectives Frame of Reference for the meeting

18 to 22nd July, 1993 in Bangalore

Objective

I. Consultation with individuals and organisations working on women's health concerns both those who were and were not at eariier meeting at Surajkund, Haryana.

17th July 1993		Arrival of participants
18th July 1993	Morning	Introduction Background, information What happened since our meeting in November 1992 in Surajkund (Ms. Indu Capoor, CHETNA Ms. Erika Fink, DSE) Presentation of revised perspective (Dr Mira Sadgopal) Discussion on the perspective
	Afternoon	Prsentation of three modules Discussion
19th July 1993	Morning	Division into 4 working groups to work on perspective and modules
	Afternoon	Working Group Continue
20th July 1993	Morning	Reports of working groups in plenary session and discussion continue
	Afternoon	Taking on responsibilities to develop the training further

Task group working session

Objective : Development training design and taking the process further

21st July 1993	Morning	Design for training and dialogue programmes 1993/94 (goals, target groups, contents, methods)
	Afternoon	Finalise concepts Methodology, resource persons for programmes
22nd July 1993	Morning	Time schedules Financing Methods of monitoring and evaluation
	Afternoon	Finalising working plan for training and dialogue programmes

Annexure – VIII

A REPORT OF WAH! CORE GROUP MEETING HELD AT BOMBAY

AUGUST 17 – 18, 1993

This was the first core group, follow–up meeting, after the Bangalore Expert Meeting on Building NGO Organisational Capacities for Women's Health held during July 18 – 22, 1993. The following members were present during the meeting.

1. Ms. Indu Capoor, CHETNA, Ahmedabad
2. Ms. Pallavi Patel, CHETNA, Ahmedabad
3. Ranjani Murthy, IWID, Madras
4. Vd. Gangadharan, LSPSS, Coimbatore
5. Ms. Philomena Vincent, AIKYA, Bangalore
6. Dr. Sharad Onta, Nepal
7. Ms. Anu Waklu, Pragati Foundation, Pune
8. Dr. Mira Sadgopal, Pune (only for one day)
9. Ms. Renu Khanna, SAHAJ, Baroda

* Dr. Mira Shiva could not participate (she telephonically communicated and conveyed the reasons for not being present).
* Ms. Manisha had an injured knee, due to which she could not participate, she sent her comments and suggestions.

AGENDA

1. To finalise the draft report of the Bangalore meeting
2. To review the Core Group (CG) decisions taken at Bangalore and progress on the task assigned.
3. To discuss Erika's letter regarding organising first training at Maharashtra.
4. To differentiate/clarify the role/tasks of core group, regional groups and resource group. To also establish norms of functioning and communication.
5. To workout the action plan, time frame budget for the pilot training programme including pre/post training concerns.
6. To fix dates/venue/agenda for the next meeting.
7. Other decisions related to programme

An important agenda which emerged in between the Bangalore meeting and the core group meeting was a discussion on Erika's letter about the urgency related to the initiation of the programme during 1993.

Proceedings :

1. To finalise the report....

Few core group members had send suggestions on the draft report. The members present during this CG provided their suggestions verbally.

2. To review the Core Group...

2.1 Decision taken

At the core group meeting held on the last day at Bangalore although a few members remained present, certain important decisions were taken.

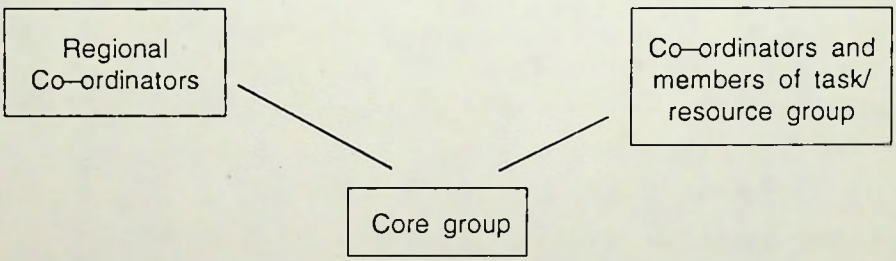
Importance of modules

* Composition of core group
* Implementation strategy for the module

2.1.1 Integration of modules

Initially module 1 and 2 would be integrated by few members for which co–ordination would be done by Vd. Gangadharan. The meeting for this would be held at Ahmedabad during 27 – 30th September, 1993. Finally, Ms. Renu Khanna would co–ordinate the integration of three modules in a design form .

2.1.2 Ms. Renu clarified the composition of the core group and resource group diagramatically.



2.1.3 Implementation strategy for the module

It was decided during the Bangalore core group meeting that the programme can be implemented in 3 phases: (refer to the main report (3.6) in form of process, content and skills. It was further clarified that :

Phase 1 : Would consist of Feminist perspective on Health, Managing Self and Others; and partial content of module on Women's Health concerns.

Phase 2 : Combined module on Women's Health Concerns with capacity building for women' health.

Phase 3 : Management and Organisational Skills

There was a discussion on how the management module would be imparted through this training programme. It was suggested that the management module should not be handled in a isolated way but integrated within the module of women's health concerns and capacity building for women. It was felt that this will help to build up the skills of participants as managers. Apart from this during the training phase III, they would emphasis on management components to develop their skill as overall programme managers.

During the Present Meeting

To have a further clarification in implementation strategy discussion on feasibility study took place.

Feasibility Study :

It was expressed that the feasibility study done by Ms. Erika and Asha is largely based on Income generation Programmes. In this process the focus of DSE project has shifted to health. In this context, the feasibility study doesn't fulfill the objective. Mira felt strongly that for WAHI programme a feasibility study in context to women's health concerns must be done to ascertain prior to the training whether the training is a recognised need of the NGOs or not.

Therefore it was decided that a feasibility study is conducted region wise prior to the training to ascertain the following:–

(a) Do NGO's feel that Health management skills/training is required and in particular in relation to women's health?

(b) Do NGO's believe that women should take on a more assertive role in Health management within their organisational context? This can be done through the 1 – 5 scale.

(c) Do the NGO's meet the criteria for participating the WAHI programme? (as in point 4.1 of main report)

(d) Do the NGO's have the time and priority for participating in the women's health programme?

(e) What is the organisational 'set up' in NGOs?

(f) What would be the participation for the NGO's in terms of resource contribution/follow–up commitment?

In response to Mira's point, CHETNA mentioned that they had done a needs assessments of NGOs in Rajasthan. It was felt that the findings may help in context to WAHI programme. The findings indicates that NGOs need their supervisors/trainers to be trained on basic training skills and content knowledge related to women's health topics.

Inspite of the above, CHETNA is not able to commit itself to extent the support for WAHI programme during 1993, due to other commitments and time and resource constraints to extent support at NGO level as a follow–up of the training.

For other regions, it was decided that feasibility data should be collected/ reconfirmed by directly meeting NGOs/participants.

Discussion on Erika's letter about organising first training at Maharashtra

Ms. Erika of DSE had requested the regional groups to start the pilot programme before 1993 on the last day of the core group meeting at Bangalore. At that time, all the regional groups including CHETNA showed their incapability to initiate the programme. Through a letter, Erika approached the Maharashtra region with a request of initiating the pilot programme.

The point was discussed in the core group meeting :

Both Mira and Manisha (who had sent a message) from Maharashtra felt that due to their prior work commitments they could not take the responsibility for launching the programme in Maharashtra before december, 1993.

A possibility to initiate a pilot project for Hindi speaking area (Maharashtra, Rajasthan and MP) was discussed. it was felt that for Hindi speaking areas, there is a need to include many more NGOs and individuals to join in the process which is not possible at this stage of programme and initiate the pilot project. It was jointly agreed that there is no possibility to initiate the pilot project, at Maharashtra as well as for Hindi speaking area.

Philomena mentioned that after assessing the situation in her area, it may be possible to take up the pilot project in South India provided the others can commit some support. Ranjani (IWID) and Gangadharan (LSPSS) stated that they were willing to help and support in every possible way. The core group wholeheartedly welcomed the southern regional groups initiative.

It was decided that pilot project will be initiated in Karnataka and Tamil Nadu after the feasibility study of the area. The core group reaffirmed all support to Philomena, Ranjani and Gangadharan in terms of preparation of design, making resources available collection of material etc.

Philomena made it clear that she arrived upon this decision as an interested member of southern region and not due to any outside pressure.

4. Clarification on the Role/task of core group, regional resource groups

4.1 Norms set for core group

During the Bangalore meeting, the need to set the norms for the core group was felt. Following norms were set.

1. The core group member should attend all the days of meeting.
2. If the member remains absent for 2 consequent meetings the core group can decide to ask the member to leave after ascertaining the commitments of the members.
3. The decision in the core group to take the process ahead needed to taken on the basis of majority.
4. This core group composition of will remain as it is for next 18 months till the pilot phase to over. After that it is subject to change.

5. The member who is absent during the core group meeting should get clarification on decisions/discussions made prior to the next meeting, workshop on the basis of minutes send to them.

6. The suggestions on the reports can be send to the concerned persons in writing and not shared during core group meeting.

4.3 Resource /Task group

This group will work on integration of module assisting in finalising the design of training under the guidance of the co–ordinator

5. Action Plan, Time frame, budget for the pilot training programme

Prior to beginning discussion on the pilot training, it was felt important to clarify the understanding about the WAH! programme.

5.1 Time frame

It was jointly decided that WAH! programme will be planned for a minimum for 5 years.

5.2 Vision for WAH! Programme

Ms. Renu articulated a 5 year vision for WAH! programme

"In the five years, WAH!, aims for multiple women's health programmes being implemented in various places with feminist perspective where traditional medicines being valued and used in programmes which are managed and even headed by women".

5.3 Participants of WAH! Training

It was clarified that for WAH! project the women's health programme managers (co–ordinator) and supervisors can participate. The WAH! programme does not aim to address the needs of health care providers.

It was discussed that at the organisational level, the organisation structure is :

Main Health Programme

↓

Co–ordinator WAH! Programme

↓

Middle Level Manager/Supervisor

↓

Health Care Provider

In small organisations, the main health programme co–ordinator may be absent and the role of manager and supervisor is played by a single person. For WAH! programme the manager and supervisors both would be invited to participate as follows :

Co–ordinator/Manager : Partially for first and second phase and fully for third phase

Manager/supervisor : All three phases

5.4 Pre–requisite for the pilot training phase

It was strongly felt that a pilot project requires a lot of support in terms of pre–preparation. Following needs to be ensured to make WAH! programme more effective.

1. The evaluation and monitoring of pilot project should be done on an ongoing basis and systematically.
2. Documentation of pilot project in local language and also in English for learning of other regions is essential
3. The pilot project should include a feasibility study prior to initiation of the training.

5.4 Training

The training tasks were divided into three phases :

- pre–training
- during training
- post training

5.5.1 pre–training

Some of the pre–training tasks/activities identified by the group were as follows:–

1. Conducting a feasibility study for identification of NGO's who could participate in the programme. One of the ways to do this could be through an introductory workshop. The end result of the study would be :
   - Identification of NGO's for participation in the programme, through personal visits for obtaining their full time commitment.
2. Identification of resource persons/material and other resources for the programme such as funds/materials/training/venue etc.
3. Developing a working team for taking the programme ahead at the regional level.
4. Conducting workshop/s to sensitise heads of NGO's on prospective about the programme.
5. Development of an information brochure about the programme.
6. Conducting at least 1 core group meeting prior to the launch of the pilot workshop.
7. Finalising the integrated training design.

5.5.2 During Training

Actual conducting of training. It was felt that the regional group would assess the activities required in the training period.

5.5.3. Post Training Task

1. Monitoring
2. Evaluation
3. Action plan

These would be discussed during next core group meeting.

5.5.4 Objectives

Prior to working on the training design, it is important that objective of the overall training and of different training phases is done. The following objectives were finalised.

Overall objective of the WAH! training programme

"To strengthen knowledge, attitudes and skills of those working an NGO's especially women, so as to :

(a) Effectively co–ordinate women's health programme with a holistic gender perspective

(b) Enable women to assume leadership in women's health programme"

Within this overall objective, the specific objectives of each phase were discussed.

5.5.5 Phase – 1

"Overview of WAH!"

To provide :

- An overview of the WAH! programme and opportunity to strengthen perspectives related to gender and Local health Traditions (LHT)
- An overview of issues in women's health/LHT and opportunity to reflect on these objectives in context of self, organisation.
- An opportunity to strengthen knowledge and skills related to issues in women's health
- opportunity to sensitise women on the current social, political, economic, environmental and developmental impact on health
- Understanding and building a positive attitude towards self.

Topics to be covered

1. Overview of health scenario in India
2. Feminist perspective of health
3. Perspective of LHT In empowering women
4. Understanding self and others in context of family, personal, organisational and society.

It was felt that the phase should end with some actual skills/content being imparted to participants with enough "home assignment" to carry out for the next phase.

5.5.6 Phase II :

"Holistic Health Approaches and Management of Women's Health"

Objectives:

- To enable participants to acquire knowledge and skills so as to integrate different approaches to women;s health.
- To build the capacities of co–ordinators and promoters of women's health programmes using traditional knowledge systems as a tool for empowerment.
- To recognise, present and strengthen knowledge systems and skills.

Contents :

1. Women's health concerns
2. LHT
3. Management of health programme – as in Annexure III & IV of the main report.

5.5.7 Phase III :

"Managing Women's Health Programmes"

Objectives

- To enable participants to acquire skills to manage women's health programmes including relationships with external environment.
- To help the participants and their organisation to plan for their future programme as a follow up of this training programme.

Content

Annexure V of main report.

5.6 Role of the Core and Task Group In the Pilot Training Programme at the Southern Area :

1. Core group will not make any decision for the regional programme but help to draw the principles.
2. The WAH! Core and other programme members can observe and contribute in the pilot programme at :
   - in the planning and at the co–ordination level
   - as an observer and for documentation, training and evaluation
   - an a training resource
3. The task group will finalise the integration of the module and share it with the core group.
4. Core group meeting needs to be organised to finalise the design after the feasibility study is done by southern group.

5.7 The Norms for involvement of consultants and core groups members in the pilot phase :

1. It was decided that a fixed honorarium of Rs.500/– be paid for each training per day and Rs.350/– day to a resource person for consultation/compiling material etc.
2. It was felt that many resource persons may ask for more honorarium, then agreed upon by core group. It was decided that it is better to keep this amount standard as it has a question of value. it will help to attract the right kind of resource persons.
3. The other approach that can be explored was that of honorarium being in terms of long term and short term involvement of consultant.
4. The payment of honorarium should be done by cheque especially for the individuals who drawn a salary from organisation as it will go in organisation and will help in the growth of organisation.
5. It was also decided that in case the consultant has to travel overnight than she/he will travel by train of it is more than that, Air travel can be re–imbursed.

5.8 Observer :

This discussion was initiated with a decision that observers can be involved in the pilot training programme. It was than thought of that there should not be more than 2 observers in each training session and it would be fruitful if one observer is out of WAH! programme which cab be a regional person. The regional organizer will decide upon the observer.

The following norms were set for observers:–

1. The observer will come with commitment for the whole process and not just as and where she/he gets time.
2. Observer will not disturb during training session and demand for translation during sessions.
3. The observer will come in the capacity of participant and not as that of an evaluator.
4. A Steering Committee to evaluate everyday training can be set up which included trainer, and volunteers from participants to evaluate the day's programme. The observer can be involved in this committee to share her views.
5. The final norms about observer can be decided upon by the regional trainer along with observer.
6. If there is difference of opinion among the observers and trainer, it should be discussed face to face, rather than take it outside the programme.
7. Whether the observer would be man or woman which may depend on module and session. It would be decided and by regional group and task group.

8. If the observer/resource person has been asked to participate based on needs of regional group, he/she will be paid but if an observer participates with a view of learning no honorarium will be paid.

5.9 Finance of the Programme :

WAH! group would like to have a commitment and support for this programme for a minimum of 5 years from DSE. It would not approve a short term support from DSE for the pilot project only.

If DSE is unable to make this kind of commitment WAH! group would not like to take financial support from DSE. It will continue the programme with full commitment and try to get funds from other resources which may not be difficult.

5.10 Time frame of Pilot Training Programme

As decided for three modules the total number of days for training would be 90 days (3 months) spread over 6 months – 1 year. The first phase would be of 10 days. The date is fixed is 6 – 16 December, 1993. Prior to this the sensitisation workshop would be held on 18 October, 1993 at Bangalore.

Dates/Venue/Agenda for the next Core Meeting.

The next Core meeting would be organised at Ahmedabad on 27th October, 1993. The major agenda for meeting would be to finalise the design of pilot training programme and workout the implementation strategy in light of WAH! group support.

7. Other Decisions Taken :

DSE was planning to sponsor a young woman from Nepal for internship to CHETNA for WAH! programme. DSE could now send her to AIKYA as they are initiating the pilot phase in 1993.

- Manisha due to her other commitments would not like to be a member of the core group. It was accepted by the core group.
- The copy of correspondence done within core group members needed to be send to the co–ordinator – CHETNA even if it is handwritten note so as to keep her informed and the communication channels open.
- Misunderstanding of Dr. Mira Shiva during the last day of the Bangalore meeting was clarified among the group.
- Dr. Mira Shiva on phone mentioned the use of the module of the women;s health concern separately by the NGOs. Pallavi has asked her to write about it to the co–ordinator WAH! and then can be discussed during the next meeting.
- Since the pilot phase is now going to be initiated in the Southern area, Indu proposed to shift of responsibility of the co–ordination to Philomena. It was decided that Indu will continue to co–ordinate the overall project.

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