Process Documentation of Dissemination of Health Information to Rural Women

Empowering WOMEN FOR HEALTH

Project Sponsord by
Ministry of Health and
Family Welfare New Delhi

Funded by
World Health Organization (WHO)
New Delhi

Documented by

CHETNA

May 2000

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CHETNA Women's Health and Development Resource Centre Chaitanyaa

Executive Summary

The reality that borrowing money for seeking health treatment is the second largest cause of indebtedness is grim in majority of rural areas. Most of the money is used for seeking treatment only for men folk although women suffer from various mental, physical and psychological disabilities. They do not have adequate access to health care services and this problem is compounded by lack of health information. In this context, the Ministry of Health and Family Welfare, Government of India undertook a challenge to train and disseminate health information among village- based women's groups. This effort was initiated on a pilot basis in 15 states.

The uniqueness of this project lies in the active participation of governmental organizations, NGOs and experts at every stage of planning and implementation. The NGOs working in the area of women's health and development were invited to draft a **state level training manual** covering 23 topics related to women's comprehensive health. CHETNA contributed in finalizing this manual which became a rich reference material for it to develop training modules for district and village level trainers. The district level and village level training modules were translated and adapted by NGOs in other states.

Once the training modules were done, NGOs were identified and involved to build capacities of master trainers to carry out training programmes. Five master trainers were selected and trained from each district which totaled to 25 master trainers from each state. CHETNA coordinated the process of training master trainers in the states of Gujarat and Rajasthan. The trained master trainers were made responsible for training women group leaders. Thus, in each district, 144 women leaders representing 72 women's self-help groups were trained.

The training process was **participatory** and people involved in imparting training had extensive grassroots experience. Debates, group discussions and exercises on self-analysis were conducted to help women explore the meaning and draw perceptions about their lives, identify and discuss issues related to gender discrimination, health and violence. Use of audio visuals, folk media and role play was used extensively at these training programmes.

As a training institute, CHETNA felt the importance of assessing the impact of the training imparted to master trainers through supportive *follow up* and took the initiative of making visits while the training of district and village level leaders was under way. CHETNA team members provided necessary guidance and support during district level training sessions. The training skills of master trainers were observed and necessary feed back was provided to them. The team observed that the master trainers were able to develop an enabling environment at these training sessions by generating an informal, conducive atmosphere and encouraging everyone to participate. They made use of participatory training methods and of the various training modules as reference developed in the initial phase.

The project was a learning experience for CHETNA. The way NGOs and GOs partnered in this process set an example of how active and constructive partnerships can change perspectives for the better. Moreover, the participatory process was a holistic one, starting from developing manual to training and follow-up at all levels. The structure of the training programmes enabled information to percolate to the grassroots level. This project succeeded in reaching out to a considerable number of women at the district as well as the village level and has started the process of empowerment of women. Self help groups by virtue of their exposure through training to health and development issues have the potential to become focal points of addressing women's health and development concerns.

In view of the success and enthusiasm generated by the project, it is suggested that this effort should be replicated in all other states of the country. Orientation training should be organized on the regular basis to upgrade the skills and knowledge of district and village level trainers. In addition, training and education material for perspective building in areas of *violence and women's health*, *mental health* and *panchayati raj and women's health* needs to be developed. A module on older women's health needs to be prepared and added to the existing module. Additionally, all government functionaries who are involved in improving women's health at the state, district and block level need to be trained and furnished with the finalized modules.

Introduction and Context

There is an increasing concern that disadvantaged and marginalized women suffer from various physical and emotional health problems but have little access to early diagnosis, cure and treatment from the primary health care system. Due to lack of access to information and services, women tend to suffer more and often needlessly, and also spend their scarce resources seeking health care, wherever they can access it usually from exploitative private practitioners. In view of the above, it is believed that if women are empowered with information on why and what causes illnesses and diseases and where and how to find assistance through which they will be able to live healthier and more productive lives. Through this process of empowerment, access and information of services established by the government and public sector may also improve.

With this vision in view, the Ministry of Health and Family Welfare (MOHFW), Government of India embarked on an ambitious project to train and disseminate health information among women's groups in rural areas.[1] Collaborating with non governmental organizations and supported by the World Health Organization, MOHFW initiated this project on a pilot basis during 1998-2000. The project envisaged to disseminate health information among village- based women's groups.

Geographical Area and Population Coverage

The pilot project was initiated in 15 states of the country and from each of these states, 5 districts were covered (refer figure 1). From each district, a minimum number of 72 self help groups (SHGs) and 144 village leaders were expected to be trained through this strategy.

Outreach Strategy

Participatory training of the trainers was the key strategy to reach out to the disadvantaged and marginalized rural women for disseminating health information. The details of the events are given in **Annexure I.**

Development of Training Manual and Modules

Training manuals were developed for three levels of training. The representatives of the NGOs working in the area of women's health and development were invited to draft a **state level training manual** covering comprehensive topics related to women's health. CHETNA contributed in preparing this manual and also took the responsibility of coordinating the process. Based on this manual, CHETNA developed district level and village level training modules which were translated and adapted by NGOs in other states.

[1] There are an estimated 2.5 lakh women groups (40 lakh adult women) constituted by the Department of Rural Development and almost 6000 villages under *Mahila Samakhya's* women's empowerment programme being implemented by the Department of Education (Government of India). In addition, there are several women's groups organised for micro credit by the Department of Women and Child Development.

a. Process of developing state level training manual

The development of training modules went through various stages. Efforts were made to make the process as participatory as possible. The following steps were followed in developing the manual:

- **Needs identification:** The Ministry of Health and Family Welfare (Department of Health) in collaboration with WHO convened an expert group meeting in November 1998 to identify and develop a training manual which would provide basic information on women's health concerns and the methodology of implementing it with women's groups. The responsibility of coordinating the process was entrusted to CHETNA and a guideline was sent to selected organizations to draft the chapters and maintain a uniform framework to ensure easy compilation (for details on guidelines and list of organizations refer **Annexure II and III).**

- **Drafting of the manual:** A workshop was organized by CHETNA at Ahmedabad in January 1999 to elicit feed back and comments from experts on the chapters written and to collectively develop a framework for the remaining chapters.

- **Review of draft training manual:** A workshop was organised by the Ministry of Health & Family Welfare at New Delhi in March 2000 to review and finalise the draft chapters of the manual and to develop a timeframe for conducting state and district level training programmes.

- **Finalization of the training manual:** The chapters were later sent to the experts for review as well to the Ministry. Suggestions made by them were incorporated.

Contents of the manual

- **Perspective building**: To develop a *women-centred health perspective* among the participants, issue pertaining to the deep-rooted gender discrimination against women was identified as the central theme. The fact that women are conditioned to eat last, least and leftovers, does not meet her energy requirements and results in her poor nutritional status. The other factors which have linkages with the existing health and social system and go against women's health are over work and violence against them. The first few chapters of the module provide the trainer with a comprehensive insight into women's health issues and factors affecting them.

- **Health topics**: Women's health topics are discussed in a life cycle approach. This approach takes into account health information at all stages of a woman's development - right from the stage of conception to her development into an adolescent and later into an adult woman. The module also contains health information pertaining to communicable and non communicable diseases plaguing women's health.

- **Special section**: Along with each chapter, there is a section on references and suggestions for further reading.

b. Process of developing district level training module

The training module for the district level was developed to train district level health trainers on the basis of the finalized version of the state level training manual. CHETNA drew upon its rich experience of participatory training and converted the state level manual into a modular form. The first edition of the module was later developed in English language. This was translated into eight languages. CHETNA translated the manual into Gujarati and Hindi.

This module was based clearly defined objectives. The technical information was provided in a simple language while giving due consideration to the socio-cultural aspects of the community. To enable the trainer to conduct training sessions effectively and in a participatory manner, guidelines containing specific tips and training tools were also provided in the module. Wherever necessary, methods for evaluating the understanding of the participants were also described.

c. Process of developing village level training module

This module was developed to train village level women leaders responsible for imparting health information to women of self-help groups and other people of the community including women. The module was first developed in English and later translated into various regional languages. The information given in the district level module was further simplified in the form of health messages for inclusion in this module. Specific ways in which panchayats, male members of the family and women's groups could contribute towards improving women's health in villages were also included.

Keeping in view the level of understanding of the community, the module was graphically illustrated. To give an overview of various diseases, illustrative short case studies and stories featured extensively wherein the social perspective was also integrated. Use of folk songs was also made. This method initiated a thought process and discussions among the participants and helped them have a good understanding of issues involved.

Experiences of developing state level manual and district and village level modules

The participatory method of developing the training manual and module was an interesting and enriching experience. It provided a space for interactive dialogue between government and non-government organizations. However, the time allotted did not seem enough. Since in the beginning, the guideline to write the training module was not prescribed, the session writers made their own outline. To standardize each module took much more time and human resource of CHETNA team than envisaged.

Training Strategy

Initially, state level NGOs were identified who had experience of organizing participatory training related to women's health. These organizations were responsible for translating the district and village level modules in local languages, print them and organize training for master trainers. About 25 participants were identified for training master trainers from each of the states. The master trainers had to train leaders of self-help groups who in turn,

communicated health information to other women of the community through regular meetings. Through this process, a total number of 72 self help groups were reached. The criteria for selecting these groups was based on their level of involvement, rapport and credibility with the community. Once the training modules were printed, the process of capacity building was initiated.

a. Training of master trainers

Five master trainers were selected and trained from each district which totaled to 25 master trainers from each state. Out of five master trainers, while one was selected from the Government department (IRDP, women and child development, health and social welfare) the remaining four were from multi-sectoral NGOs and individuals capable of conducting training at the district level. The master's training was conducted for 15 days. The state level institutes were given the flexibility to organize the training of 15 days either at a stretch or in two phases of 7-8 days each.

Participatory training methodology was the key feature of training programmes. Group discussions, role play, structured exercises, demonstration, body mapping, resource mapping, audio-visual methods were the major tools used for training. In order to build the capacity of the participants, NGOs used varying and different strategies to build up the training skills of participants.

b. Training leaders of self-help groups

The trained master trainers, were made responsible for training women group leaders. Two group leaders were selected from 12 women's groups hence a total number of 24 group leaders were trained in each training programme. Six such trainings were conducted in each district to cover 144 group leaders in each district. The training was conducted for 7 days. While some training programmes were conducted in one phase, some NGOs conducted the training in two phases. However, the total number of days remained the same. The trained group leaders were made responsible for communicating health messages and information to other women members through meetings by using village level training module.

CHETNA's Role and Involvement

CHETNA played three different roles in this programme

- **Liasioning** and **facilitating** the process of developing state level training manuals in English and contributing in writing the manual.
- **Developing** district and village level modules, translating, printing them into Hindi and Gujarati and disseminating the Hindi modules in Hindi speaking states.
- **Facilitating** masters training in **Gujarat** and **Rajasthan** and providing follow up support at village level training sessions in these states.

In addition, on special request, CHETNA also trained the state level trainers for *Mahila Samakhya Society* trainers from the States of Assam, Bihar, Karnataka and Uttar Pradesh.

Training Efforts

Training efforts included preliminary meetings with various NGOs and training master trainers in the states of Gujarat and Rajasthan.

Preliminary meetings: In both the States (Gujarat and Rajasthan), a day's meeting was organized for the participating NGOs. The main aim of this meeting was to share with them the training strategy, criteria for selecting master trainers, objectives of the masters' training and village leaders' training programme. The meeting was also used for explaining the financial procedures and the budget.

Master trainers training: A 10 day training was organized for master trainers of Gujarat and Rajasthan by CHETNA. The objectives were to:

- ***build*** perspective on women's comprehensive health
- ***strengthen*** their knowledge base on women's comprehensive health
- ***enhance*** their skills as trainers and make them aware about their role in information dissemination

A. Masters Training – Gujarat

The master trainers of Gujarat were from Self Employed Women's Association (SEWA), Ahmedabad and Mahila Samakhya Society, Vadodara and Rajkot. A ten days training for master trainers was organized during November 30 to December 10, 1999. The stipulated 15 days were covered by providing a support of a shadow trainer, at the village leaders training conducted by master trainers.

a. Background of the participants

A total number of 28 participants from 5 districts of Gujarat attended the training programme. While 3 persons were from the government department, 25 participants represented Mahila Samakhya Society Gujarat and SEWA. The educational level of the participants ranged from semi-literate to graduation .

b. Training methodology

Participatory training methodology was the key feature of the training. Small group discussion, use of role play, structured exercises, demonstration, body mapping, resource mapping, slide show, screening of video films, lectures followed by discussions were some of the participatory training methods used during the training.

To build the training skills of the participants, one participant joined the trainer team every day by way of which the participants got an exposure on how to plan and execute a training session. They were also given an opportunity to play the role of a trainer and encouraged to conduct a session on the subject of their choice. This mechanism helped them to become sensitive to the needs of the participants and develop training skills in an enabling environment.

c. Expectations of the participants

To begin with, the participants were encouraged to share their expectations from this training. They expressed the need to acquire technical information on women's comprehensive health and to upgrade their skills on training methods.

d. Actual training

The district level training module on 'Women's Health - Towards Empowerment' was made use of to cover various topics related to women's health with reference to gender discrimination, nutrition and work. These modules were discussed by encouraging the participants to share their own life experiences. This enabled the participants to view women's health from a gender perspective.

Debates, group discussions and exercises on self-analysis were conducted to help women explore the meaning and draw perceptions about their lives, and the work they do. Listing of incorrect beliefs on food intake and cultural practices gave an idea of the deep-rooted causes for women's poor health.. The participants were sensitized on the issue of violence against women and its impact on health, a subject very often neglected by health functionaries. The participants related their own experiences of violence and were able to realize the importance of integrating this issue with women's health programmes. The wide ranging topics including the one on mental health helped the participants to widen their perspective on women's health.

There were detailed discussions on the reasons for poor health status of women such as lack of accessibility to health care services and ways of making use of govrnment infrastructure such as PHCs. The participants were apprised of the merits of traditional health practices and this was exemplified by holding the session in an environment where they got an opportunity to observe different types of herbs and medicinal plants. A session was held to discuss, in simple language, causes, symptoms and prevention of common ailments and diseases related to health in general and women's reproductive health in particular. Prior to providing knowledge, the basic understanding on the topic was assessed by using various participatory training methods. Participants were encouraged to give suggestions and develop action plans on the same lines. Role of panchayats in increasing access to primary health care was discussed as a separate topic.

e. Feedback

To elicit the participants' views/reactions on the training subjects, methods, approach, language and logistics employed, a *steering committee* comprising a few participants was formed every day to carry out this job. The committee was also responsible for bringing out a newsletter highlighting the major achievements and lessons learnt during the day. Based on feedback, changes were made in the design and the logistics of the programme. Since all the participants got an opportunity to be part of the steering committee, an environment of openness and understanding of various aspects was created. Some highlights on the feedback in terms of the methods and contents are as follows:

- Most of the participants expressed their satisfaction with the training sessions which provided a holistic and comprehensive perspective on women's health.

- Integration of gender with various health topics was well appreciated
- Use of participatory training methods, audio-visual media and simple language was well appreciated. It has inspired many of them to adopt the same methods for conducting training of this kind.

Expressions of participants

"When I came here for ten days training, I was worried about how I shall pass ten days! But now as training is drawing to a close, I feel sad that I have to live my swajan (own people). I feel more responsible now as I have to conduct this training effectively at village level" - *Ms.Saroj, Mahila Samakhya, Rajkot.*

"In seventeen years of my government service I have attended so many trainings, but the experience of the training here is unique. I liked the participatory training methodology and contents covered. CHETNA has provided us excellent facilities during the training programme"- *Ms. Sheela, Government Health Department, Mehsana*

"I am working with SEWA for the last twenty years. After attending this training I am infused with more courage and confidence. We suggest that CHETNA should organize this kind of trainingmore often" - *Ms. Madhu, SEWA, Ahmedabad.*

B. Masters' Training - Rajasthan

The master trainers for Rajasthan were selected from CUTS (Chitorgarh), Seva Mandir (Udaipur), URMUL Marusthali Bunkar Vikas Samiti, Rajasthan Voluntary Health Association (RVHA) and Indian Institute of Rural Development (IIRD) and a child development project Baran. A 10 days training was organized during **November 17-27, 1999**. The stipulated 15 days were covered by providing a support of a shadow trainer, at the village leaders training conducted by master trainers.

a. Background of participants

A total number of 21 participants from 5 NGOs of Rajasthan, including one government representative participated in the training. They were of the supervisory level responsible for conducting training in their organizations. All the trainers were educated, their educational level varying from higher secondary to post graduation.

b. Training methodology

Apart form using participatory training methods to enhance the skills of the participants, volunteers were encouraged to join the trainer team every day. They were involved in planning sessions with the core trainer team and facilitated sessions on subjects they were comfortable with. This provided them hands on experience in learning different techniques and training methods.

c. Expectations of the participants

The expectations of the participants were solicited through the pre-registration questionnaire administered before the training which was reconfirmed during the first day of training. They expressed the need to acquire technical information on women's comprehensive health and to upgrade their skills on training methods.

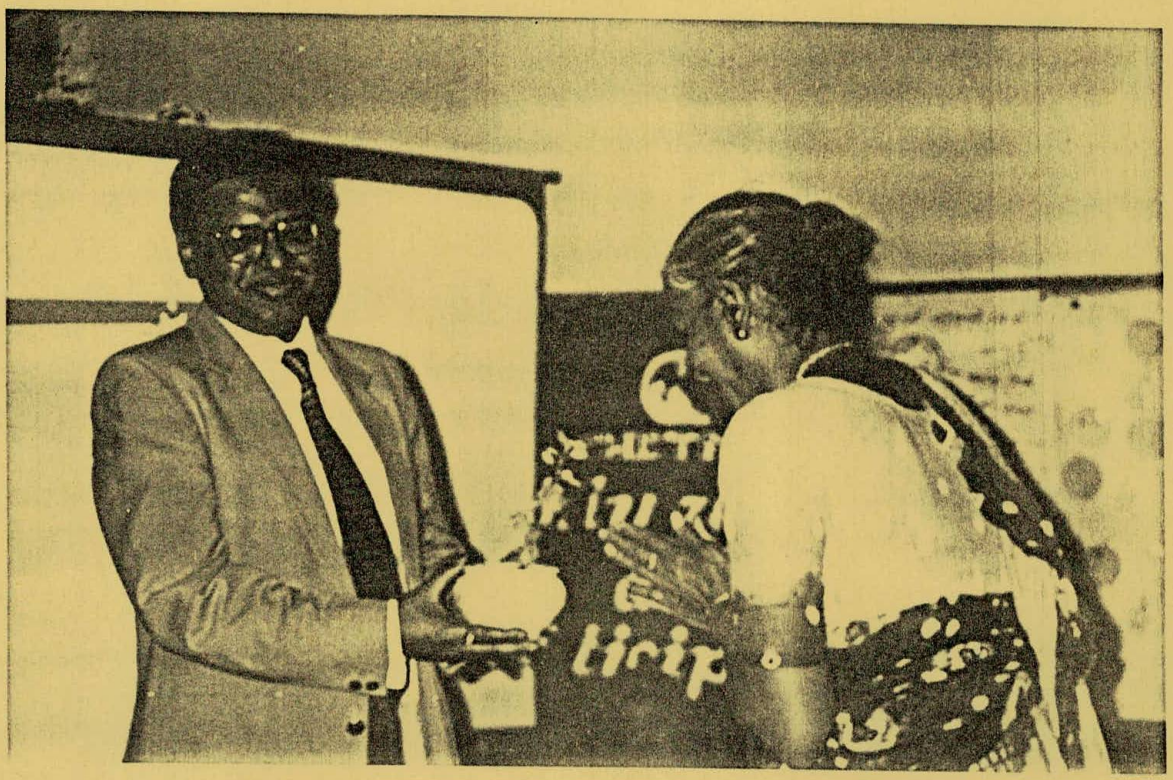
d. Actual training

Debates and structured exercises were conducted to identify and discuss issues related to gender discrimination, women's nutritional status and health problems. Although the male participants agreed that gender discrimination, overwork and violence, as factors affecting women's health, some of them did not accept it gracefully. Problems related with mental health were regarded as important and discussed. The participants were apprised of health infrastructure provided by the government and to demand the same by creating pressure groups at local level. Traditional health and healing practices were discussed as a strategy to empower women and communities and enhance their self-reliance. The role of *dai* as a healer and resource was also discussed. With the *panchayats* attaining more autonomy, the need to involve them in addressing health needs of the community was highlighted. There were discussions on common disease patterns, their symptoms and ways of prevention. Participants were encouraged to express their views on these issues. In order to orient the participants to the use of village level module, chapters were reviewed and discussed. The participants expressed the usefulness of the module to facilitate learning at the field level.

e. Feedback

A committee was formed to provide feedback on the subject, methods, approach, language and logistics of the training programme. The committee also prepared and shared with the participants report and newsletter based on the proceedings of the training sessions. Some of the highlights on the feedback in terms of the method and content are as follows:

- Most of the participants expressed their satisfaction with the training sessions, which provided a holistic and comprehensive perspective on women's health.
- Integration of gender with various health topics was well taken.
- Use of participatory training methods, audio-visual media and simple language was well appreciated. It has inspired many of them to adopt the same methods for training village level women leaders.
- Some of them suggested simplifying certain questions for better clarity. They also suggested providing some more time during the training, to fill up the questionnaire.
- The district and village level modules were found very comprehensive and useful in imparting training.



Follow Up

As a training institute, CHETNA was keen to assess the impact of the training imparted to master trainers through supportive follow up. It was earlier decided that the Ministry of Health and Family Welfare would employ an outside agency for this job. This did not happen and therefore, CHETNA took the initiative to organize follow-up visits. The trained master trainers planned to organize village level training within a span of two months, i.e. January to March 2000 at each district. The objectives of the follow up visits were to:

- provide support and guidance to master trainers and enhance their confidence
- assess the level of transfer of information and knowledge from master trainers to the village leaders.
- observe the skills of the trainers in conducting village level training programmes
- assess the utility of training modules

Follow-up - Gujarat

CHETNA team planned to visit each master trainer at least once during the process of the training. However, due to paucity of time and human resource it was not possible to remain present for all seven days. To get a feel of the over all process of training, some follow-up visits were made during the initial two days, some during the middle two days of the training and a few during the last two days. A standardised performa was developed to collect information and to assess the impact of training on master trainers and village leaders/trainers, informal interviews were also conducted. Detailed schedule of follow up visits made by the CHETNA team is given in Table 1.

Table 1: Detailed schedule of follow-up visit conducted by CHETNA team

Date (Jan-Feb 2000)	Organization involved	CHETNA team
05-07 Jan.	Mahila Samakhya Society (MSS), Rajkot, at Gondal	Ms. Gayatri Giri Ms. Anjana Dave
10-12 Jan.	SEWA, Ahmedabad, at Sanand	Ms. Pallavi Patel Ms. Bhanu Makwana
17-18 Jan.	Mahila Samakhya Society, Vadodara at Sindhrot	Ms. Bhanu Makwana
28-29 Jan.	Mahila Samakhya Society, Vadodara at Jambughoda	Ms. Anjana Dave
14 Feb.	SEWA, Ahmedabad, at Dholka	Ms. Anjana Dave
14-15 Feb.	Mahila Samakhya Society, Rajkot, at Vankaner	Ms. Gayatri Giri
17-18 Feb.	Mahila Samakhya Society at Kadipani	Ms. Gayatri Giri
21 Feb.	Mahila Samkhya Society at Mehsana	Ms. Bhanu Makwana

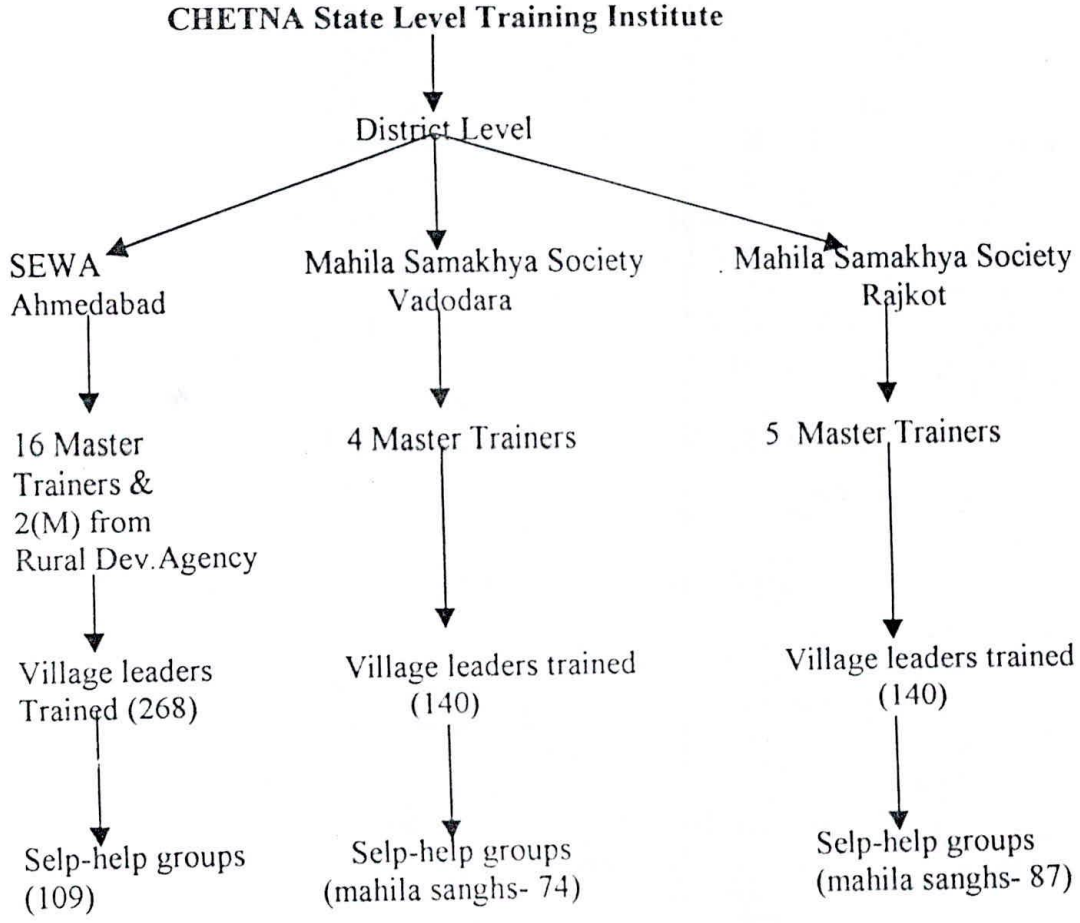
During these visits, CHETNA visited 15 trainers. The team members provided necessary guidance and support during district level training sessions. Their training skills were observed and necessary feed back was given. The details of the village level trainers/women leaders who participated in the training is given in Table 2.

Table 2: Profile of village level trainers

Name of Training Organization	Number of Village Leaders /Trainers			Total SHGs covered
	Total	Literate	Illiterate	
Mahila Samakhya Society, Vadodara (3)	78	53	25	41
Mahila Samakhya Society, Rajkot (3)	53	32	21	23
SEWA, Gujarat (9)	268	177	91	109
Total (15)	**399**	**268**	**137**	**173**

Numbers in parenthesis indicate the number of district level trainers
Training wise details attended by CHETNA team is given in **Annexure I**

Flow Chart of Masters Trainers Training Process on Women's Health



Observations made during the follow-up visits

- **Enabling environment:** It is well known that it is important for trainers to create a conducive environment for people to learn effectively. During the follow up visit it was observed that all the trainers were able to develop an enabling learning environment at the district level training sessions. The positive approach of the trainers towards the participants, facilities provided and training methods used during the training played a major role in creating an enabling work environment.

- **Rapport building:** At the beginning of each training, the trainers used various games to create an informal atmosphere. In all the training programs, although half the participants were illiterate, the master trainers made special efforts to encourage them to share their experiences. They entrusted the literate participants with the task of helping the illiterate ones which enabled effective rapport building between the trainers and the participants and among participants as well.

- **Commitment to learn:** It was observed that village women were able to concentrate more, whenever the training was organized far away from their own villages. *Mahila Samakhya Society* successfully organized residential trainings, wherein late evening sessions were held to enable women to interact amongst themselves. During this interaction they exchanged the knowledge gained from the training sessions and related those with their life experiences. They also spent considerable time reading the training manual. In the non residential trainings, which were organized by SEWA, women spent a lot of time in commuting and and the trainers had to constantly innovate new methods to motivate women and keep their interest alive. Both, the participants as well as the trainers showed commitment towards their responsibilities.

- **Sharing life experiences**: Each training programme commenced with sessions on gender, violence and nutrition. During these sessions women shared their life experiences, feelings and pains. At the residential training, master trainers and village trainers stayed together.

- **Use of familiar language:** The master trainers were part of the community and in close contact with the village trainers hence, their acceptance in a group was very positive. The master trainers used local vernacular language, which ensured active participation of all the village trainers.

- **Use of participatory training methods:** It was satisfactory to note that master trainers had internalized the participatory training approach, which they learnt during masters training organized by CHETNA. An important approach adopted by them was that they first collected information on the existing knowledge base of the participants and built additional one on the basis of existing resource. This approach helped raise the confidence of village level trainers and ensured their active participation.

- **Efforts made by trainers:** Most of the trainers developed the training design prior to training and followed the district training module meticulously. They made efforts to read and prepare themselves on the content, training methods and exercises given in

the training module prior to training. Since the group was hetrogeneous, it was a challenge for the trainers to train them. Due to this, the trainers found that the time mentioned in the session and the activities inadequate.

- **Use of district and village level training modules**: In most of the training programmes, the district level training module was used as a reference/guide by the trainers. The trainers used the village level modules creatively by asking the participants to read out the stories given in it and later initiated discussions on it. While illustrations given in the village level module were used to explain the technical information, in some cases, reading topics were read aloud to make the points clear. The module was also used to clarify their doubts and misconceptions. It was observed that participants read the village module given to them very keenly whenever time permitted so.

Views of district level trainers: The district level trainers were asked to give their opinion on the techniques and methods adopted in the district level training module.

- The trainers found the training methods in the module appropriate and helpful
- Participatory methods were found useful to interact with participants, understand their training needs sustain their interest
- The structured exercises were very found effective to explain and reinforce the content.
- The exercises were easy to adopt to the local situation.
- It provided scope for interaction amongst trainers and participants.

Views of village level trainers: The views of village level trainers/ leaders on the content of the village level module were as follows:

- They found the module very useful partly because of its being narrative
- The language used was simple and easily understood
- Technical information was adequate and presentations were effective. Illustrations made the module interesting, and the contents easy to understand.
- The module could be related to with ease because of its contents on social aspects
- The module helped in shedding inhibitions

Feedback from the trainers

"It was an excellent training experience"- **master trainer.**

"Tame je vaue che te lanai jay to saru. (What you have sowed needs to be reaped) Whatever we have learned from the State level trainers' Training we want to take it up to village trainers." **Master trainer.**

"Moole ropya CHETNA ea ane fanga futya SEWA na" (seeds are sown by CHETNA and they sprouted at SEWA.) **-Master trainer**

"Ame to andhla hata tame dekhta karya (we were like blind person, illiterate; you gave us vision). The pictures given in the module are like an asset for us. We will use it in all our trainings." **Village trainer.**

Listening to Master Trainers

Training as a tool for empowerment: Ms. Meena Chauhan[1]:

"The joy of this experience of training from CHETNA and of being together is yet not over. ***Je dab dabo che te nikali jase tyarej shant thashe*** (we had enjoyed training, we have to share that experience and learning with others, without that process of learning is not completed.) Initially I was worried, whether I will be able to impart the same quality of training that I have received from CHETNA? The training module, which you have provided to us, is very useful. Due to it my confidence as a trainer has increased.

After receiving the training I went for fieldwork. One woman talked to me about her health problem. She had an ulcer in her private parts. I took her to the hospital and spoke to the doctor with confidence which I was able to muster due to the training. I could use health terminology. I informed the doctor about having undergone training from CHETNA. He examined the woman and gave the necessary treatment. My enthusiasm and information on health aspects impressed him. He told me to contact him whenever necessary without hesitance. His faith and confidence in me was my personal achievement. It is all due to the training.

When I showed the district level module to my friends, they got interested in acquiring information and read the module with interest and appreciated my knowledge on health aspects. At Mahila Samakhya Society where we have various committees on different issues I refused taking responsibility of health committee, as I was not confident of imparting the training. I am now ready to take on that responsibility."

We at CHETNA also noticed great transformation in Meena's attitude towards her own body. When she first came to the organization, she was hesitant to sit through the demonstration on the use of condom on a banana. She even refused to eat a banana, which was served as part of the meal. To our surprise during village level trainers' training while explaining different contraceptive methods and their use, she conducted the same demonstration without any inhibitions. She informed us that her first aim was to teach the village trainers. She later decided to keep all her personal inhibitions aside. According to her, this attitude of hers has helped her to be a confident and effective trainer.

In our follow-up visit we observed that, she had taken up her role of trainer very seriously. She was confident while imparting training. She was using vernacular language and giving due respect to elderly women participants and their experiences. The village level trainers greatly appreciated her as a trainer.

Follow up - Rajasthan

During December'99 to March 2000, CHETNA provided follow-up support to Seva Mandir, Udaipur, **CUTS**, Chittorgarh and IIRD, Alwar. It is important to note that

[1] One of the master trainers attended the training on women's health organized by CHETNA. She had done post graduation and is working as a Sahiyogini with the **Mahila Samakhya Society, Rajkot**. Her maturity reflects when she interacts with the village trainers/women.

Rajasthan Voluntary Health Association (RVHA) and URMUL did not conduct the village leaders training due to, some administrative reasons. The detailed schedule of the follow up visits made by CHETNA team is given in Table 3.

Table3: Detailed schedule of follow up visits conducted by CHETNA team

Date (Jan-Feb. 2000)	Organization involved	CHETNA team
17-18 January	Consumer Unit Trust Society (CUTS),Chittorgarh	Vd. Smita Bajpai
18-19 January	SevaMandir, Udaipur	Vd. Smita Bajpai
7-9 February	IIRD,Alwar	Dr. Veena Dwivedi
17-19 February	Seva Mandir Udaipur	Vd. Smita Bajpai
20 February	CUTS,Chittorgarh	Ms.Jyoti Gade

Observations made during the follow up visits

- **Trainers and training methods:** In all the three organizations, the master trainers facilitated most of the sessions with support from their colleagues and CHETNA team. They handled the groups were confidently and deftly. However, they felt the need for more guidance in session planning and conducting the training. **Participatory training** methodology was used to strengthen the capacities of the participants. While following the guidelines given in the training module, based on their long years of work experience, the master trainers adapted to their specific situations. These included visuals, games and stories. For example, the team from CUTS developed a health triangle by using local grains and discussed the problem of anemia through local *bhajans* (devotional songs). While master trainers from Seva Mandir created stories to bring home various issues, the IIRD team made use of case studies to highlight sensitive issues such as violence and infertility.

- **Enabling environment:** In CUTS and IIRD, exhibition of posters and charts created an enabling learning environment which was not adopted by Seva Mandir. A lot of emphasis was put on the use of models and other audio visuals. One of the master trainers pasted four blank charts on the wall. At the end of each topic, the participants listed various points of action that could be taken at the individual, family, community and panchayat level. The trainer summarized the key action points. It was observed that the training venue which was away from the city, with clean surroundings offered conducive environment for conducted training programmes.

- **Contents covered:** While the master trainers meticulously followed the content outlined in the training module, each trainer made changes based on the local situation. While specific issues pertaining to gender, violence, panchayati raj, local health and healing practices, RTIs/STDs, HIV/AIDs, maternal health were discussed in details, some general topics related to diseases such as T.B, malaria, could not be discussed due to lack of time. Some of the topics pertaining to violence, mental health and gender created a feeling of helplessness and depression.

- **Inadequacy of time:** In all the three organizations, time was found inadequate. In order to build capacities of the leaders, a one time training input was not considered

enough. Each topic had to be introduced and absorbed gradually through repeated follow-ups. The level of comprehension of the participants was such, that a lot of time was required to explain issues, discuss them and help them to develop action plans. In many cases, therefore, the facilitator had to initiate and take lead in identifying action areas.

- **Use of training modules:** The module was a guide to all the master trainers and proved useful to the participants because of the contents were lucid and given in an illustrative manner. The district level manual served as a reference book and helped them plan their sessions. The participants were happy to receive a copy of the module and after initial hesitation were able to share it at the community level. The response generated by the module is tremendous. The module also proved beneficial to school teachers who found the information contained in it very useful. Since the literacy level are low, one of the participants from IIRD made efforts to overcome this barrier by taking her daughter- in- law to the group meetings. While the daughter-in-law read out the information, the mother in law explained the details to the group. The group members the information useful and expressed a desire to possess a copy of the same as well as participate in such trainings. Most trainers distributed the manual on the first itself day and religiously used it as a teaching aid. However, in CUTS, the module was given only on the last day with the fear that they may not come back for the training after having received the manual. In this case, the use of module by the leaders is questionable.

Views of the participants: As discussed earlier, the participants were experienced members and leaders of the self-help groups. Each organization provided training to 72 women's groups, the number of members participating from each group, varied from one to two participants. The participants found the topics covered during the training very useful, easy to comprehend and relevant to their area of concern. The discussions were found relevant and lively. However, it was not easy for them to develop action points on their own and in most cases, the trainers helped them to identify key issues. The participants expressed that the training has helped bring about attitudinal changes in them. One of the participants said that she has started filtering water and after having explained the advantages of doing so, the other village women have followed suit.

"When we started training the village leaders, they wanted medicines. However, when they learnt that we were offering some thing that was linked to their own needs and would help them grow, they participated enthusiastically. The book that has been developed is now the community's property. From husbands to ANMs to school teachers, every one wants to read this book and after reading, they are immensely satisfied that they have now achieved something that they were deprived of". ***- A trainer in Alwar District***

"I felt as if you are telling the story of our village dai. She is very similar to Kantabai, However, we never thought of electing her as Sarpanch. In the next election, we will make sure that she contests the election and emerges as a winner.-" ***- a leader of village group in Rajasthan.***

Towards Improvement of Women's Health: A Case Study

"Sister, I have white discharge which is foul smelling, my husband does not allow me to consult the doctor and I also feel shy to go to him. What should I do, kindly let me know some solution"? These are the words of a village woman shared during one of the training sessions. After talking to them, it was realized that reproductive tract infections are very common among them which are visible in the form of white discharge, menstrual disorders, prolapse of uterus, and cervical cancer. These problems are rarely treated because of hesitance on part of women in bringing these problems to the fore and the fact that men do not permit their wives to take treatment.

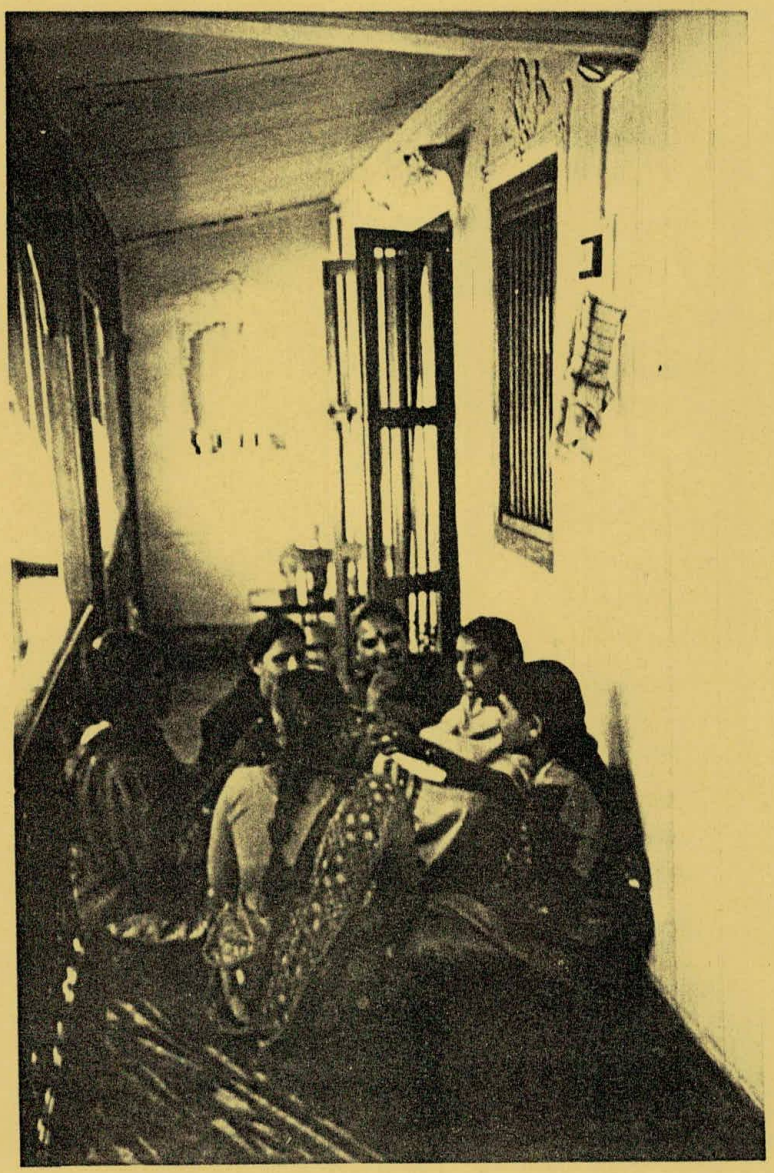
After participating in the masters training programme conducted by CHETNA, the need to create awareness among women with regard to their own health needs was realized. Rigorous efforts to train women had to be made in the initial period as women were not ready to participate in the training partly because of overwork and partly because of reluctance on the part of their husbands to send them. Therefore, the training was split into two phases. The first phase was of four days duration and the second one of three days.

During the training sessions, the contents covered were gender discrimination, women's work and health, access to health care services, indigenous health practices, violence, pregnancy, reproductive tract infections and STDs. Issues of self governance and role of women in p*anchayati raj* were discussed in a participatory manner.

Two months after the training, when follow up visits were made, change was visible among village women. They have started following simple hygienic practices like filtering the water before consumption. Some of the women have started to take young girls into confidence and make them aware them about their own health. Women have now started to discuss their health problems openly in a group and taking relevant treatment. They have started attending panchayat meetings, which they never did before and have become vocal about the problems faced by them. Self help groups meet regularly and often invite auxilliary nurse midwives (ANMs) to their meetings. Muslim women who were initially opposed to contraceptives have started adopting them as a family welfare measure. Due to encouragement of other women in the panchayats of Ramgadh and Rajagadh women were elected as members and sarpanch.

Who says that women can not do anything
If she want she can grow flowers in the throne!

Lessons Learnt, Constraints and Recommendations



Lessons Learnt

- **Reaching out to a wider community:** The need for spreading information at the mass level has been realized. Through this effort, a considerable number of women and men were reached at the district as well as the village level. NGOs and technical experts from all over India came together to interpret women's health concerns in the socio-economic and cultural contexts. This extended the outreach to many more groups and individuals, particularly in the remote and rural areas which are otherwise difficult to access.

- **A comprehensive and integrated approach to women's health:** Years of working on women's health concerns has lead to the realization that women's health has to extend beyond certain phases (adulthood), conditions (pregnancy) and issues (physical) of her life. Health and development concerns should be addressed throughout her life and in all conditions. This concept formed the premise of this programme. The module covers 23 health and development concerns, from conceptional to later years of developemnt.

- **Empowering women:** Empowerment is a widely used term and has different meanings in different contexts. In this context, women's empowerment implies her ability to understand, analyse and take decisions for her own health and development, which is information based. This project focused on enhancing women's participation in the panchayats, creating pressure groups to demand quality health care services and strengthen local health and healing practices to increase self- reliance in health care.

- **Participatory approach gives richness and realistic perspective:** Since the process was participatory and involved people having grassroots experience therefore, realistic and need-based concerns were incorporated in the modules and training programmes. NGOs and GOs partnered in the process to set an example of how a positive partnership can change perspectives and bring about desired results.

- **Holistic process more effective impact:** This process was holistic and started from developing manual and training programmes at all level (State, District, and Village level functionaries).

- **Involvement of NGOs from the planning stage is critical:** Even before the conceptualization of the project, the GOI involved NGOs for preliminary discussions and throughout the planning process. Therefore NGOs also felt accountable to maintain the quality of the manual and the training programmes.

- **Structure of the training programmes:** The training programmes were structured in a way that they met the needs at all levels and percolated down to the grassroots level.

Constraints

Coordinating with a number of individuals, organizations and the government was an enormously challenging and time consuming task for CHETNA. Since the project outcome was excepted a tight time schedule, meeting deadlines often became a rushed affair. Due to paucity of time, the training module could not be field-tested. This should be considered in future programs.

Recommendations

Following recommendations have been drawn to strengthen the project for the future implementation.

- Regular orientation training should be organized for trainers from government as well as NGOs at the state and district level to up-date their knowledge and motivate them to continue the process.

- Since the process of change is slow, there is a need to allocate more time to village level trainers to enable them to internalize the concepts and take action. Duration of training of at least ten days is recommended to enable the trainers to cover the wide range of contents.

- Since CHETNA's experience about follow up visits in Gujarat and Rajasthan was positive, the same has been recommended as mandatory both at district and village level trainings

- Self help groups by virtue of their exposure to health and development issues have the potential to become focal points of addressing women's health and development concerns.

- The training manuals need to be published after incorporating the suggestions and made available for wider circulation and dissemination of information.

- An additional module on older women's health concerns needs to be developed

- The State Level Training institutes need to meet in New Delhi, to share their experiences among each other and concerned government officers. Similarly, a meeting can be organized for all the district and village level trainers at the national level to share experiences and plan future strategy to continue and enhance the process of learning.

Annexure I

Development Phases

Stage	Details	Outcome
I 19-20 Nov'98, New Delhi	Technical experts, NGO representatives and training organizations identify health education material for women's health and decide to develop a training manual.	Various experts take responsibility of writing chapters. CHETNA requested to coordinate this effort.
II. 3-4 Jan'99, Ahmedabad	CHETNA coordinated a meeting of writers to elicit feedback and develop framework for remaining chapters	The number and content of each issue was finalized. Writers took responsibility for writing 23 chapters. Time frame was decided and so were the title, language, reader, and levels. Regional adaptation and translation responsibilities were shared. Regional training centers were identified.
III March'99	Writing and finalization of chapters of the State level module	Standardized state level modules were finalized in English
IV. June-99	Developing of district and village level modules by CHETNA	Illustrative training modules for district and village levels were finalized in English
V July- Oct. 99	Regional adaptation and translation by different organizations in 9 languages	District and village level modules were developed in Hindi, Gujarati, Marathi, Malyalam, Telegu, Oriya, Bengali, Tamil Kannada and Assamese.
VI. Nov- Dec'99	Training of district level trainers	Capacities of approximately 450 trainers in 15 states were enhanced. These were later expected to build capacities of 144 women leaders from each districts.
VII. Jan.-Mar.2000	Follow up and Training of leaders of women's groups .	Capacities of 144 women leaders of 72 SHGs
VIII. April-May 2000	Reports of all the above events	Process Documentation and Follow up report

Annexure II

Responsibilities of writing the chapters

S. No	Topic/Title	NGO responsible
1	Women's Health Perspective	Dr. Sathyamala*
2.	Women's Work and Occupational Health	SEWA, Ahmedabad
3.	Reproductive and Child Health	CINI, Calcutta
4.	HIV/AIDS, RTIs and Cancer	CHETNA, Ahmedabad
5.	Adolescent Health	CHETNA
6.	Promotion of Traditional Health and Healing Practices	Dr. Saraswati Swain/ CHETNA
7.	Mental Health	Jagori*
8	Women and Nutrition	Dr. Sathyamala*
9.	Gender and Self-esteem	CHETNA, Ahmedabad
10.	Women and Violence	Sakshi *
11.	Tuberculosis	CHC, Bangalore
12.	Malaria	CHC, Bangalore
13.	Rational Health Care	CHC, Bangalore
14.	Water & Sanitation	FRCH, Mumbai
15.	Women & Panchayati Raj	FRCH, Mumbai
16.	Access to Health Care Services and other Government Programmes	FRCH, Mumbai

*Initially, these individuals and organizations had agreed to write the chapters. However, for some reason they were not able to do so. Therefore CHETNA team members wrote all these chapters.

Annexure III

Broad guideline and framework for chapters of training manual

This is the general guideline to maintain a similarity in format of all the chapters in this manual. However, you are free to ignore the points, which are not applicable for your chapters and add if you require any new/specific point for your chapter. For the facilitation of writing your chapter, we are enclosing two draft chapters written by CHETNA team members: STD/HIV/AIDS, Gender, Self-esteem and Empowerment.

The chapters may be formatted in the following way:

Scenario/situation/statistics related to the subject that you are writing, particularly keeping focus on women and gender relations.

- Efforts/successes to change this situation (please give some practical examples if possible).
- Technical information on the subject (Fact-sheet)
- Module for training
- Content
- Duration required to cover this topic
- Training methodologies
- Teaching aids required
- List of training reference material to be referred by the trainer (for reading purpose and useful during the training such as particular songs, booklet, articles and teaching aids in regional/local languages etc.)
- List of material to be given to the participants
- Any other

Annexure IV

Following **chapters/topics** are included in the modules

1. Me and my society
2. Nutrition and Women's Health
3. Women's Work and Health
4. Women's Mental Health
5. Access to Health Care
6. Panchayati Raj and Women's Health
7. Traditional Health and Women's Health
8. Traditional Health and Healing Practices
9. Malaria and Women's Health
10. Tuberculosis and Women's Health
11. Water, Sanitation and Health
12. Our Growth (reproductive system of men and women)
13. Conception
14. Adolescent Health and Growth
15. Ante Natal Care
16. Child birth and Care after Childbirth
17. Contraception
18. Abortion
19. Infertility
20. Reproductive Health Infections /Sexually Transmitted Diseases
21. HIV/AIDS
22. Cervical Cancer
23. Breast Cancer

These modules include 23 topics related to women's comprehensive health along with training design and description of the training methods. The village level module has an added feature of roles of various stakeholders at village level to improve the health status of women. It includes role of family, male members, panchayat members and women's group for each of the health topics included in the module. The illustrative module was first developed in English and later translated into Gujarati and Hindi languages by CHETNA and Marathi , Malayalam, Telugu, Oriya, Bengali, Kannada and Assamese by other non governmental organisations

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