

Background and Objectives of Workshop

Nari Gaurav Niti- Gujarat State Policy for Gender Equity was formally adopted by the Government on 26th of August'2006. The Niti is a very comprehensive document, which looks into various spheres of a women's life and aims to deal with them for holistic development and empowerment of women. The Niti has mentioned time bound action plans for each sector while also allocating responsibilities to all state departments. Each department is required to further develop detailed action plans for the outputs to be delivered by them.

Gender Resource Centre (GRC) along with Department of Women and Child Development (DWCD), has been liaising with all state departments on implementation and monitoring of the Nari Gaurav Niti. After completion of six months of the policy, a format was circulated to all departments for compilation of the report. In the process it was felt that most departments had not developed individual action plans. There were also suggestions from various departments (and nodal officers for GEP) that GRC support them to further deliberate on the action plans and formulation of tasks and monitoring indicators.

This workshop is the first in this series being undertaken with the Health and Family Welfare department. Prior to the workshop, GRC had been in touch with many civil society organizations and experts on the issue to develop a list of suggestive tasks under each action plan. We would like to widely acknowledge the contributions of Chetna, Deepak Foundation, Shri K.N.Patel and Dr. Subhada Kanani in this process.

A compilation of the suggested tasks was presented by GRC in the workshop before the health department and other civil society groups. An attempt was also made to develop subsequent monitoring indicators for each action plan. It is expected that this would be guiding enough to initiate concrete action on Nari Gaurav Niti in future.

The workshop began with a welcome and introduction of all participants by Director, GRC. The sessions were divided into three parts;

- Brief recapitulation on background and objectives of Nari Gaurav Niti
- Presentation and discussion of suggested tasks for Health and Family Welfare Department under GEP.
- Discussion on monitoring indicators for the department.

Session 1: Briefing on Nari Gaurav Niti-2006

Presenter: Ms Jigna Surkar

The presentation focused on the need and background of formulating the Nari Gaurav Niti in Gujarat, its objectives and guiding philosophy, goals and approach, structure and institutional mechanisms.

Constitutional mandate in India:

The Constitution of India guarantees equality to all citizens irrespective of their gender. Also it is part of various ratified international treaties like:

- UN Convention On the Elimination of all forms of Discrimination Against Women (CEDAW)
- Declaration On the Elimination Of Violence Against Women
- Beijing Platform for Action
- Declaration on the Right to Development

Which aims to ensure equal rights, inherent human dignity and fundamental freedom to women.

Gujarat a development paradox :

Gujarat on one hand has a high level of economic development, yet on the other it has low Gender Empowerment Measure (GEM) and high gender inequality in education, economic activity, women's political and work participation.

Comparatively if we see that Gujarat is way too low at 876 in the 0-6 years sex ratio from the national average of 927. Likewise Gujarat's adult sex ratio is also lower than the national average. Female literacy and work participation of women is a little higher than the national average but in comparison to men it is very low.

Formulation Process on Nari Gaurav Niti:

The formulation of the Policy started in January 2002 with the formation of nine working groups. After inviting inputs from various stakeholders they were included in the final draft. The policy was approved as 'Nari Gaurav Niti' on 26th August 2006 and the GR was issued on 30th October 2006

The Guiding Philosophy of the policy is that *'Women and men have equal rights and opportunities to contribute to the well being of a society.* The Niti is guided by the following principle of Mahatma Gandhi, which says, *"But I am uncompromising in the matter of women's rights. In my opinion she should labour under no legal disability*

not suffered by men. I should treat the daughters and sons on a footing of perfect equality. A daughter's share must be equal to that of a son"

Goals of Nari Gaurav Niti:

Creating an enabling environment for enjoyment of all human rights and fundamental freedom by women on equal basis with men in all spheres- personal, political, economic, social, cultural and civil. This includes right to life, right to health care and quality life, right to quality education, right to employment, equal remuneration, social security and right to decision making.

- a) Shared responsibility for children and the home
- b) Mainstreaming gender perspective in the development processes, policies, programs.
- c) Strengthening participation of civil society, in particular women's groups, networks and organisations.
- d) Eradicate all forms of violence against women and girl child.
- e) Strengthening legal systems to eliminate all forms of discrimination against women
- f) Eliminate, step by step, prejudices as well as customary and other practices that are gender discriminatory by active participation of and involvement of both men and women.

Approach:

Following approach shall be adopted in policy formulation, program planning, implementation and impact analysis.

Gender planning - to develop strategies that aim at providing equal opportunities for both women and men.

Gender sensitization - amongst policymakers, program managers and the civil society.

Gender mainstreaming - at all levels of development, with efforts to encourage equal participation in governance and decision-making processes.

Gender analysis & audit - to systematically analyze the impact of development policies and programs so as to facilitate equitable socio-economic growth.

Gender convergence - to promote convergent programs and schemes of various departments and organizations to address identified cross-cutting issues.

The Policy Structure :

It is divided into eight key sectors of concerns, which are:

1. ECONOMIC ENVIRONMENT
2. GOVERNANCE AND DECISION MAKING
3. HEALTH AND QUALITY OF LIFE
4. VIOLENCE
5. NATURAL RESOURCE MANAGEMENT
6. EDUCATION
7. LEGAL ENVIRONMENT
8. ADVOCACY AND CAPACITY BUILDING

Action Plan – Sector 3 – Health and Quality of Life

Goal – To achieve equal access to quality of health care services, safe drinking water and sanitation.

To achieve this goal the follow *action points* have been formulated.

- Create conditions for safe delivery.
- Strengthening PDS to maintain the nutritional standards.
- Public education campaign on differential nutritional needs.
- Address micro- nutrient deficiency through ICDS and education related schemes.
- 100 % registration of Birth, Death & Marriages.
- Mass awareness on PNMT, Dowry Act, age of marriage and the decline in sex ratio.
- Civil society action to register complaints for violation of PNMT Act.
- Water and Sanitation:
 - Put under Consumer Protection act
 - 30% participation of women in water related decision-making committees.
 - 100% coverage by school sanitation program.
 - Community user groups and low cost technologies, specially among women and weaker sections.
- Regulate advertisements for health food habits.
- Health insurance with modest premiums
- Formulate a charter of rights of patients.

Institutional Mechanism:

- A policy review committee will assess the progress of policy implementation and provide guidance.

- Concerned departments to implement and submit reports every three months to responsible department and every six months to nodal department (DWCD).
- DWCD would be the nodal department
- Gender Resource Centre (GRC) to provide technical support

Department wise Detailed Action Points:

All the responsible departments are expected to develop individual detailed action plans which include the following:

1. Measurable goals to be achieved by 2010.
2. Identification and commitment of resources.
3. Responsibilities for implementation of action points.
4. Structures and mechanisms to ensure efficient monitoring, review and gender impact assessment of action points and policies.
5. Introduction of gender perspective in the budgeting process.

Objectives of the Workshop:

- Preparing detailed Action Plan for Health and Family Welfare Department
- Developing Monitoring indicators for each action point
- Proposing a system for regular review and monitoring of progress within the sector

Session 2: Action Plan for Health and Family Welfare

Chairperson: Ms. Renu Khanna

Panelist: Dr. Vikasben Desai, Mr. Rajeev Tewari

Presenter: Ms. Dharmistha

A detailed presentation was done by Gender Resource Centre on the Action Plan under the Nari Gaurav Niti - 2006. This had been compiled on the basis of inputs from Chetna, Deepak Foundation, Shri K N Patel, GRC and the six monthly progress report of Health and Family Welfare Department for GEP.

The presentation was divided into two parts, brief overview of data on critical indicators and suggestions on tasks under various action points. The overview is given in Annexure 1; it includes data on Critical Health Indicators, Status of Health Infrastructure, Health Person Power and Health Services.

Tasks Suggested to implement GEP Action Plan

Charter of Rights of Patients

- The charter was formulated long back and might need revision especially from Gender Perspective. Need to redevelop a charter with gender perspective, on urgent basis in a partnership with experienced NGOs. This should particularly include issues of women suffering from domestic violence and sexual assault, provisions related to MTP.
- Develop banners/ pamphlets based on this charter in simple Gujarati language depicting rights of patient. Include especial section on rights of women for ANC/ Natal and PNC care.
- Ensure the display of these banners/pamphlets in District Hospital/ CHC/PHC/sub-centers and public places. Messages should be simple and effective.
- This charter should also be shared with Panchayat and displayed in their office.
- Partnership with NGOs to create awareness among CBOs on this charter.
- Develop a monitoring system and action accordingly in a partnership with NGOs. Community monitoring by VHC to ensure rights of patient.

Regulate Advertisements on Baby Food

Celebration of Mamta Divas and Group Meetings of Targeted Audience

- Stricter rules to provide detailed information on the ingredients and develop pamphlets to be displayed in all hospitals and clinics
- IEC department to develop jingles on home-based weaning food rather than tinned baby food (some of them are already developed). Coordination with the Radio, Television channels, Akashwani and Doordarshan.
- More stress on traditional baby food options, information dissemination in all government hospitals
- Anganwadi workers to have information packs on cooking low cost high nutritional food for infants and children
- Encourage articles by NGOs on low-cost, locally available food for weaning and publish them in local leading newspaper.
- Provide case studies/data base and encourage journalist to prepare articles on importance of home cooked weaning food verses tinned baby food, (nutrition and cost) to publish in daily News Papers/magazine.
- Organize press conference and media advocacy workshop.
- Provide forums for journalist, NGO and civil society for discussion and debate.
- Involving key organizations like MICA-Ahmedabad, INTAM and other media research organizations through annual contracts as media watch.

Health Insurance

Launching of Chiranjeevi scheme for pregnant women of BPL families. Also furthered the implementation of Janani Surakhsha Yojna Insurance coverage for family planning operations

- Create awareness on 'Chiranjivi Yojana' and 'Janani Surksha Yojana' and health insurance scheme.
- Have regular sensitization meetings with IRDA by the office of Commissioner.
- Linkages with the Life Insurance Corporation and other private insurance agencies to introduce packages for women and disadvantage community.
- Request insurance agencies to come-up with customized products on trial basis covering mother and child as a unit. Also develop attractive packages for newly married couples in rural and tribal areas.
- Develop insurance packages to cover different stages of pregnancy.
- Linkages with NGOs who have initiated health insurance such as Self Employed Women's Association, Ahmedabad and adoption (mainstream) of such schemes to provide benefit, especially to BPL families and families in unserved and underserved areas.

- Explore possibility of providing health insurance to SHG groups formed under Sakhi Mandal by linking up with insurance agencies for group hospitalization policy
- Develop IEC material to promote medical insurance for working women in urban areas
- Cover Anganwadi workers under ESI scheme
- Pension scheme and subsidized medical insurance for families with only two girl children

100% Registration systems for birth, death and marriage

Monthly exchange of data on death and birth by talati, women health worker, anganwadi worker and TBA.

- Task to be allocated to ASHAs and anganwadi workers instead of talatis.
- Data to be compiled by ANMs and collated at block level with involvement of BHOs.
- At village level there can be a provision wherein every quarter this information (on registered births and deaths) is read in Gram Sabha
- Conducting block level committee meetings for data sharing in standard format to avoid disparity in data collection.
- Have camps for registration of birth, deaths and marriages at regular intervals.
- More systematic registration of death causes, especially for women
- Involving professional organization for evaluation of the system on sample basis and mobilize funds from INGO / private organization.

Functioning of community based rehabilitation programmes

- Collaborate with SJED for mapping of CBRC
- Have separate health check up camps for disabled women.
- Health cards issued to disabled women and special scheme for free regular health checkups of disabled women at district hospitals
- PHCs , CHCs and District hospitals to be made accessible
- Sensitization of community on the issue through public campaign.

Public campaign on Critical Issues

Already launched Beti Bachao Campaign

- Need to have a second round of Beti Bachao Campaign with focus not only on female feticide but also the infant girl child
- Provide PHC and CHC officers with training and information material on DVA and issue a notification to declare all PHCS and CHCs as health service providers.

- Widely disseminate provisions of DVA, name and addresses of POs and service providers in all PHCs and CHCs.
- Partnership with NGOs, MNGOs/FNGOs, corporate houses, civil society, doctors to create awareness on these Acts.
- ASHA or Village Link Workers/ANM/ VHC/Field NGOs (FNGOs) to ensure birth and death registration, marriage registration. If they have stopped early marriage or Sex determination test, give information to the district authorities. District authorities should organize 'Sanman' programme for such functionaries to motivate them and other functionaries.
- Linkages with National Service Scheme (NSS) and youth groups and Mandals to create awareness on these Act and Issues at village and urban slums.
- Small clippings in mass media (electronics and print) and broadcast them during prime time.
- Information board in every village (at a prime place) giving information of these Acts.
- Information board and pamphlets in religious and cultural places and fairs such as Tarnetar Mela, Garba Venues, Handicraft exhibitions, temples, Mosque, Churches etc.
- Integration of these Acts in religious speeches such as Moraribapu, Ramdevbaba, Ravishankar Maharaj. Asharambapu and many others. They are extremely influential in middle/high class society where maximum violation of PCPNDT Act is happening.
- In urban area in every society (now a days corporate companies are providing tin boards to the societies 'Do not park in front of the gate'. In this way we need to motivate/ encourage companies to showcase boards 'Sex selection is a crime and sin' to all the societies.
- With involvement of mother NGOs, field NGOs and service NGOs can be given specific targets for mass awareness campaigns.
- These issues should be covered during Village Health Committee (VHC) meetings. VHCs are to be formed as per the National Rural Health Mission (NRHM) guidelines.
- ANMs should be involved in writing this information on wall paintings. This information is recorded with her in the ANM register. She should also coordinate with talatis to get information on vital registration.
- Involvement of ASHAs in creating mass awareness on these issues.
- Birth registration certificates to have information on vaccination and nutritional needs of girl child on the back side
- Marriage registration certificate to have information on family planning and sensitivity towards girl child on backside.
- Death certificates to have information on schemes and rights related to widows
- Campaign and camps for registration of marriage and death at regular intervals

- Linkages with Education department to incorporate a lesson in textbook of 11-12th class or even earlier classes. Training of teachers to deal with gender issues.
- Linkages with other departments such as, Tribal Development, Rural Development, Education. Social Justice and Empowerment to create awareness and ensure to provide information on these Acts during their activities/events.
- Coordinate with PRHRD and Urban department for having preference or more subsidy for families with only one or two girl children in housing schemes

Campaign on nutritional needs

Initiation of mamta divas every Monday and Thursday wherein the ICDS workers provide awareness on these issues to mothers. The same is also a part of village level health workshops. Trainings on IMNCI in 9 districts and on early newborn care in 3 districts provided to doctors, nursing staff and anganwadi workers.

- Birth registration certificates to have information on nutritional needs of girl child on the back side
- Targeting mothers for health of girl child's nutritional needs.

Civil Society Action under PC-PNDT Act

Initiated awareness camps, training of trainers and media campaign

- Provide standardize complaint format to all members of civil societies so that complete information is obtained.
- Allow online complaints under PC-PNDT Act and popularize the same
- Involvement of mother NGO, Field NGOs and service NGOs in this activity.
- Promote local monitoring committees for implementation of the Act.
- Regularize meetings of the committee at the district level and popularize the action taken by the same
- Conduct a study on implementation of norms of PC-PNDT Act in selected districts

Strengthen PHC/CHC to deal with women specific health issues

18 new AFHS centres open. Strengthening TBA (Dai) institution and efforts to ensure timely material supply for TBA kit. 300 skilled birth attendants trained 600 medical officers and 1200 nurses trained in EmOC services and 18 CEmOC given anesthetic trainings, both of which effect child delivery services

- Telephone and internet connectivity in all SCs, PHCs, and CHCs to promote tele-medicine in case there is shortage of specialized shops.

- Have labour rooms in all PHCs as in Andhra Pradesh and Karnataka
- Atleast 30% of total PHCs to have 24hrs delivery facility
- Have residence facility for doctors in villages attached to PHCs. (can we also look at coordinating with education department to link up with teachers quarters)
- Strengthen the laboratory facilities / or outsource it to private laboratories to facilitate delivery of health services at peripheral health facilities.
- Budgetary provision to be made for transport facilities for referrals or outsource the emergency referrals to private transport bodies for an attractive package. This will be a win-win situation for both the private operators and the emergency case.
- Staff position at CHCs, PHCs should be made for Hospital Administrator.
- Improve availability of specialist in CHCs through special packages.
- Have a scheme for specialized health services at PHC level with private doctors, as done for CHC. May be once in a week or fortnight Gynecologists registered under Chiranjiv Yojana may be asked to take up special consultancy in atleast 2 PHCs
- Counselors available (%) in all district hospitals and selected CHCs for providing counseling support on RTI/STI/violence against women (medico-legal) /HIV, to all women in need identified by the doctors.
- Staff Nurses from CHCs other than included above to be trained in the technique of counseling for providing counseling support on RTI/STI/violence against women (medico-legal)/HIV, to all women in need identified by the doctors.
- All MOs of PHCs and at least one nurse per PHC to be provided short training in counseling on RTI/STI/violence against women (medico-legal)/HIV
- Compulsory screening of all ANC cases for HIV/AIDS at all peripheral hospitals.
- Focus on capacity building of AFHS centres.
- Incorporate learning of MYFC from IPD project in RCH-II.
- Special facilities at PHCs of saltpan work and mining areas etc especially for women.
- Include training on right postures during agriculture activities etc in women's health trainings and IEC material.

Conditions for safe delivery at cluster levels

- Mandatory availability of 24x7 at all EmOC:
 - Staff
 - Transport facility
 - Blood facility
 - Laboratory facility
 - Hospital Administrator

- Counselor
- System Operator with computerized MIS on expenses so that funds are directly transferred to the bank linked with EmOC
- Linkages with bio-disposable waste system
- Decentralized powers to procure drugs instead of approval from purchase committee.
- More efforts to popularize the Chiranjivi and Janani Suraksha Yojana
- Information dissemination on Dai Sangathan, list of trained dais to be displayed on community halls and panchayat buildings along with a message of safe delivery
- Ensure at least one PHC within 25 kms to have EmOC facilities, with exceptions in Kutch and tribal districts where the distance could be more
- Collect data on 24 hrs PHCs with labour room operation theater, etc as in other states such as AP and Karnataka

Ensure Basic Amenities at PHC

171 PHCs and CHCs underwent major or minor repairing works. 29 new construction works in progress. Initiation of quality programme.

- Promote VHCs to collect user fees from non-BPL families for sustenance and maintenance of basic amenities like water, toilet and disposable systems.
- Outsourcing repair and maintenance of infrastructure at PHCs and SCs and allocating the task of monitoring to mother NGOs, service NGOs, field NGOs, or any active VOs.
- Have separate provision for sanitation facilities in PHCs under TSC with RDD
- Liaisoning with WASMO for running water facilities in PHCs

One 24hrs functioning PHC within cluster

273 CHC and 25 district hospitals working 24 hrs. For interior areas 85 mobile health units functional

- Involvement of local communities, trained staff of NGOs or trained TBAs in ensuring 24x7 availability of service at PHCs.
- Collect data on 24 hrs PHCs with labour room, operation theater, etc as in other states such as AP and Karnataka
- Have a norm for 24X7 PHC availability for given population (50,000)

Mapping Exercise of PHCs

Availability of Health facilities as per rural health norms. Staff position of critical staff in PHCs and CHCs

- Conduct one time survey for facilities available at PHC as done for CHC
- Outsourcing this task to a professional organization having GIS facilities.

- Publish district wise rural bulletin statistics in line of National Bulletin
- Ensuring mapping of all gynecologists covered under Chiranjeevi Yojana and other private organizations / grant-in-aid hospitals.
- Based on the IPD experience promote development of referral transport plan with VHC and panchayat

Micro Nutrient Efficiency

- Teaching institutes particularly those involved in Foods and Nutrition and Public Health should have mandatory placement of students in rural areas.
- Formal intra departmental coordination between Department of Health and Family Welfare, DWCD, Department of Higher Education and NGOs to facilitate the process.
- Delivery outcome indicators to track BCC after the campaign.
- Replicate schemes in tribal areas for girls all over the state.
- Targeting Mid Day meals Programme for nutritional awareness

Social Audit of PHCs etc

- Task to be outsourced to a private organization having offices at district level.
- Involvement of VHCs in conducting social audit.
- Involving mother NGOs, field NGOs and service NGOs wherever possible as a part of outsourcing activity having a standardized data collection module and standardized data collection manual so that collating the data is not a problem.
- Have a citizen's report card developed and published every year
- Sharing of PHC budget in gram sabha and motivate VHCs/Panchayat to collect fees for additional facilities.

Membership of Village Institutions

Currently VHC are formed under NHRM with 33% women's representation

- Activate formation of Village Health & Sanitation Committees (VHC) in each village and ensure that 50% members are women in this committee.
- Collection of data on women in VHCs, Rogi Kalyan Samities and Matru Mandals
- Organise special trainings for women in this committees making them sensitive to women's health issues
- Ensure women participation in decision-making processes in these committees.
- Facilitate the process of Gender Sensitive 'Village Health and Sanitation Action Plan' through VHC. Give importance to women's health alongwith Reproductive and Child Health.

- Activate Matru-Mandal (infact they should be parent mandal) and emphasize role of father in child- care as well as his role to ensure health care services to his wife and children and other women members of the family.
- Community monitoring committee should be formed with 50% women and they should be guided under NRHM format to monitor village health activities and progress with gender perspective.
- Develop IEC material such as pamphlets targeted to VHCs on roles and responsibilities of VHC, services to be provided at PHCs, Charter of Rights of patients, RCH programme, NRHM, etc.
- Have special sessions with Rogi Kalyan Samiti Members on issues of women patients and women relatives of patients
- Self-Help Groups should have one of their norm for providing loan for maternal emergency and women's health services. (need to link with Sakhi Mandal Project of RDD)

Sensitivity of Health Functionaries

Particularly for Medical Officers (Doctors esp.), Forensic Science Lab Officers. Interview Panels instructed to check the gender sensitivity of candidates

- Sensitization meetings within the department for having a gender policy.
- NGOs to prepare gender sensitive policy for their own organization.
- Training for gender sensitization to Medical Officers, ANM, other health and administrative functionaries of health department.
- Each department to develop gender sensitive recruitment and promotion policy.
- Have at least one gender expert on panel while selecting medical officers especially when on mass scale. Alternatively there can also be a sensitization test paper developed while selection
- Information on simplified gender sensitization policy be mandatory displayed in all SCs, PHCs, CHCs and private doctors who are working in partnership with the government.
- All MIS maintained from grassroots to district level should have bifurcation by male and female.
- Introduce gender mainstreaming course in Medical education
- Create awareness and advocacy for the implementation of the Domestic Violence Act 2005.
- Partnership with the Civil Society Organization for community mobilization and awareness on Domestic Violence Act 2005.
- CHETNA, National Commission of Women and UNFPA have already developed a training module on Violence Against Women -Role of Health Care providers. With the help of this training module training can be conducted for them.

- Organise training for Medical officers on gender issues and DVA
- Organise gender training for Forensic science lab officers particularly to deal with cases of dowry deaths/ suicide, Victims of Domestic Violence and rape
- Follow-up support should be provided after any training/event/meeting.

Mandatory Gender Trainings

- SIHFW to announce bimonthly programmes on gender sensitization.
- Organize trainings on women's health for animators appointed under Continuing education programme, ICDS functionaries, etc
- Compulsory certificate course on Gender (minimum three days) required for promotion.
- Gender trainings for health gram mitras to be organized at taluka levels.

Promote Women's participation in Public Bodies

- Letter through respective government departments to all the decision-making bodies to ensure at least 30% women's active participation in these bodies.
- Any new trust/ society/ association/body; promoted/ supported by health department henceforth should have at least 33% women on board
- Preference to be given to women headed organisation
- During the State, district, block, village level meetings propagate and ensure women's active participation in decision-making process.
- Ensure at least one-third participation of women in Village Health and Sanitation Committees, Panchayat bodies and other Community Based Organizations (CBOs).
- Linkages with Regional Resource Centre (RRC), NGO, MNGOs and FNGOs to convince and counseling to such bodies to ensure women's active participation. The NGOs to empower women for their active participation.
- Role of Panchayat must be reviewed and powers to them to perform their responsibility effectively.
- The district and block level committees should be involved in implementation.

Discussions/Suggestions Shared by Participants:

After the presentation, the floor was opened for all participants to give their comments on the suggested tasks as well as additional suggestions if any.

1. The first suggestion was from Ms. Utkantha Dholakia that the presentation should be converted into an article in both Gujarati and English languages and disseminated through different newspapers.
2. Concerns shared by Ms. Sejal Dand
 - Anemia and malnutrition are of primary concern in Gujarat. The Department of Food and Civil Supplies has started work on micronutrients. However, this needs to be done in collaboration with health department. We would like to see what are the engagements of the department of health in the quantification of micronutrients that are being given to infants. Currently the health department is not part of the planning of what components are going into it or what are the formulations. It would thus have been good had FCSD had also been invited for the workshop.
 - Also we continue to have a very large shortfall of 75% staff – like trained surgeons and others. The Chiranjeevi Yojana is one way to deal with shortage of gynecologists. However, it needs to be taken with caution since it should not become an alternative to institutional services already being provided. We need to look deeper into data to ensure that these schemes work to increase access to health services and do not become an alternative to state provided services.
 - Further to improve access to health services mapping of available health services needs to be done on a priority basis. We need to see where the mobile clinics are and whom are they catering to. There need to be increased access to such health facilities and reach out to other reproductive health facilities as well.
 - Also as far as IEC is concerned, there may need to have a more proactive disclosure of health education budget and to what is being promoted as health education.
3. Suggestions by Ms. Gayatri Giri
 - We have to take stock of what has been done and what needs to be done in the field of health services. There is a need to prioritize the health issues in a time bound manner and exclude those things, which are not available at all or are available on an irregular basis.
 - In sharing responsibilities of Health and Family Welfare department, civil society organizations we should not forget the community's involvement. Now under the NRHM and through the department's efforts the community is at the central point. All suggestions are from

provider's perspectives but the need is that they should be from the community's perspective as well as the policy level so that we can redesign our budget.

4. Sharing by Ms. Ilaben Pathak

- The first priority should be to fill the appointments at the PHCs and CHCs. Unless that is done or unless the PHCs are run 24 hours all the seven days of the week, it is not going to help. It may be difficult but at least for four hours from Monday to Saturday they should be functional and available for the people. For this it is also essential that we monitor number of resident MOs rather than only MOs.
- Also female health workers are not as many as are needed. If this is not available there is no use saying that we are providing services. Gynecologists and Pediatricians coming in every 15 days do not serve any purpose in a rural area. It is very difficult to appoint a gynecologist but one must try.
- There is no legislation available in Gujarat for Registration of marriages. It was cancelled in March 2006 and the new one has not been put into place.
- Opposed to the idea of collecting user fees from non-BPL families and those who are non-BPL are also poor. The BPL list itself is no good and people have been protesting against it. The rationale behind charging the fees is so that freshly washed linen can be provided to the patients. Let user fees be collected from government run hospitals.

5. Suggestions by Ms. Jyoti Gade

- Transportation facility should be available everywhere.
- Gender mainstreaming should be strengthened in medical education. Workshops should be organized at Gujarat level. A resolution should be passed that there should be least two-three questions on gender issues, which should be compulsory and not optional.

6. Suggestions by Dr. Vikasben Desai

- Online complaint system should not be restricted only for PCPNDT Act. We should have it in place for all women's health related problems including violence.
- Suggestion was made for counselors at various levels. Counseling should be a part of the basic training of individual. Everyone in the system - starting from midwife to a specialist is a counselor at his or her own levels and capacities. HIV/AIDS brought a special cadre of counselors because there was a need for that. But otherwise counseling training should be part of basic training of all cadres. We can't appoint

counselors at the PHC-CHC levels for all issues. One suggestion is that HIV/AIDS counselors be converted into multipurpose counselors.

- There is hesitation in agreeing to the suggestion of compulsory screening during ante-natal checkups as this will lead to more discrimination than helping them. This suggestion should be reviewed again. Compulsory screening for HIV/AIDS of all pregnant women – is for the benefit of whom and what – that is a question mark.
 - GIS mapping is already available for location of PHC/CHC.
 - On the issue of micronutrient one needs to understand that it is not only anemia but there are other issues and other ways to tackle that. Moreso there is a need to focus on basic nutritional/ calorie intake of people rather than only focusing on micro nutrients.
 - There was one suggestion of sensitization of medical doctors for social health related issues. It should become part of basic training or give them opportunities to participate in workshops for sensitization.
 - Ad-hoc training does not lead to sensitization. It leads to only information shared. Training should be a continuous process. Everyone dealing with human beings need sensitization.
 - Objection was voiced to 33% participation of women in the bodies – why not 50% - why not all – let it be said that there should be rightful representation by women
 - Not knowing causality of death – 71%, is a matter of training and putting into practice by those who are certifying the death. Death Certification can be done by private practitioners. It is not hiding the cause, but it is lack of confidence, or clarity as to what is to be written and in which language or which column.
 - The focus of the policy is more rural. There is no bifurcation of urban health facilities and rural health facilities.
 - If figures are being used in newspapers then there should be proper interpretation of statistics, updating of figures and what we want to convey.
7. Ms. Ilaben Pathak also shared here that “Many a times she has been told that the medical students always opt out of answering questions on legislations concerning forensic medicine. This education is much needed by them and it should not be made optional. Even Mamlatdars who write dying declaration need to be trained for this by introducing new forms for post mortems, which give the anatomical frame of woman – to show rape injuries and other injuries.”
8. Dr. S R Patel asked “What was being done about food security?” Also raising the concern that urban health is a huge issue in Gujarat. There are large pockets in urban and semi-urban areas where people who have

migrated live. These areas are no-man's land, which do not get any of the government amenities like sanitation or water, health services, etc. There is urgent need to do a ground reality check of status in these areas. This work can be done by NGOs in collaboration with the government.

Response from Panel

Sharing by Mr. Rajeev Tewari

- We need to have the latest data on health. This can be probably accessed from the DNE cell in the commissionrate. It would be very appropriate if we can link the progress of the last two years to what is being suggested in the workshop.
- There are a lot of issues of human resource. We need to know what the position of the state is. Find out how many vacant positions are there and have linkages with the training institutions for providing the human resources. Try and work out a strategy, which will help us in filling the acute shortage of human resources. We also have to think how the private sector can be roped in this exercise.
- There are many programmatic issues, which need to be separated into management issues, budget issues, coordination issues, human resources, programme issues.
- There is need to re-strengthen IEC or BCC. Thought needs to be put into how to reorient the IEC material.
- Link up should be set up between the Citizen's Charter and the Right's of Patients.
- In the Chiranjeevi Yojna inclusion of abortions, MTP, child-infant care, neo-natal care, family planning services
- Role of men in adopting RCH Services has been missed out.
- When we talk about sex-ratio it is felt that this presentation should be divided into four parts
 - Status of implementation of PCPNDT Act
 - Work with Judiciary
 - Work with Civil Society
 - Social monitoring of Sex selection

Suggestions by Dr. Renu Khanna

- The one thing coming out was that there were suggestions for government of Gujarat - health department, for GRC and third is for civil society. So the need was to separate out suggestions for each category. What is it that we want the health department to do, what it is that we want GRC to do and what is it that we want other specific bodies to do. Also prioritization is of activities is needed.

- Malnutrition in women – should be an inter-sectoral priority. We have to be very serious about improving monitoring and the nutritional status of women. For this we need to formulate very sound strategies.
- Women should have access to safe abortion services. In our indicators there is nothing on access to safe abortion. One of the major causes of maternal mortality is unsafe abortion and the need is to bring it in focus. Registered facilities, which can provide safe abortion facilities.
- Social determinants of health – water and sanitation- is women’s work. How it is going to be monitored and what will be the convergence of health department with the other departments needs to be worked and the role of the health department needs to be pinned down.
- Number of resident ANMs, and other medical, paramedical staff at the PHC-CHC. We need to find out the number of resident ANMs and if the number is increasing or not. Our efforts should be that this number increases. We should monitor that our resident health care providers’ (including doctors) number is increasing.
- Focusing on urban poor and especially women is very important. Women of the poor are all the more poor. This is going to require a lot of reform. What is the responsibility of the state health department, councils and municipal corporations? All this needs to be done and done urgently.
- What are the women’s perspectives in the Citizen’s Charter of Rights. Charters should not be written with the help of inputs from users, Non-users perspective should also be used.
- GRC or Jan Swasthya Abhiyan or state health commission should have an evaluation of Janani Suraksha scheme from the women’s perspective.
- What is the effect of privatisation on access of women to health facilities – if they are not increasing then we have to map the existing facilities. Who is reaching-and who is not reaching the women.
- Human resource planning. We should have a course on women’s health. Bachelors or Masters course on health care for women. It should be certified through the universities.
- Vulnerable women – disabled women, Sex workers, positive women, and other vulnerable women have to be accounted for. Since the state has a mental health policy we should see what is the gender perspective of the policy, how it is being implemented, tracking it – and drawing attention to what is happening to women – the levels of dignity or indignity or inhumanity that they are treated with in these institutions.
- Budget allocation is very important.
- Is our IEC material produced in a gender sensitive way. Some screening is required. Maybe GRC can do that. Another question is that if it just produced and kept or is it disseminated.

- Introduction of rape kit for rape survivors. The standardized kit, which CEHAT has produced. There has been some sort of formal sort of intervention with the medical colleges.
- Weekly Clinic is a very important thing. One is the information and the regularity of the visit is very important. It does not matter if it was weekly.

Response from Dr. Vikasben Desai

- Malnutrition in women and children is a major issue, but it is more of a food gap that leads to higher level of micro nutrients deficiency. Because it is easier to quantify micro nutrient deficiency our entire concentration is on it and we are forgetting about food gap. It is much more about community counseling and awareness of feeding and is not about non-availability of food. Hardly 25% under the age of five children have adequate calorie and protein intake in their diet. Unless we fill this food gap even micronutrients will not work. Infact the issue is to be tackled first at the stage of pregnancy only. More than 25% of the children born in Gujarat are underweight. The issue needs to be touched at its roots. The need of the hour is to take care of infections, and low birth weight of babies. Counseling of expectant mothers is very important for her to take proper diet. If we reduce low birth weight even by 50% it will make a large amount of difference.
- It is very true that urban health components, particularly needs of urban poor should be brought in the project implementation plan.
- Also as far as usage of services is concerned we are concentrating on who are using the facilities. We need to study the rest 80%, those who cant afford private services but still do not prefer to go to PHCs, CHCs.
- Also there is a need to have a balance between user charges and giving free treatments.
- Talking about services for mentally ill women - any child who is challenged and unfortunately is a girl child has a problem - any physical problem also.
- Confidentiality component of MTP is difficult to analyze. We need to work on how to best use the information coming to us.
- Extention of Chiranjeevi is being worked on. Pre-delivery and post-delivery needs of mothers need to be looked into. Trying to attend to the first day care of child is important. Atleast 48 hour stay in hospital should be mandatory so that any critical mother or child is taken care of. We have fewer pediatricians than obstetrician.
- We are not going to get doctors everywhere and doctors are also not required everywhere. Transport facility is needed. Doctors everywhere is not possible - no system will get it. If we know that we are not going to get doctors up to grass root level we have to adopt some alternative method.

- In case of MAMTA the whole philosophy is different. At least at block level someone is available one day after MAMTA divas - OPD level referral patients can be brought. It should not be restricted to MAMTA referral. Even for a minor illness a child can be brought.
- Attending to flurosis diagnostic and counseling need at health institutions or medical institutions as well as calcium supplementation to some extent minimizes the toxicity i.e. it can prevent a deformity.
- We have a budget for IEC, which is quite adequate. Working on distribution of budget between various medium. Celebration of particular days should be made a little more streamlined. Gender screening of IEC material needs to be done. It should also be made more systemic so that no subject is left out.
- Stationed functionaries are the centers, rather than the number of functionaries is more important.
- ASHA has to go a long way. There is no disagreement about the importance about their role. Lot more needs to be done to make them more empowered to be of real assistance. We need a team. We should not forget about anganwadi worker and ASHA. Let us talk about a health team or health panchayat in a village.
- There is no denial of the importance of gender sensitisation of doctors.
- The Government has already initiated talks on Health insurance and we need to wait for the results.
- There are 86 mobile health units functioning in all. They are monitored but their role needs to be integrated.
- As far as transport facilities are concerned the Rogi Kalyan samiti or VHCs already have budgets to hire a vehicle to transport the patient. There is a need to create more awareness among their rights and roles.
- Also one should not forget that the health department deals with the end result of the gaps of the department of water and sanitation, environmental pollution and any other mitigating factors, malnutrition extra. So instead of focusing on only cure, we need to also lay emphasis on prevention.

Session 3: Developing Monitoring Indicators

Chairperson: Dr. Vikasben Desai
Panelist: Ms Jyoti Gade, Ms Sejal Dand
Presenter: Ms Jyoti Gade

The session began with a brief presentation by Ms. Jyoti Gade on the concept of indicators particularly with respect to gender sensitive health indicators. This was followed by breaking up of the participants into two groups to discuss indicators under each action plan. The groups discussed under the following themes;

Group 1: Development of IEC and Infrastructure,

Group 2: Human Resources and Programmatic Intervention

Introduction to Indicator

An indicator is a measurement, such as a number, an opinion or a perception, which points at how a specific condition exists or certain situation has changed or not changed overtime. An indicator is to access progress towards the achievements of intended outputs, outcome, goals and objectives.

Indicators are an integral part of a result-based accountability system.

Role of Indicators

- Highlighting problems
- Identifying trends
- Contributing to the process of priority-setting
- Planning the health services
- Monitoring and Evaluation

Criteria of selecting Indicators

- Development of a successful accountability system requires that several people be involved in identifying indicators.
- Collect the data
- Use the data
- Technical expertise to understand the strengths and limitations of specific measures.

Types of Indicators

1. Input:

Physical inputs – Material, supplies, training

Human inputs – Type and number

2. Process:

Resources devoted – activities, tasks

Actual delivery of services – Clinics, camps

3. Output: Intermediate results (coverage, quality of care, increase in knowledge)

4. Impact: Long term – measure the effectiveness.

Guideline to select Indicators

- Does this indicator enable one to know about the expected result or condition.
- Is the indicator defined in the same way overtime? Are data for the indicators collected in the same way overtime?
- Will data be available for an indicator?
- Are data currently being collected? If not, can cost effective instruments for data collection be developed?
- Will this indicator important to most ? Will this indicator provide sufficient information about a condition or result to convince?

Indicators: Measuring Gender Equality

- No. or percentage of pregnant or lactating women eating green leafy vegetables and complete course of 100 Iron Folic Acid tablets
- No. or percentage of men/husband who accompany their wives for ANC.
- No. or percentage of girls/boys married after the legal age of marriage.
- No. or percentage of births among married girls after 20 years of age for the first time.
- No. or percentage of couples adopted spacing and permanent methods of family planning those who have only daughter.
- No. or percentage of increase in use of family planning methods among men.
- No. or percentage of boys and girls referred to a health facility for RTI, STD and infertility (disaggregated by sex and reason for referral)
- No. or percentage of PHC and sub-centre having private space for RTI and STI check up for women and men.
- No. or percentage of men sharing household responsibilities and child care.
- No. or percentage of girls and boys immunized in regular immunization programmes
- Availability of Gender sensitive IEC material with messages to motivate and involve men.

Monitoring Indicators suggestion by Group Work

Action Plan for IEC:

7.3.12 - Create mass awareness on PNNDT Act, Dowry Act, Age of marriage and Registration of birth and death and the decline in sex ratio.

Output Indicators: Number of cases registered against PNNDT violators.

Monitoring Authority - Gender Resource Centre, Health and Family Welfare Department

Time Period: Quarterly

7.3.10 - Address micro-nutrient deficiency on priority basis among girls and boys through ICDS centers and public education systems.

Input Indicators: Percentage of IEC expended on nutrition education. Number of male participants in Mamta Divas.

Responsible Department: Health and Family Welfare Department

Time Period: One year

Output Indicators: Decrease of micro-nutrient deficiency among children (gender segregated data)

Action Plan for Infrastructure:

7.3.2 - Strengthen the PHCs, CHCs and higher levels to deal with health and family welfare services, gynecological cases, adolescent sexual and reproductive health, occupational health, HIV/AIDS, RTI and STI and basic mental health.

Output Indicators: At least 6000 trained TBAs per year

7.3.3 - Create conditions for safe delivery by training local birth attendants, ensuring emergency obstetric care services (EmOC) at cluster levels and ensure regular supply of drugs and delivery kits.

Output Indicators: Percentage of clusters having EmOC in underserved and rural areas - 20% by 5 years.

7.3.5 - Create 24 hours functioning PHC within a cluster of PHCs which could be accessed during emergency.

Output Indicator: Number of deliveries in CHCs and FRUs.

Action Plan for Human Resources:

7.1.17 - Membership of all village institutions/management committees shall be made open to both men and women instead of household as a unit.

Input Indicator: Total number of VHC formed. Total number of VHC - 50% women position. Position of Women in VHC (president)

Responsible department: Health and Family Welfare Department

Output Indicators: Number of active VHCs

Monitoring Authority: At district level CDHO and at state level Additional Director of health.

7.4.13 - Sensitivity to gender issues shall be part of the selection criteria for those who seek appointment as Public Prosecutors, Magistrates (judicial and executive), Medical Officers, Forensic Science Lab Officers, Educators, Textbook writers, Principals of Schools and Colleges.

Input Indicators: Number of trainings conducted for Medical Officer, ANM, L.P (HSP). Has selection criteria become gender sensitive.

Responsible Department: Health department

Time Period: One year

Output Indicator: Number of men and women who are gender sensitive

Monitoring Authority: Chairman GPSC

7.2.8a - Promote women's participation and ensure mandatory and substantial membership of women in public decision-making bodies, monitoring and vigilance bodies by amending all Acts and Rules pertaining to registration of Trusts, Societies, Associations, Financial Institutions, Cooperatives and others to include one-third women in the governing board. In all decision-making for a quorum shall be linked to the proportionate women membership.

Input Indicators: 50% women membership in decision-making bodies. 50% women as chairperson of - PCPNDT, VHC, Rogi Kalyan Samiti (PHC), District Health Society, Block Health Society, State Health Society.

Responsible Department: Additional Director - FWH and District Health Society.

Output Indicators: Actual participation of women

Monitoring Authority: Additional Director Health

7.3.8 - Social Audit of PHCs and other health care delivery mechanisms at the gram sabha level.

Input Indicators: Participation in Gramsabha

Monitoring Authority: Block Health Society, District Health Society

7.8.2 - Incorporate gender as a central dimension in apex training institutes and various training programmes organized by ongoing developmental programmes in different inter-linked sectors for all levels of government functionaries.

Input Indicators: To review the existing training module. Modification by gender perspective.

Output Indicators: MIS is gender sensitive

7.1.2 - Cover women under various beneficiary oriented programmes from existing 30 to 50%.

Input Indicators: Increasing awareness programme. Use of IEC material. Number of meetings conducted.

Responsible Department: Panchayat, VHC

Output Indicators: Percentage of women participating. Awareness checklist – what is a scheme, whom to contact, where and when to contact.

Action Plan for Programmatic Intervention:

7.3.1 – Formulate a charter of rights of patients.

Input Indicators: Facilitate/invite complaint registration – Redressal mechanism for rights denied. Review should have gender perspective and in reference to illiterate groups also

Responsible Department: Health and Family Welfare Department, Gender Resource Centre.

Time Period: One year

Output Indicators: Revise charter from feedback obtained. Online complain and redressal mechanism.

Time period: One year

7.3.15 – To regulate advertisements on baby food, tinned/processed food so that nutritional messages and healthy food habits are encouraged

Input Indicators: Monitoring of ICDS nutritional supplementation by HFWD. To conduct periodic check-ups, audits/rates of baby food menu. Promote indigenous food through media.

Responsible Department: FDA – HFWD, I & BD

Time Period: One year

Output Indicators: Taking action against unsafe baby food. Percentage of IEC budget spent on baby food awareness.

Monitoring Authority: HWFD, GRC (in existing channel of HWFD)

These are just suggestive indicators and since the time was less it was decided that GRC would work on it further in coordination with the other members present and send the final one to health department.

The workshop helped generate a number of ideas, which can be taken up by the Health and Family Welfare department in furtherance of the implementation of the Nari Gaurav Niti, 2006. GRC has further attempted to compile both the action plans and monitoring/reporting indicators in annexure 2.

It is also however felt that there needs to be more specific reviewing mechanisms to be put in place within the health department in line with the suggested actions. **GRC would like to suggest a system wherein a team of the nodal person for GEP in health department, Dr. Vikasben Desai, Director GRC and one NGO representative, comes together every three months to review the progress and submit a report of the same to Principal Secretary Health and Family Welfare Department.**