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NIPI – Norway India Partnership Initiative

Quality Maternal and Newborn Care - Gender and Social Equity

Norwegian Agency for Development Cooperation

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NIPI – NORWAY INDIA PARTNERSHIP INITIATIVE

QUALITY MATERNAL AND NEWBORN CARE

- GENDER AND SOCIAL EQUITY

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List of abbreviations

ANC	Antenatal Care
ANM	Auxiliary Nurse Mid-wife
ASHA	Accredited Social Health Activist
AYUSH	Ayurvedic, Unani, Siddha and Homeopathy
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BPL	Below Poverty Line
CHC	Community Health Centre (secondary level care at Block)
CM&HO	Chief Medical & Health Officer (at District level)
DC	District Collector
DHA	District Health Authority
DoH&FW	Department of Health & Family Welfare (at State level)
DPHNO	District Public Health Nurse Officer
EmOC	Emergency Obstetric Care
FRU	First Referral Unit
GoI	Government of India
GP	Gram Panchayat
HC	Health Commissioner (IAS at State level)
ICDS	Integrated Child Development Services (under Dept of Women & Child Development)
IMR	Infant Mortality Rate
INC	Intra Natal Care
JSY	Janani Suraksha Yojana
MMR	Maternal Mortality Rate
MoHFW	Ministry of Health and Family Welfare (GoI)
NBC	New Born Care
NFHS	National Family Health Survey
NIHFW	National Institute of Health & Family Welfare
NNMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PIP	Program Implementation Plan
PNC	Post Natal Care
PRI	Panchayati Raj Institution
PWD	Public Works Department
RCH	Reproductive and Child Health
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
VHC	Village Health Committee

Executive summary

1. The Norway - India Partnership Initiative (NIPI) works within the National Rural Health Mission (NRHM) of India. NRHM aims to provide effective health care to the rural population, especially tribal groups including women and children, by improving access, enabling ownership and demand for services. NIPI focuses on reducing child and maternal mortality in five of the 18 states of NRHM in order to assist India in reaching the MDG 4 goal by 2015.

2. The criteria used for the selection of districts in the five NIPI states is not clear and noone seems to have an answer to why the actual district were chosen. The districts should have been representative for the geographical and socio-economic condition in the state.

3. The NIPI secretariats in the five states employ nine men and one woman. In a programme working on MDG 4 and MDG 5 there is a need to recruit more women into decision-making positions in NIPI.

4. Maternal fatalities are highest among illiterate women from SC and ST.[1] Studies show that child mortality is also highest in these groups. The caste system is still functioning in many villages in rural areas of the five NIPI states. Women, and especially women from SC and ST, have low status in India. Men have control over their productive labour, reproduction, mobility and economic resources. This control is the key to the suppression of women and their poor health. Gender mainstreaming in NIPI has to take into consideration both the caste system and the patriarchal family structure.

5. The team found several shortcomings in the "ASHA chain" from village to hospital. ASHAs are not recruited from SC and ST due to educational requirements. The quality of ASHA training is questioned. Coordination between different actors in the villages working on health issues is also a concern. There is very little emphasis on homebased care of the mother and child in the programme.

6. Incentive systems where ASHAs, yashodas and pregnant woman are paid create much corruption and conflict. ASHAs from SC/ST are not aware of their rights and have to pay up to 50% of the money they receive in bribes to hospital staff. This has to be looked into by NIPI.

7. Hospital infrastructure investment at hospitals has to prioritise beds, sheets, sanitation and generators. Supply of food to patients, visitor accommodation and hygiene improvements have to be looked into. Investing in LCD screens should not be prioritised.

[1] UNICEF: Maternal and perinatal death inquiry and response (MAPEDIR), 2008 –pg 41

8. Most doctors employed in public hospitals run private clinics. This is alleged to impact on investments in public hospitals. The health managers must be empowered to do their jobs.

Recommendations

1. *The NIPI secretariats should receive gender and equity training, and secretariats at different levels should hire dedicated gender specialists.*

2. *In some areas of the NIPI states the demand for grade 8 level of education could be reduced in order to recruit women that are closer to the poorer castes and classes.*
3. *NRHM does not have any gender specialists, NIPI can assist the salary of one or two such persons at senior level who could sit in the centre.*

4. *NIPI should make an assessment of the training of ASHAs: the quality of training, the training modules, how the training is organized, the use of trainers from NGOs, governance issues, the use of drug kits etc – in order to come up with better system of training for ASHAs.*

5. ***E**lected panchayat members (women) could oversee coordination between the actors and follow up on their work. This could be tried out in districts where i.e. the Agaz Foundation's academies have trained women counsellors from SC and ST who are elected to the Panchayat. Panchayat women at village level could receive small NIPI-fund for co-ordination,transportation and monitoring purposes.*

6. *A study should be made of how conflicts between permanent staff (principal medical doctors, nurses, and paramedic staff) and contract staff (yashodas and health managers) can be avoided.*

7. *There is need for clear and simple information on what the expectant mother is supposed to receive from the hospital, explaining that service and medicines are free of charge. The information should be posted in the hospital reception. The information should also be printed on leaflets that the ASHAs could spread in the villages. Women from SC and ST that are illiterate could pass on the information from ASHAs by word of mouth.7.The ASHAs and yashodas in the NIPI districts should receive gender and equity training from NGOs. They should learn how they can improve their communication skills and their behaviour towards women and poor patients (respect and dignity) as well as increasing their awareness of gender barriers for women.*

8. The ASHA should not receive her full amount when she hands over the expectant mother to the hospital. Instead some part of the money could be handed over after two weeks' follow-up of the woman and her new born.

9. A tracking study on how the 1400 rupees, received by the women, are spent could be conducted. The possibility of paying the1400 rupees in a manner that reduces the demand for bribes should be examined.

10. *Payments made to yashodas should be looked into. If they earn more than educated permanent staff it could give rise to conflicts at hospitals*.

11. The team recommends cooperation with the Aagaz Foundation in Madhya Pradesh (MD). NIPI in MD could be asked to start activities in Hadra district where Aagaz Academy has trained 101 elected panchayat women from SC and ST in this district. The elected women and their groups could identify activities /investments able to improve the MMR and CMR. Funds could be made available for the implementation of the proposals.

12. *Sanitation facilities (bath and toilets) inside the hospital should be <u>exclusively</u> for pregnant women. Visitors should use outside facilities. The team recommends that responsibility for sanitation facilities be outsourced to the NGO Sulabh who specialize in running sanitation facilities inside and outside hospitals. Outsourcing could be an action research under the NIPI-initiative.*

13. No male assisting staff or delivery staff except for the doctor in the labour room should be allowed.

14. *The team recommends that poor women from the Takha village near Bharatpur hospital form a group and be paid to make breakfast for women in the hospital. The food could be a part of the delivery kit.*

15. The team recommends an annual prize for journalists who follow developments in the health sector in the NIPI states and write reports in local newspapers.

16. Hospitals where the Health Manager and Principal Medical Doctors cooperate to improve their services should be publicly applauded and held up as examples of best practices that other hospitals could learn from.

17. Previously health centres and hospitals were visited by inspection teams. These teams should be revitalized. The teams should be particularly gender sensitive when inspecting and reporting on the infrastructure.

18. A high number of stillborn babies are reported in hospitals. This should be looked into.

19. *All children should be enlisted in the Nutrition Rehabilitation Centre (the Anganwadi centre). However, only 50% of children are enrolled. Who are the children that are not enrolled? Are they the children of single mothers, day labourers, a particular caste? This should be studied.*

20. *Anaemia among women is growing in India, according to UNFPA staff. The reasons for this should be looked into. Several field-based programmes are addressing anaemia. Why is the development negative?*

21. *The CEDAW NGO shadow report points to unsafe abortion as one of the most important reasons for maternal fatalities in India. Complications resulting from abortion are responsible for 15 – 30% of all maternal fatalities in the state of UP. Serious complications resulting from unsafe abortion include infection, bleeding, and injuries to the reproductive tract*[2]*. NIPI could conduct a study on abortion*.

[2] Study report of Johns Hopkins University – www.jhpiego.org/pubs/TR/tr516sum.htm 104

1. Introduction

The Norway - India Partnership Initiative (NIPI) is an outcome of a commitment by the Prime Ministers of Norway and India to reduce child mortality and improve child health with a view to attaining Millennium Development Goal 4 by 2015. Norway has contributed USD 80 million for this purpose to **Orissa, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh.** These five states together constitute 40 per cent of India's population and account for almost 60 per cent of child deaths in India.

The NIPI activities run for five years (2007-2012), corresponding to the duration of India's National Rural Health Mission (NRHM). NIPI's **objective** is to provide up-front, catalytic and strategic support to accelerate the implementation of NRHM, specifically to improve child health and related maternal health service delivery quality and access.

The activities under NIPI are put into operation through public health societies in the states, facilitated by UN organizations such as UNICEF, WHO and the United Nation's Office for Project Services (UNOPS). The interventions are aimed at accelerating the Child Health interventions: (i) based on block, district, region and state-specific situations (ii) through partnership and collaborative arrangements with professional organizations, NGOs, local elected bodies and administration within the state.

In order to ensure that gender concerns are addressed across all aspects of NIPI activities, NORAD has been asked to analyze how different interventions address gender concerns related to access, quality of care, systems and governance in child health and related maternal health.

1.1. Methodology

The study of gender mainstreaming within NIPI activities was carried out in the period 4 to 11 November. The team consisted of Bodil Maal from NORAD/Oslo and Renu Wadehra from the Norwegian Embassy in New Delhi.

The study is based on a review of documents and fieldwork. The team had meetings and interviews with staff of NIPI, UNICEF, UNFPA, WHO, the Ministry of Health and Family Welfare, Agaz Foundation, and the Centre for Social Research in New Delhi.

In Rajasthan and Madhya Pradesh the team visited hospitals and health centres and had discussions with yashodas, health managers and principal medical doctors. In the villages in the two states we had meetings with local NGOs, elected women representatives, women's groups, village leaders and ASHAs.

We have reviewed NIPI documents, CEDAW reports from India and reports and studies related to maternal and child health in India and the sub continent.

1.2. Outline of the report

The report contains seven parts. In part 2 we present India's National Rural Health Mission (NRHM). In part 3 we give a short description of the rural context of the NIPI programme. We show how many Indians perceive their society. The various perspectives are important both for issues related to equity and gender concerns. In part 4 we present a short description of the NIPI organization and districts selected for NIPI-related activities.

We follow the "ASHA-chain" from the village to the hospital in part 5 and point to gender and equity issues. The "ASHA-chain" is the chain of service delivery related to pregnant women and their babies. In part 6 we discuss and comment on the health infrastructure: the enabling environment for maternal and child health.

In part 7 we propose different research/study initiatives that can increase knowledge in the field of MGD 4 & 5 in India. In all the parts of the report we give recommendations on training initiatives, action research and studies.

This study of gender issues in NIPI has its limitations given the short time available for fieldwork in India and for writing up the report. However, we have tried to voice the views of poor rural women, NGO staff and journalists who follow the implementation of National Rural Health Mission and NIPI. The feed back are important for the improvement and sustainability of the different systems put in place by NRHM and NIPI.

2. Background

The National Rural Health Mission (NRHM) is an Indian government scheme that focuses on 18 states in India. The major objectives of NRHM are to:
- lower the infant mortality rate and maternal mortality rate.
- provide access to public health services for every citizen
- prevent and control communicable and non-communicable diseases
- control population as well as ensure gender and demographic balance
- encourage a healthy lifestyle and alternative systems of medicine through the Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH).

In order to meet its objectives NRHM focuses on strengthening Panchayati Raj institutions and promoting access to the institutions through Accredited Female Health Activists (ASHA). It also plans to strengthen existing Primary Health Centres (PHC), District Health Centres (DHC) and District Health Missions, in addition to making maximum use of NGOs. There is a recognition in the states of the need to reach out to poor and vulnerable groups such as urban poor, BPL (below poverty line), tribal groups

(ST) and adolescent groups. States have also undertaken various programmes and innovations to bridge social gaps.[3]

The NIPI –Programme

The overarching principles of NIPI are:

- To conduct all activities within the National Rural Health Mission (NRHM) framework.
- To support NRHM child health initiatives incorporated in state and district plans, developed with full participation of the state health system.
- To work within the existing institutional mechanism at the state level. No parallel structure created.
- To identify and bridge critical gaps, stimulate innovation, and promote reforms through evidence based advocacy.
- **To promote an equity-based, gender-sensitive empowering approach.**
- To ensure recruitment and financial accountability through existing state procedure.
- To leverage NRHM resources for child health

NIPI focuses on three thematic areas in the five states where the programme is implemented:

Focal Area A: Enabling mechanisms that ensure effective delivery of NRHM's MDG 4-related services.

Focal Area B: Accelerated delivery of quality services for reducing infant, neonatal and child mortality and morbidity.

Focal Area C: NIPI lessons and experiences being used throughout India and in other countries to improve policies, strategies, outreach and provision of MDG 4-related services.

3. The rural context of NIPI

NIPI has selected the five most traditional and conservative states for implementation of its programme. The five states have different cultures, but share common issues in regard to equity related to the caste system. The Indian constitution does away with the caste system. India has enacted several laws to prevent violence and facilitate social inclusion of Schedule Castes and Schedule Tribes (ST) into society. The act of 1989 contains affirmative measures to weed out the root cause of atrocities that have denied SC/ST basic civil rights. In spite of the constitution and other laws the caste system still operates in many rural areas of India.

[3] Observations and recommendations on Gender and Equity –Aide Memoire for MTR –NRHM 2008

In order to explain how the caste system functions within a village we present an interview with a village leader from the Harda district in Madhya Pradesh. The village-leader explained the caste-system and situation for landless in his village as follows: "In my village there are 1100 people divided into 220 households. Forty households belong to schedule castes (SCs), 70 households to schedule tribes (STs), 100 households to Other Backward Classes (OBCs) and 10 households to General Castes (GCs). Within SCs there are three categories and within STs two categories. Among the OBCs there are 5-6 categories. Among the GCs there are six Brahmin households and four Rasputin households.

The land in the village is owned by GCs and some OBCs, a total of 70 acres. The landless day labourers within agriculture are from SCs and STs. As a day labourer a woman will earn 40 rupees per day (5 NOK). She works from 10:00 to 18:00. A man would earn 70-80 rupees, but the men work harder and longer then the women", the village leader told the team.

"The different castes and categories of caste live in clusters in the village. There is no inter-marriage between the castes and the relationship between them is functional and not social. Traditionally the different castes and tribes would never visit or eat in each others' houses."

Poverty and caste influence the way women are treated in the villages, in hospitals and by government staff. It influences their access to education and public services.

Due to the practice of untouchability (SCs), Dalit communities are usually not allowed to access basic services on equal terms. When village level plans are developed, the needs of the Dalit communities would very often not be given due consideration. As a consequence Dalit communities do not have adequate access to facilities and services. In many villages Dalits are not allowed to sit with the rest of the community in the panchayat or in schools. Even the midday meal scheme providing a hot lunch to school children is an arena of caste discrimination, with dominant caste parents refusing to let their children eat food cooked by Dalit women, or in the company of Dalit children.[4] Because of this dehumanizing practice Dalit children often drop out of school and Dalit elected representatives do not attend meetings. Although the government has fixed reserve quotas in government jobs and educational institutions, very little has been accorded to the Dalits.

All key health indicators are markedly negative for SCs and STs. SCs/STs together comprise about 24% of India's population. A study conducted by UNICEF (MAPDIR) underlines that most maternal fatalities are among illiterate women from SCs and STs.[5]

A study[6] on "Infant and Child Mortality in India" focuses on some of the effects of caste/tribe membership. The study underlines that mortality may be due to differences in lifestyle

[4] CEDAW-second shadow report from Indian NGOs 2006 s.14
[5] UNICEF: Maternal and perinatal death inquiry and response (MAPEDIR), 2008 –pg 41
[6] National Family Health Survey Subject Reports Number 11 • December 1998

based on traditions and beliefs among SCs/STs. Such differences may include customary practices related to childbirth, infant feeding, and health care, and these have an effect on infant and child mortality independently of other variables. The findings indicate that children of Hindu-caste/tribe households often show higher neonatal mortality than other children primarily because they are disadvantaged in terms of other variables, such as mother's literacy or household economic status (indicated by ownership of consumer goods), rather than because of their household's caste/tribe affiliation per se. As with the results for neonatal mortality, the Hindu-caste/tribe group has the highest unadjusted post-neonatal mortality in India as a whole.

Women's status and role

The UN CEDAW committee commented on India's report on the implementation of the CEDAW Convention in 2000. Below are some of comments listed:

- The committee considers that widespread poverty, such social practices as the caste system and son preference, as reflected in a high incidence of violence against women, significant gender disparities and an adverse sex ratio, present major obstacles to the implementation of the Convention.

- The Committee is concerned that there is a high incidence of gender-based violence against women, which takes even more extreme forms because of customary practices, such as dowry, sati and the devadasi system. Discrimination against women who belong to particular castes or ethnic or religious groups also manifests itself in extreme forms of physical and sexual violence and harassment.

- The Committee is concerned with the continuing discrimination, including violence, suffered by women of the Dalit community, despite the passage of the Scheduled Castes and Scheduled Tribes (prevention of atrocities) Act of 1989.

The Committee urges the Government to enforce laws preventing discrimination against Dalit women and prohibiting the devadasi system. It urges the Government to introduce affirmative action programmes in such areas as education, employment and health so as to provide life chances to Dalit women and girls and create an environment conducive to their progress. The Committee calls upon the Government to set a time-frame for those interventions and provide information on the progress made in the next report.

The Committee recommends the adoption of a holistic approach to women's health throughout the life cycle in the country's health programme. It urges the Government to allocate resources from a "women's right to health" perspective, following the guidelines of the Committee's general recommendation 24.

The second NGO shadow report to the GoI CEDAW report was presented in November 2006. According to this report:

"The status of women in India causes concern, with socio-economic indicators showing a disturbing trend – a falling juvenile sex ratio, rising levels of poverty and unemployment, starvation deaths linked to the denial of right to life and livelihood and increased violence in all spheres. This trend cannot be viewed in isolation but needs to be seen in the light of globalization and rising caste and religious intolerance, which have given an impetus to increasing and varied forms of violence against women"[7].

Studies maintain that one reason why institutional health care fails to reach the majority of women has to do with women's status, women's lack of control over income and assets, and that their lack of direct access to outside medical facilities means that they are dependent on men to decide how serious their condition is, and when and if medical assistance from outside should be sought.

The perception of the female body is also described as something which hinders institutional delivery. Belief in "impurity" and shame related to childbirth are complicating cultural factors for pregnant rural women. The "impurity" determines the location, the attendants and many practices followed during delivery. Among Hindus the prohibitions imposed by the impurity of childbirth are especially demanding. It would be important for NIPI to understand the "women's own understanding" of issues related to pregnancy and childbirth, and take that as a point of departure for the different NIPI initiatives.

In the five NIPI states traditional views on caste and cultural beliefs would be a special challenge and influence the relevance of the interventions.

4. Organizational set-up of the NIPI programme

[7] INDIA, Second NGO shadow-report on CEDAW, NAWO November 2006

The funds from Norway to NIPI (NOK 100 mill per year) are channelled through WHO, UNICEF and UNOPS. The Embassy of Norway on behalf of the Norwegian Ministry of Foreign Affairs has signed three operational agreements with UNOPS, UNICEF and WHO. The NIPI secretariat is located in New Delhi and other major agreements have been signed with NIPI focal states.

In each of the five states there are two NIPI employees located in the State Health Societies in the respective state. In each state NIPI has chosen three districts for activities.

The principle of NIPI is to identify and bridge critical gaps, stimulate innovation and perform reforms through evidence-based advocacy. NIPI also aims to promote an equity-based, gender-sensitive empowering approach.

4.1. Observations concerning the NIPI organization

- The NIPI organizations in the five states comprise a total of 10 people. At present there is only one woman among the 10 staff. The NIPI secretariat leadership in New Delhi includes three men. For the outside world it seems strange that a programme working on MDG 4 and 5 employs so few women - especially in a country where pregnancy and childbirth issues have always been the domain of women in rural areas.

  Recommendations:
  The NIPI secretariats should receive gender and equity training, and secretariats at different levels should hire a dedicated gender specialist.

- In the five NIPI states - Rajasthan, Bihar, Madhya Pradesh, Orissa and Uttar Pradesh - NIPI funds channelled through UNICEF, WHO and UNOPS should be coordinated by the state level NIPI office.

  In our visit to Rajasthan and MP we saw no coordination at state and district level. UNICEF was working in some districts, while NIPI had chosen to work in other districts. In order to try out models NIPI should have selected districts where UNICEF already was working. Instead NIPI funds from different channels are spread thinly over several districts. This does facilitate tracking of results or "modelling".

  We also believe that UNICEF has not started up new projects after receiving NIPI funds. The organization is implementing the same projects and programmes as it has done for the last few years. The team did not identify any special NIPI projects implemented by UNICEF. The same observation was made by the Ministry of Health and Family Welfare.

4.2. Selection of NIPI districts

The rationale behind the selection of NIPI districts in the two states Rajasthan and Madhya Pradesh was not clear to the team. In Rajasthan, for example, there are three distinct types of geographical areas: flat terrain, hilly terrain (5 districts) and desert (14 districts). The people living in the hilly terrain and desert areas are the poorest and have less access to education and health services from the state government. The population here is mainly of ST and SC origin, and problems are faced in terms of infrastructure, human resources, illiteracy and cultural beliefs. Child and maternal mortality rates are particularly high in these geographical areas. We learnt that there are usually no ASHAs in these districts and that only 40% of pregnant mothers deliver at hospitals. In the other seven districts of Rajasthan 90% of deliveries are expected to take place in hospitals by the end of this year.

Instead of selecting three districts with different characteristic, NIPI has selected three districts in the flat terrain close to Jaipur, which can be reached by car within two to three hours.

The Ministry of Health and Family Welfare maintained that the NIPI districts had been chosen out for the wrong reasons. It was maintained that NIPI districts are close to Delhi and that the districts are usually showpieces for the states concerned.

5. The "ASHA chain"

The NIPI partnership aims to facilitate rapid scale-up of quality child related health services that are equitable and sustainable. NIPI will test and introduce new ways of scaling up quality services by community health workers (ASHAs, or Accredited Social Health Activist), including their support needs and referral requirements ("ASHA chain"). Globally, there is evidence that most maternal fatalities can be averted if the three following delays are successfully tackled:

- delay in decision to seek professional care
- delay in reaching the appropriate health facility
- delay in receiving care after arriving at hospital

In the National Rural Health Mission and NIPI districts numerous systems are put in place in order to avert the three delays and increase institutional delivery. The various initiatives are discussed below.

➢ Asha

The ASHA system was established as part of the National Rural Health Mission (NRHM). The ASHA will be a health activist in the community, create awareness of health and social issues in regard to health, and mobilize the community towards local health planning and increased utilization of existing health services. She will create

awareness in areas like nutrition, sanitation and hygiene, existing health services and their utilization.

Another important role of ASHA is counselling women on birth preparedness, immunization, contraception, RTI and STI. The ASHA guidelines also underline that ASHAs should undergo induction training and in-service training supported by training material. There will be one ASHA for every 1000 population, but in hilly terrain and deserts, the norm of 1000 may be relaxed.

The ASHA is not a paid employee. However, she will be eligible to compensation for services provided under various ongoing schemes and programmes run by GoI and state-governments, for example institutional delivery under Janani Suraksha Yojana; completion treatment under the TB control programme, promotion of household toilets under the Total Sanitation Campaign, all under the overall guidance of the District Health Mission.

- The selection of ASHAs

According to the guidelines the Village Health and Sanitation Committee will enter into an agreement with the ASHAs. This will be done after going through a community mobilization process. ASHAs should be accountable to the community, the Gram Panchayat. She will be guided by the Aganwadi worker and the ANM (nurse-midwife) on a daily basis.

In villages we were told that in order to be an ASHA you would need to have passed grade 8. Since women from the poorest ST and SC clusters usually do not have this level of education, ASHAs are seldom from these groups. Maternal and the child mortality are generally highest in these groups.

"There are no women with education in my village - so we have no ASHA. There are four villages close to mine in the same situation", the team was told in a village in Madhya Pradesh. The women maintained that caste thinking was still prevalent, with the implication that ASHAs would do the minimum required to receive payment under the institutional delivery scheme. The ASHAs would treat persons from their own caste better than those from other castes. The ASHA would usually never drink a cup of tea in the house of an ST or SC. The relationship would be functional and not social and caring. If only districts close to the main cities in the states are chosen as NIPI-districts, NIPI will not learn about the functional relationship between castes.

It was recommended that in some areas of the NIPI states the requirement as to grade 8 level of education should be lowered in order to recruit women that are closer to the poorer casts and classes.

- **Training of ASHAs**

Training of all the ASHAs is a challenge in the NRHM states. Usually there are only two or three staff at the different levels of government (central, state, block, district) that administer training programmes. According to the plans ASHA would undergo three trainings. Two of these trainings should last for seven or eight days. A drug kit would be available to each ASHA after completion of training.

In Rajasthan we were told that 46 000 of the 52 000 ASHAs had been recruited and trained.

However, the administrative burden of assembling and training ASHAs has been shown to be a huge task for many states. In Madhya Pradesh we learnt that the two week-long trainings had been reduced to one training. The quality of the training was also questioned by many interviewees. One ASHA said that she had been trained by an accountant and that she had heard about administrative staff having trained ASHAs.

The governance issues related to all training were mentioned. "If the number of trainings is reduced and less qualified staff are used as teachers, this would reduce the expenditure for training. Reducing the training given to 42 000 ASHAs would have implications.

It was recommended that NIPI should make an assessment of the training of ASHAs: the quality of training, the training modules, how the training is organized, the use of trainers from NGOs, governance issues, the use of drug kits etc – this in order to come up with better system of training for ASHAs.

It is also recommended that ASHAs in the NIPI districts receive training in gender and equity.

- **Home based care**

Traditionally women in rural areas usually feel shame during pregnancy and birth. This is may discourage rural women from attending antenatal clinics. Antenatal care by ASHA is

therefore of importance. The ASHA should support pregnant women and enable them to be excused from hard work in the field during pregnancy. Traditionally, the cultural expectation is that women should be active until birth, this is hard for women especially for those who are anaemic. The ASHA and the Aganwadi worker should also inform the woman of dietary prescriptions during pregnancy. Traditionally women are not expected to gain too much weight during pregnancy. It is feared that women who eat more in pregnancy will reduce the space available for the child and therefore give birth to underweight babies. Studies have shown that underweight babies are born in larger numbers to poor women, so indeed poverty must be recognized as the primary cause of maternal malnutrition. The ASHA could also motivate the household to change the pattern of food distribution within the household. In poor households women who eat last are also most likely to eat least[8]. Follow-up of the mother after birth is also important. At present the ASHA receives her entire payment once she has accompanied the pregnant woman to hospital. The women would need to be followed on returning to the village - and the woman and her baby need to be followed up for some weeks.

Since many poor women are day labourers it is difficult for them to stay at home after giving birth because they need income for food. UNFPA staff told the team that many undernourished children have mothers that are day labourers. If the ASHA and Angewani in the village worked together they could prevent malnourished children in category 2 from falling into category 3 and 4.
In the Ministry of Health and Family Welfare the team learnt of an ongoing effort to develop a model of home-based care in the 5 NIPI states.

- ASHAs must be accountable to villagers

ASHAs must be accountable to the Gram Panchayat and the Village Health and Sanitation Committee**.** ASHAs are communities' "health activists", they should serve the community. NGO staff in Madhya Pradesh maintained that a lot of work is imposed on the ASHAs by various government-run projects. The NGO staff underlined that ASHAs should <u>not</u> be part of the top-down health delivery system. If ASHAs are not trained in the activist role they should have in the communities, they may be caught up by the government system. It was also underlined that ASHAs work better in areas where their services are in demand from villagers. In most villages the poorest communities are not aware of their rights and what demands they can make on ASHAs and the health sector. A key finding from the UNICEF MAPEDIR data is that family members of most women who died during pregnancy/birth were not aware of the Below Poverty Line (BPL) entitlements regarding medical care.

- **Many actors – lack of coordination**

Several actors are working on health issues at the village level:

- In every village there would be an **Aganwadi centre** usually run by a female **Aganwadi worker**. She looks after about 1000 people, provides outreach services to poor families in need of immunization, healthy food,

[8] Maternal mortality in Bangladesh- Anthropolgical assessment report. Dr. Therese Blanchet. 1988

clean water and clean toilets, and the centre aims to be a learning environment for infants, toddlers and pre-school children. She also provides similar services for expectant and nursing mothers. Anganwadis are India's primary tool against the scourges of child malnourishment, infant mortality and for curbing preventable diseases such as polio.

- **The ANM (midwife-nurse**) is responsible for 3-5000 people (3-5 villages). The ANM has contact with the Aganwadi workers in the villages.
- **The Janmangal couples** (only in Rajasthan) are trained and linked to the state Family Welfare Programme for counselling and behaviour modification related to "spacing", prevention, and sterilization. 38 000 couples have worked in Rajasthan since 1994.
- **Dais (Traditional Birth Attendants)** are outside the institutional set-up in villages. The dais perform essentially two traditional functions: they deliver babies and they remove "pollution". (There are ancient cultural beliefs in India concerning "Bhut", "bad air" and "evil eye" in connection with complications of childbirth).
- There are **Health committees** in villages under the National Rural Health Mission. These committees consist of 11 members, two or three women, plus SC. However, these committees seldom work satisfactorily.
- **ASHAs** are introduced into the villages by NRHM.
- In addition to all the required actors, every village is expected to keep a health register including all data on health issues in the village.

All the different actors and systems in the village should work towards a common goal on improving the health-situation. But, in the villages there seem to be none or little coordination between above-mentioned actors. The team suggests that there is need for something that can strengthen the horizontal cooperation, increase accountability and transparency.

The team recommends that elected panchayat members (women) oversee coordination between the actors and follow up on their work. This could be tried out in districts where e.g. Agaz Foundation academies have trained women counsellors from SC and ST who are elected to the Panchayat.

Panchayat leader from SC (left)

- **Dais**

Many village women fear hospitals and are alienated from government health services. The role of the ASHA is to motivate the pregnant woman and her family to prepare for institutional delivery.

However, in many places there are no ASHAs and women deliver at home assisted by a dai. Every household would have their own family dai belonging to the same caste. Usually "dais" are older, poor women. In Madhya Pradesh about 71% of women from Schedul tribe deliver in the villages, according to DLHS 3 data.[9]

The team learnt that a dai still accompanies the woman to hospital together with the husband, mother in law and ASHA. A dai is called upon in case the pregnant woman delivers while travelling. Conflicts frequently arise between the hospital and family when a dai is brought along. The dai knows the pregnant woman and will often stay in the hospital together with her. There are also quarrels about the 200 rupees traditionally paid to the dai.

“If you are in pain you cannot start on the road to the hospital, and you have to resort to the dai,” the team was told in a village in Madhya Pradesh.

Investing in training of dais is therefore not a waste. The dais continue to be important in geographical areas where access to a hospital/ health centre is difficult – i.e. in the hilly and desert areas of Rajasthan.

- **Yashoda**

[9] Observations and recommendations on Gender and Equity – NRHM 2008

As from 2006 India saw an increase in use of health facilities by expectant mothers. However, health facilities suffered from deficiencies in infrastructure and in skilled manpower and have had problems meeting the increasing number of patients. NIPI introduced yashodas, a non-medical support volunteer, for mothers and newborn babies in the district hospitals and some selected community Health Centres. The role of the Yashoda has been to create a friendly atmosphere at the facility level and to help and assist the mother to understand basic newborn care. The Yashoda is not a regular employee of the hospital, but is paid a performance-linked incentive, The yashoda releases nurses from non-medical work and motivates mothers to stay beyond the current 6-8 hours after delivery since the initial 24-48 hours are critical. The Yashoda takes over after the ASHA has brought the woman to hospital.

Yashodas and nurse in Bharatpur hospital, Rajasthan.

The yashodas are recruited from the hospital neighbourhood and need to have passed grade 10 in school. Every Yashoda has responsibility for five mothers and their babies. The yashodas will initiate immediate breastfeeding. They will try to change an old tradition of not giving colostrums to the newborn baby. As in other countries in South Asia the first food given to a baby would not be colostrums, but a few drops of mustard oil placed on the baby's tongue to clean the inside of the baby. This is followed by honey or sugary water. Then, for the first two days or so, the child would traditionally be fed diluted goat or cow's milk. Colostrums are not regarded as milk. Some find it disgusting and associated with the pollution of childbirth.[10] The Yashoda will counsel for exclusive breastfeeding.

The Yashoda will assist the mother with basic newborn care practices; ensure general cleanliness of the beds and wards and inform the mother of follow-up activities for the

[10] Maternal mortality in Bangladesh – Antropological assessment report
Therese Blanchet 1988

newborn.[11] The yashodas work in three shifts and are administered by a Health Coordinator. The team learnt that the yashodas were very much appreciated in the hospitals and health centres by the women.

- **Incentive based systems**

Both ASHA and Yashoda are contract staff who are paid performance-based incentives, and mothers that deliver in a health facility are paid per delivery.

- ASHAs receive 600 rupees upon arriving at the hospital with the pregnant woman. She is also paid 400 rupees for transport for herself and the pregnant mother.

- The pregnant woman receives 1400 rupees after giving birth at a health facility. The 1400 rupees are primarily an incentive for women living along major roads.

- The Yashoda is paid an incentive per delivery. The overall cost could go up to 140 rupees per delivery.

Below, we will mention some concerns related to the introduction of contract staff and the incentive system.

Observations

- The incentives have increased the number of deliveries at hospitals. In Rajasthan the institutional delivery for SCs/STs had increased from 24.3% in 2005 to 39.9% in 2006. [12]

- Women in villages told of fewer complications after childbirth if the baby was delivered in a hospital.

- UNICEF in Rajasthan maintains that service quality in hospitals has not improved.

- Increases in the number of temporary contract staff at all levels in the health system have increased bribes, NGO staff maintain.

- Inside health facilities the confusion around the yashodas' line management has created conflicts among staff. In Bharatpur hospital there was no Health Coordinator to oversee the 20 yashodas and it was maintained that many yashodas did not turn up on a regular basis.

- According to their guidelines, yashodas are required to remain near the labour room if required. When there are many childbirths yashodas are often kept in

[11] Yashoda(mamta) – an enabling intervention for quality maternal and newborn care at the facility level.
[12] Observations and recommendations on Gender and Equity – Aide Memoire for Mid Term Review, 2008

the labour room. In this way they give less attention to the mothers and their babies in the ward.

- In Rajasthan the number of expectant mothers in hospitals has increased so much that confinement after birth has been reduced from 48 to 24 hours. The first 24 to 48 hours after delivery are critical for ensuring the well-being of the mother and new born.

- When the number of births increases the yashodas can earn more than permanent staff at the hospital. In Rajasthan we learnt that yashodas had earned up to 4000 rupees per month, which was more then the paramedics received in payment.

Governance and corruption

- The team learnt that when expectant mothers arrive in the hospitals without an ASHA, the paramedical staff would often fill in the forms and keep the money that was meant for the ASHAs.

- All service and medicines related to deliveries are free of charge in the hospitals for people below the poverty line (BPL). But when a poor expectant mother is admitted to the hospital she usually has to pay. Village women related that pregnant women would pay 2-300 rupees for medicine, 200 rupees to the nurse, 75 rupees in hospital fees, 200 rupees for the dai, 50-200 rupees to the clerk that issues the cheque for 1400 rupees. Usually 50% of the money would be paid to staff and others. NGO staff told the team that most expectant mothers in public hospitals are very poor and travel to the hospital to get the 1400 rupees, but since they are vulnerable people around them will try to extract the money.

- Women often lack control over money and the general view is that in a situation of scarcity men's needs come first. Hence, in the household too, we would expected poor illiterate women to find it difficult to keep any money left from the 1400 rupees. It would probably be used to meet all the expenditure related to travel and food in relation to the childbirth. However, the money would have benefited women who are day labourers if they were able to save some of the money received for the first weeks after birth.

Recommendations:

- *A study should be made of how conflicts between permanent staff (principal medical doctors, nurses, and paramedic staff) and contract staff (yashodas and health managers) can be avoided.*

- *There is need for clear and simple information on what the expectant mother is supposed to receive from the hospital, explaining that service and medicines are free of charge. The information should be posted in the hospital reception.*

The information should also be printed on leaflets that the ASHAs could spread in the villages. Women from SC and ST that are illiterate could pass on the information from ASHAs by word of mouth.

- *The ASHAs and yashodas in the NIPI districts should receive gender and equity training from NGOs. They should learn how they can improve their communication skills and their behaviour towards women and poor patients (respect and dignity) as well as increasing their awareness of gender barriers for women.*

- *The ASHA should not receive her full amount when she hands over the expectant mother to the hospital. Instead some part of the money could be handed over after two weeks' follow-up of the woman and her new born.*

- *A tracking study on how the 1400 rupees, received by the women, are spent could be conducted. The possibility of paying the1400 rupees in a manner that reduces the demand for bribes should be examined.*

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- *Payments made to yashodas should be looked into. If they earn more than educated permanent staff it could give rise to conflicts at hospitals*.

- *The team recommend a cooperation with Aagaz Foundation in Madhya Pradesh (MD). NIPI in MD could be asked to start activities in Hadra district in the south, a poor tribal district with 4.7 million inhabitants and 340 panchayats. Aagaz Academy has trained 101 elected panchayat women from SC and ST in this district. The elected women form small groups of women in their villages, which make their own action plans. The training has enabled some of the elected women to take up leadership roles. The elected women and their groups could identify activities /investments that could help to improve the MMR and CMR in Hadra district. Funds could me made available for the implementation of the proposals*

Elected women from SC and ST

6. The health infrastructure

User-friendly hospitals for women needed in order to reduce the child mortality rate and maternal mortality rate. Since the health sector is the largest employer of women in India, there is also a need for infrastructure that can meet the needs of female health personnel and enable them to work in rural health centres and hospitals.

1) Infrastructure for female employees in the health sector

In rural areas it is difficult to find places to live for female staff that are safe. Many health centres lack water and sanitation, which creates problems not only for female patients but also for female staff. The staff also need mobile phones in order to refer pregnant women who need to travel to hospitals.

2) Hospitals

Since the number of institutional deliveries has increased this has put pressure on the capacity of hospitals and health centres. The team visited two hospitals and one health centre. Although the two hospitals were quite new, they needed improvements related to water and sanitation.

A journalist with the Dainik Bhaskar newspaper in Rajasthan told us that medical staff (doctors) are usually not interested in improving conditions in public hospitals since they all run private clinics beside their work.

In the implementation of the NRHM a new model involving health managers in hospitals is being tried out. The health managers are responsible for the health infrastructure and the staff. However, the health managers experience power struggles with the principal medical doctors who were previously in complete control at hospitals.
In Baratphur the health manager told the team that funds were available for hospital improvements, but that he was unable to get the PMD to sign tenders. The hospital needed a generator, water tap outside the hospital, more beds etc. It is impossible to get the work done, he said. He also said that inside the hospital in Bharatpur there were different factions among the staff. One faction was not willing to work, and the health manager tried to "break it up" by moving some staff to another ward. This transfer of staff resulted in political interference, and the staff went on strike. The staff transfer has now ended in Rajasthan High Court, where 20 November 2008 has been set as the day for the case in the court..

All new health managers are contract staff, giving them less power inside the hospitals, the team were told.

Recommendation: *Hospitals where the Health Manager and Principal Medical Doctors cooperate to improve their services should be publicly applauded and held up as examples of best practices that other hospitals could learn from.*

3) Hospital equipment

The team questions some of the proposed equipment in hospitals and the potential for replication to other hospitals. If the NIPI-supported hospital in Baratpur were to serve as a model for other hospitals, investments in technically advanced equipment would probably be difficult to replicate to other district hospitals in the state.
The NIPI budget suggests placing **LCD screens** on the walls in the hospital in Bharatpur. We believe that this would make for a very chaotic situation in the hospital. Women need rest after giving birth. There is also greater need of a generator, sheets and beds. (The suggested LCD screens would most probably end up in private homes.)

In Bharatpur in Rajasthan we were told that when equipment and machines for medical check-ups break down, they are be repaired. The medical doctors are consequently compelled to refer patients to private hospitals, where the patients would have to pay. In Baratpur hospital a sonography machine was out of order, requiring patients to be sent to a hospital where they had to pay for the service.
Many hospitals and health centres lack curtains that give the women privacy during delivery. Many health centres lack sanitation facilities. We were told that water/sanitation facilities are often skipped when health centres at subdivision level are built. This in done in order to save money or due to corruption. Lack of sanitation facilities at subdivision health centres makes it difficult not only for the patients, but also for health personnel who then are not able to live there.

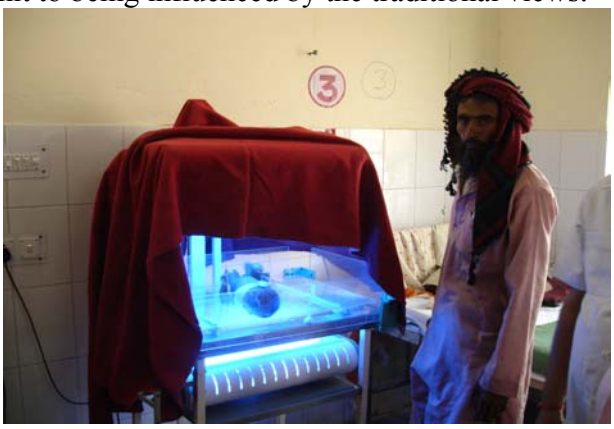
Recommendation: *Previously health centres and hospitals were visited by inspection teams. These teams should be revitalized. The teams should be particularly gender sensitive when inspecting and reporting on the infrastructure***.**

4) Sanitation and hygiene

When an expectant mother travels to the hospital she is usually escorted by her husband, mother in law, the family dai and in some cases the ASHA. In the Bharatpur hospital in Rajasthan there were some 30 deliveries per day, prompting up to 120 visitors to the hospital. The hospitals are therefore becoming overcrowded. Since there are no sanitation facilities for visitors, the toilets inside the wards are used by everybody. The sanitation facilities are not kept clean and pose a threat of infection to women with newborns, and especially to women who have had a caesarean. A journalist who followed the situation in the hospitals in Bharatpur reported that wards, labour rooms and sanitation facilities alike are usually very dirty, but that they had been cleaned just before the team arrived in the hospital.

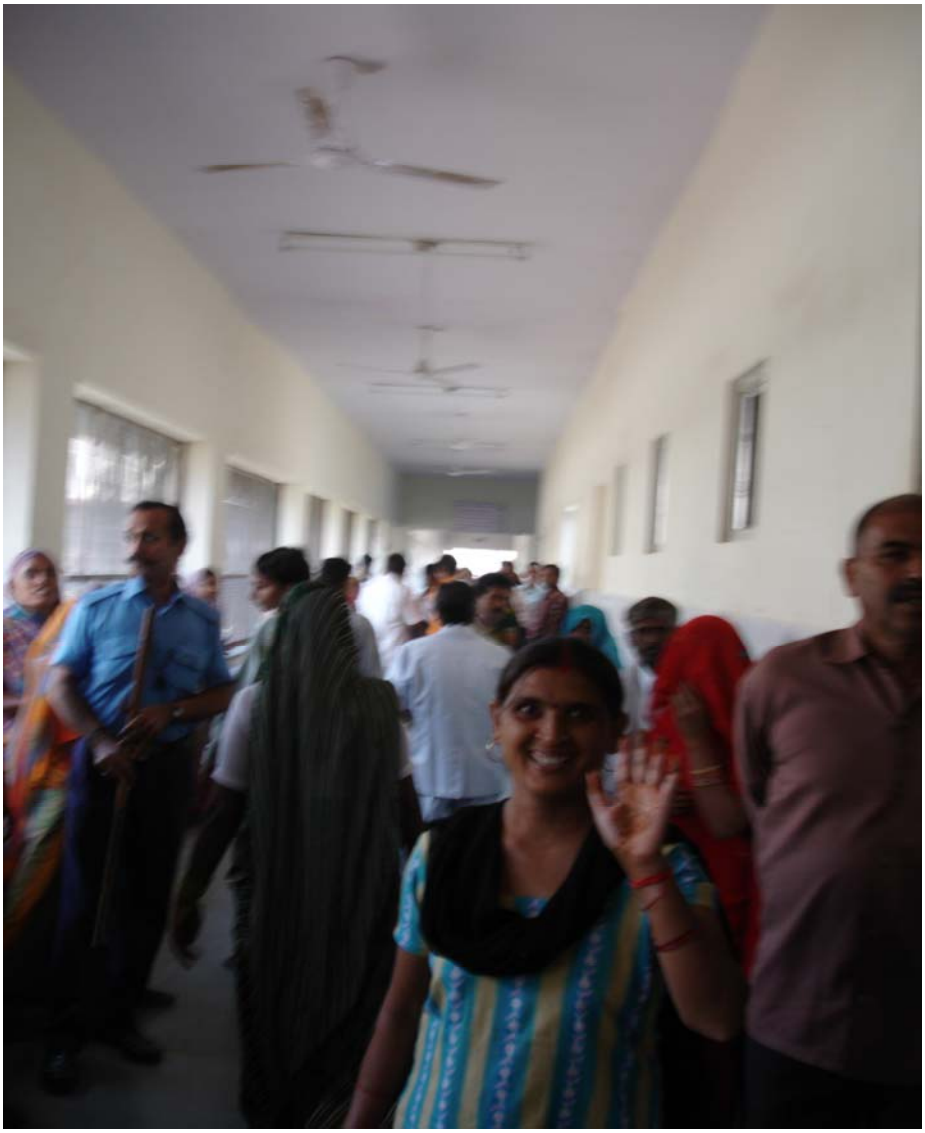
Hygiene is a complicated issue in India. Usually people belonging to the special sweeper caste (Dhobis) do the cleaning. According to traditional beliefs the ritually impure status of this caste group derives from the associations with bodily impurities. Women from this caste group assist in childbirth, again a highly impure activity.[13] Other staff at the hospital would probably define what they can do of cleaning based on their attitudes to caste. In the traditional belief women are impure during delivery. Dirty conditions in delivery rooms are therefore common.

An in-depth study on "impurity-related" behaviour inside hospitals would provide a useful key to explain the quality of care and the distribution of tasks among various categories of workers in the health services. It would be valuable to know more about how middle-class and urban staff in health facilities relate to rural SC and ST women. Even if staff are educated and socialized to some extent into western ideas of care, they would not easily admit to being influenced by the traditional views.



The husband decides on institutional delivery

[13] Subhadra Mitra Chama : Discrimination against Dalits and Dalit women in India , 2005



Inside the hospital in Bharatpur

5) Nowhere to stay

Family members that accompany the expectant mother to the hospital have no place to stay that is affordable, near to the hospital. Usually they stay outside and inside the corridors during childbirth.

Studies show that pregnant women have little or no role in deciding to seek care; usually the husband plays a major role in this decision [14]. When there are no facilities for the husbands or other family members close to the hospital, the chance is that the husband will bring the wife back to the village earlier then advisable. We believe that it will be

[14] MAPDIR (UNICEF) 2008

difficult for the yashodas to empower the women to stay longer in the hospital if the husband and mother in law decide to return to the village. The cost implications of travelling, staying close to the hospital, buying food and being away from work, are burdensome for day labourers earning 80 rupees a day.

6) No food available in hospitals and health centres

Since hospitals do not provide food for patients, the family would need to supply the mother with food. A family living close to the hospital can live at home and deliver on a daily basis. However a Yashoda told us that mothers had to wait for breakfast until 11-12:00 every day, so they were very hungry. Many women leave the hospital earlier due to the lack of food in the hospital. Caste thinking.

7) Transport

Transport to hospitals is available in only a few places. In Rajasthan the team learnt that ambulances often were used by doctors for private purposes. The journalist in Rajasthan told that he had written about the ambulances in the local newspaper. In Madhya Pradesh village women told us that many women needed to be transported on motorbikes or hired cars to hospital since there were no ambulances.
Ambulance management is a problem in many localities.

8) Men in the labour room
In Bharatpur the team was also told that there were paramedic men in the labour room, something that the women reacted against strongly. A sense of shame regarding women's body is instilled in girls from their earliest years. Inevitably, there are strict norms regulating female behaviour. Men's honour depends very much on how they control and protect their wives. If villagers get to know that male paramedics work inside the labour room in the hospital this will have a negative impact on institutional delivery, especially among illiterate villagers.

Recommendations:
- *Sanitation facilities (bath and toilets) inside the hospital should be exclusively for pregnant women. Visitors should use outside facilities. The team recommends that responsibility for sanitation facilities be outsourced to the NGO Sulabh who specialize in running sanitation facilities inside and outside hospitals. The NGO also provides cheap sleeping facilities for family members. In Bharatpur hospital the outsourcing could be an action research under the NIPI initiatives.*

- *The team recommends that poor women from the Takha village near Bharatpur hospital form a group and be paid to make breakfast for women in the hospital. The food could be a part of the delivery kit.*

- The team recommends an annual prize for journalists who follow developments in the health sector in the NIPI states and write reports in local newspapers.

7. Learning and sharing of experience

In the ToR for the review we have been asked to make suggestions for specific operational research topics. Below, we present some issues where there is a need for studies:

- **Reporting on MMR**

The team learnt that the pressure on reducing the MMR are high. The implication of this is that the numbers are manipulated. If a woman dies in hospital it is often said that she died on the way to hospital or in the village, the team was told by some villagers. This could be looked into more closely by NIPI.

- A high number of still-born babies are reported in hospitals. UNFPA reports that a small investigation conducted by a doctor showed that nearly all the stillborns were females. What is happening in hospitals? The sex ratio throughout India is worsening, in some districts there are fewer than 800 women per 1000 men.

- A UNFPA staff member believes a useful role would be played by child death audits that registered whether a dead baby/child belonged to a SC or ST and its gender.

- All children should be enlisted in the Nutrition Rehabilitation Centre (the Anganwadi centre). However, only 50% of children are enrolled. Who are the children that are not enrolled? Are they the children of single mothers, day labourers, a particular caste? This should be studied, according to UNFPA staff.

- Anaemia among women is growing in India, according to UNFPA staff. The reasons for this should be looked into. Only macro data showing the level of anaemia are available. Several field-based programmes are addressing anaemia. Why is the development negative?

- The CEDAW NGO shadow report points to unsafe abortion as one of the most important reasons for maternal fatalities in India. Complications resulting from abortion are responsible for 15 – 30% of all maternal fatalities in the state of UP. Serious complications resulting from unsafe abortion include infection, bleeding, and injuries to the reproductive tract[15]. NIPI could conduct a study on abortion.

[15] Study report of Johns Hopkins University – www.jhpiego.org/pubs/TR/tr516sum.htm 104

Gender mainstreaming in the Norway India Partnership Initiative (NIPI)

Programme for Ms. Bodil Maal - Gender Consultant

Day&Date	Time (hrs)	Programme	Remarks
03.10.08	**1105**	**Arrive from Norway- KL 0871**	**Claridges Hotel will pick up from the airport. Hotel tel. no: 41335133**
04.10.08 Tuesday	**8 00** **1500**	**Leave for Jaipur** **In Jaipur-** **Meeting with Dr. Yadav for an overview, meeting with the mission Director, Health & Family Welfare, NRHM and UNICEF representative**	**Embassy car will pick up from the hotel** **NIPI-Medical directorate** **Room 213, Jaipur** **Tele: 0141 2222589** **Mobile: 9414068014 (Adesh)** **Night stay in Jaipur**
05.10.08 Wednesday	**0800** **1130** **12-1300** **1500** **1600** **2100**	**Leave for Bharatpur** **Arrive Hotel** **Meetings.** **Visit the Rarah health centre in the village.** **Meeeting withTakha Sarpanch Mr. Kushal Pal Singh (09414654664)** **Meeting with journalist Deepak Singhal**	**Night stay at Laxmi Palace Hotel, Bharatpur.**
06.10.08 Thursday	**0900** **1200** **1500**	**Leave for Delhi** **Arrival at Delhi** **Lunch at hotel Claridges** **Meeting in the embassy with Jan Olsson, Dr. Bernadette, Dr. Somesh Kumar and with Ms. Therese W. Bazard**	**Check in at Claridges Hotel** **Venue: Embassy**
07.10.08 Friday	**0930** **1130**	**Meeting at NIPI secretariat** **Meeting with Ranjana Kumari** **In the evening leave for Bhopal by air**	**Dr. Ranjana Kumari Centre for Social Research** **C-1 Vasant Kunj**

			2, Nelson Mandela Marg Phone No. : 26899998, Mob:.9810054264
08.10.08 Saturday		**Field visit to Bhopal- Agaz Foundation -Visit to Hadra District – meeting with elected women representatives in Panchayati Raj - Visit to village**	**Hotel booking by Aagaz Foundation**
09.10.08 Sunday		**Meeting with Aagaz Academy in Bhopal**	
10.10.08 Monday	**1000-1045 1100 1300-1400 1500**	**Lecture by Dr. Møgedal in the Embassy Meeting with Dr. Sangeeta Saxena, Ministry of Health & Family Welfare WHO-Dr. Paul Francis & Dr. Mehta Dinner at Ambassador's residence Anita Pitre (9910992301) UNFPA**	**Nirman Bhawan WHO, 537 A Wing, Nirman Bhavan, Tel: 23061922, 23062179 Mobile: 9818255387; 98103 23100**
11.10.08 Tuesday	**1100-1200 1400-1500 1530**	**Meeting with Rita Sarin at Agaz Foundation Meeting with UNICEF – Dr. Pavitra Mohan Meeting with Ambassador Ann Ollestad**	**Shaheed Bhawan, 2nd Floor 18/1, aruna Asaf Ali Marg UNICEF, 55 Lodi Estate Embassy**

Note: Renu Wadehra from the Embassy will accompany Bodil Maal throughout the programme. Tel: Mobile- 9818666858. Office direct:41779222, Embassy tel no: 41779200

TOR for the consultant

Gender mainstreaming in Norway India Partnership Initiative (NIPI)

Background:

The Norway- India Partnership Initiative is an outcome of a commitment by the Hon' able Prime Minister of Norway and the Hon' able Prime Minister of India, to reduce child mortality and improve child health in order to attain Millennium Development Goal 4 by the year 2015. Norway has contributed USD 80 million over five years for this purpose to five states of **Orissa, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh.** These states together constitute 40 per cent of India's population and account for almost 60% of child fatalities in India. The NIPI activities run for five years (2007-2012), corresponding to the duration of the NRHM.

The objective is to provide up-front, catalytic and strategic support to accelerate the implementation of the National Rural Health Mission (NRHM) in five focus states, specifically to improve child health and related maternal health service delivery quality and access. The catalytic input will also aim to improve the visibility of child health in public health and create mechanisms that will ensure sustainability under NRHM processes
The activities under NIPI are put into operation through state health societies in the respective states, facilitated by the UN organizations UNICEF, WHO and United Nation's Office for Project Services (UNOPS). All the interventions are aimed at accelerating the Child Health interventions: (i) based on block, district, region and state specific situations (ii) through partnership and collaborative arrangements with professional organizations, NGOs, local elected bodies and administration within the state.

The overarching principles of NIPI are:

- To conduct all activities within the National Rural Health Mission (NRHM) framework.
- To support NRHM child health initiatives incorporated in state and district plans, developed with full participation of the state health system.
- To work within the existing institutional mechanism at the state level. No parallel structure created.
- To identify and bridge critical gaps, stimulate innovation, and promote reforms through evidence based advocacy.
- **To promote an equity-based, gender-sensitive empowering approach.**
- To ensure recruitment and financial accountability through existing state procedure.
- To leverage NRHM resources for child health

Scope of work:

While promoting equity based gender sensitive and empowering approach is an overarching principle of NIPI, it would like to ensure that gender concerns are addressed in a specific manner in all aspects including institutional mechanisms, program implementation strategies, policies, advocacy, capacity building, documentation etc.

NIPI specifically would like to address the misconception that health initiatives automatically address women's empowerment because women are visible in the health-care system both as caregivers and as clients and that in the case of child health there are no real gender issues since all children require equal care.

NIPI is a learning initiative that aims to contribute significantly to policies related to investments in the child health sector in public health, and in the planning, implementation and monitoring of child health interventions. This will require policy makers and planners to recognize women's role as providers and promoters of health care for the newborn and children in the household and the community and to recognize them as agents of change who can facilitate changes in the social and cultural barriers that reduce the use of quality child care services and good practices that can promote child health by the families. Identification of strategies for mainstreaming gender through training for policy makers and planners in gender sensitization and gender planning and participatory approaches is a major task.

NIPI recognizes the fact that in the NIPI focus states women clients tend to make better use of the services that are available for reproductive health services and services for reducing neonatal illnesses/mortality where the health care providers are female, accessible and culturally sympathetic. Introduction of Janani Suraksha Yojana, (JSY) a maternal health programme and Accredited Social Health Activist (ASHA) under the NRHM has enabled a quantum leap in the use of institutional facility for delivery by women from marginalized families and under served areas from 2005. To maximize the outcome of JSY the NIPI focus states have an innovative cost effective method to improve quality of care for mothers and newborn at the facility by placing a 'yashoda' 'mamta', a non medical support volunteer.

In continuation of the women empowerment approach, NIPI is strengthening the capacity of the ASHA to provide newborn care at the home and community level. Simultaneous efforts include strengthening of sick newborn care at the facilities, improving immunization coverage and systems, data collection and reporting, nutritional interventions, documentation and dissemination of best practices and policies to front line health workers, and promoting opportunities for continuing education and distance education of the primary level health workers.
The challenge is to ensure that the above mentioned services contribute to empowering women to make decisions for treatment of children without delay, and give them choices in accessing children's health needs.

While NIPI has created avenues for women-to-women services and empowerment of women, space has to be created for better engagement of men at home and community through in the newborn care, child health and community health activities. This approach will ensure that child health issues are addressed by both men and women at home and community level.
The implementing agencies and partner organizations require intensive understanding in addressing the gender concerns in the implementation of these initiatives and identification of indicators that will ensure that cross-cutting gender issues are addressed at all levels.

Deliverables:

Facilitate the development of appropriate gender mainstreaming strategies for all NIPI partners by:

- Analyzing how the intervention objectives explicitly address gender issues related to access, quality of care, systems, governance etc in child health and related maternal health.
- Examining the implementation strategies to link to other health determinants that influence child health such as sanitation, water, education etc.
- Examining the data collection methods and their use for addressing the gender gap in child health and related maternal health services.
- Reviewing the recruitment and training processes of the implementing agencies/partners for recognizing the need for, and taking action to increase the number of, female health service providers for all areas of child health delivery from facility to community.
- Analyzing how the monitoring and evaluation process have established qualitative and process-oriented gender-sensitive indicators of inputs, outputs, and outcome for programme design and for implementation.
- Reviewing the documentation by all the agencies for their gender sensitive approach and ability to address gender gaps.
- Making suggestions for training in gender sensitization and in gender planning and participatory approaches for the executing agency.
- Making suggestions for specific operational research topics.
- Making suggestions to align the NIPI gender policy with the national gender policy under NRHM.

Method:

Discussions with:

- Royal Norwegian Embassy, NIPI Secretariat, UNICEF and WHO
- Discussions with NRHM, Ministry of Health, Government of India
- NIPI focus state government health system
- Development partners - DFID, PATH, and UNFPA, Save the Newborn Lives, USAID etc.
- Field visits to selected interventions sites
- Review of documents /reports/formats/training materials

Duration: 04-11-08 till 11-11-08.

Norad
Norwegian Agency for Development Cooperation

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