

GENDER and HEALTH Ready Reckoner

**An Application guide for gender-
sensitive health service delivery**

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PREFACE

This Gender Ready Reckoner is a simple guide to understanding the concept of gender and how this concept relates to the health sector and our day-to-day work as service providers. The National Institute of Health and Family Welfare undertook a detailed review in 2003-04 to mainstream gender issues in all RCH training. This review led to the need for building the capacities of all health training institutions including SIHFWs to mainstream gender in their own training programmes. To aid the process of capacity-building, one of the recommendations was to develop a reader-friendly guide for trainers and providers to understand and be alert to integrating gender concerns in training as well as service delivery. Therefore, in 2004-05, when NIHFW organised a training of Master Trainers on mainstreaming gender issues, this gender ready reckoner or 'Kunji' was shared with the participants. Many of them found the inputs easy to understand and very useful. To further answer the question of 'how do I apply my understanding of gender issues to my work?' the section on suggested actions for service providers was added.

The Ready Reckoner, as the name implies is a ready-to-use guide. The guide is divided in several sections. At the end of each section, there is a "test yourself" quiz. A reader can study the content of each section and test her/his knowledge by answering the quiz. The first seven sections are presented in this manner. In terms of content, this guide moves from the concept of gender to the various aspects of life that it influences such as division of labour, decision-making and family roles and responsibilities. It elaborates the different dimensions of gender-based violence, how it operates at the household and the community levels and with what health implications. Section seven differentiates between practical gender needs and strategic gender needs to emphasise the movement from improving the 'condition' of women to improving their 'position' in the society.

The eighth and the last section provides suggestions on actions that health service providers can take in their day-to-day work to make health services gender-sensitive, and thereby, more accessible to all.

We hope that this ready reckoner will be widely used as a guide in creating sustained awareness on gender issues and its application in the improving health service delivery and utilisation.

Section 1: Gender and Sex

Sex

Sex is biological term that represents the genetic and physical identity of the person. It is meant to signify that one is either male or female.

Sex is a biological term. It refers to the physical make-up of a person as determined by his/her genetic make up. The female body is naturally different from the male body. The genes of the female, specifically the sex chromosomes (XX) provide her with breasts, internal reproductive organs (uterus, fallopian tubes, and ovaries) and external reproductive organs (vagina) that males (with XY sex chromosomes) do not have. Males have their own reproductive organs, totally different from the females. Outwardly also, females have rounder hips than males. Note also the differences between both sexes become less clear when organs other than those associated with reproduction are concerned. Some males may look like females, and vice versa.

The above definition given, does not mention anything about how males and females should behave or act.

What is Gender?

Gender is defined as the socially learned behaviours and the expectations that are associated with men and women.

You would notice from this definition that there is no mention of physical characteristics of male and female. Whereas maleness and femaleness are biological facts, masculinity and femininity are culturally constructed attributes. As culture varies, the attributes attached to masculinity and femininity vary.

Therefore, the attributes attached to masculinity / femininity are not universal. They differ geographically and culturally; for example, taking a ghunghat in north India is a must for all married women whilst no such thing exists in South India.

In different geographical areas, these attributes may also change according to the caste groups to which the men and women belong.

For example, a young illiterate scheduled caste widow in a village in Uttar Pradesh would support herself and her children by working as a casual labourer whilst a young illiterate Brahmin widow of the same village does not have the same option for supporting herself.

These attributes also change over time. These changes, some time occur due to external factors and some time, a group of people consciously bring changes. For example, in Japan, before the start of Second World War, women hardly worked in factories and offices. As more and more men were needed to fight the war, women were asked to run the factories and offices. After the World War, there was no going back. Now, more than 90% women in Japan work either in factories, offices or in the service sector.



Take the efforts made by Savitri Bai Phule to bring education to girls in mid 19th century. This woman, with the help of a group of conscious citizens, initiated a school for girls and the efforts bore fruits and now we find, roughly 54% women are literate – the figures for 1901 was only about 3%.

In large many cultures, there is a hierarchical relationship between men and women. The work done by men is valued more than the work done by women. In fact, most of the tasks performed by women as `domestic chores` have never received any economic value. In large parts of India, less wages are paid to women for doing the same work as men. Men are regarded as inheritors of the family wealth and assets and thus their position is valued more than that of women.

Differences between Sex and Gender: --

From above paragraphs, the differences between Sex and Gender are clear. Let us put them in the following fashion:

Sex	Gender
Biological	Socio-cultural construct
Nature-made	Society made
Constant	Variable
Individual	Systemic
Non-hierarchical	Hierarchical
Can not be changed	Changes over a period

Evaluate Your Learning

To check what you have learned from this lesson, do the following exercise.

On the list of words below, encircle the words associated with SEX. Underline the words associated with GENDER

	Gender /Sex	Gender/Sex
1. Menstruation		9. Strong
2. Estrogens		10. Circumcision
3. Emotional		11. Doctor
4. Testosterone		12. Tolerant
5. Gossip-monger		13. Weak character
6. Nurse		14. Courageous
7. Pregnancy		15. Sperm cell
8. Persevering		

For answers, refer page No.7

HOW DO YOU RELATE THE CONCEPTS OF SEX AND GENDER WITH YOUR WORK?

Sex

1.-----

2.-----

Gender

1.-----

2.-----

BEAR THIS IN MIND

- Sex is a biological term that represents the genetic and physical identity of a person. It is meant to signify that one is either male or female.
- Gender is defined as the socially learned behaviour and the expectations that are associated with being men and women.
- Maleness and femaleness are biological facts, masculinity and femininity are constructed through a process of socialisation
- There are many similarities between men and women
- In terms of differences, there are **biological differences**, also called sex differences and socially created differences called **gender differences**. These differences are learned from society – from family, from peer groups, from literature, from media – and often manifest as biases.
- The unconscious biases and assumptions people have of each gender can affect personal as well as professional life by:
 1. Shaping how one recognises the capacities of male and female child – providing higher/technical/ management oriented education opportunities to the male child and desk job oriented education opportunities for the female child
 2. Health seeking behaviour of a person depends upon the gender – men generally seek health services earlier than women
- Since most of the differences between women and men are socially created, they can be changed.

Answers to - Evaluate Your Learning

- | | |
|-----------|------------|
| 1. Sex | 9. Gender |
| 2. Sex | 10. Sex |
| 3. Gender | 11. Gender |
| 4. Sex | 12. Gender |
| 5. Gender | 13. Gender |
| 6. Gender | 14. Gender |
| 7. Sex | 15. Sex |
| 8. Gender | |

Section 2: Formation of Gender

As mentioned earlier, Gender is formed through a process of socialisation. To understand this, let us go through the `story of Munna and Munni – a twin.`

Munna and Munni: The social construction of gender

Situation 1

Let us imagine that twins have been born to someone we know. One of them is a boy and the other, a girl. We go to visit them in the hospital. They are wrapped in cloth from below the neck. Can we make out the sex of the children? No, because the sex of infants can be found out only through differences in their external genitals. So, when can biological differences show the Munna is a boy and Munni is a girl? Only at puberty, when secondary sexual characteristics develop. However, in reality, do we need to wait so long to find out the differences? No, because the clothes they wear, the hair they keep and the way they behave are different for both from early childhood. Many believe that this difference in behaviour between boys and girls is `natural` because it comes so early. Therefore, let us look at another situation to explore whether this is true.

Situation 2

Munna and Munni are three months old. They are both hungry. Does Munni cry less? Does she sacrifice her share of the milk for Munna? She doesn't. So how can we say that women are sacrificing by nature? Even when the twins are one year old, they both fight equally for toys, sweets, and their parent's attention. So why do they become so different when they grow up? We need to visit the twins again to find out?

Situation 3

The twins are now two years old. Munna is given a shirt and shorts to wear. Munni gets frocks and dresses. Do the children choose their own clothes at the age of two? We decide that, `because` Munna is a boy, he is expected to wear a shirt and not a frock. Where do these expectations come from? They come from society, not from the children's natural desires. Therefore, society determines the way in which boys and girls dress up, the manner in which they keep their hair, and so on. Next, because Munni is wearing a frock, she is asked to sit properly with her feet close together and is told not to climb or jump in a way that reveals her underclothes. Gradually, she is told not to shout, not to laugh loudly, not to .. not ... not. The list never ends. The social influence is called the social construction of gender. This begins around the age of one, and by the time the children are two or three years old, they get to know their gender. Later on, when they notice their own external genitalia as well as that of others, they get to know their biological differences. As the children grow up, gender begins to play a bigger role in their upbringing. Let us see how that happens.

Situation 4

The twins are now six years old. We have been invited to their birthday party. We go to a toyshop to buy presents for them. What is the question the shopkeeper asks us even before he enquires about our budget? Whether the present is for a boy or a girl isn't it? If it is for a boy, he shows us cars, bats and balls, planes, guns, mechano sets, and so on. And if it is a girl? Dolls, kitchen sets, embroidery and stitching sets, items to `pretty up` such as hair clips, miniature cosmetics, fancy combs, and so on, are shown. We decide to buy a bat and a ball for Munna and a doll with the kitchen set for Munni. What are the ramifications of these

presents for the children?

Situation – 5

Munna plays with the bat and a ball. Where is this game played? Out in the open, away from home. Therefore, gets a chance to go out, to learn to cross the road, to learn to negotiate with children of his age (or even older children, when they snatch his toys); he gets fresh air, his muscles develop, his appetite grows and he learns to face the big bad world outside his home. He becomes 'tough', he learns to handle situations on his own and soon earns the confidence of his parents. They begin to trust him with outdoor work, and they begin to involve him in decision-making.

On the other hand, Munni plays with the doll and the kitchen set. Where is this game played? Inside the home, in the kitchen or in the corner of living room. What is the script used when she's playing? 'feed the baby'; 'kiss the baby, it is sleepy now', what have you cooked today?' 'What does your baby like to eat ,' etc. Munna can enter the house; banging his bat on staircase, but if Munni bangs her doll on the wall, we immediately tell her not to hurt the baby! In reality, we are inculcating in her the values of motherhood and wifeness. We are creating a future homemaker, instead of letting her play and enjoy her childhood. This is the reason why women are considered to be better parents. We sometimes also believe that women are naturally gentler. This is not true. Gentleness (which is a good quality for both men and women) is expected more of a woman, so we train her to be like that. If a woman does not like to cook, or does not want children, or is not a good homemaker, she is ridiculed or ostracised. She dare not say that she does not like children because she will be labelled 'abnormal'.

All this while one may be wondering why we are making such a fuss about toys. If the twins enjoy their respective toys, why should we read so much meaning in to their play? What happens if the children refuse to play with the toys that we gave them?

Situation 6

After few days of playing with their own toys, the twins get bored and want to exchange their presents. Munni picks up the bat and ball and gets ready to go to the playground. What is our response to that? "You'll be the only girl, how can you play with the boys?", "What will the neighbours say?", "You'll tear your nice dress", "What will you do if someone follows you or harasses you?", "Why are you behaving like a Tomboy?" On the other hand, if Munna get tired of going out and wants to play at home with Munni's doll, what would our response be to that? " Oh no, he's going to be a sissy when he grows up", "Why does he want behave like a girl?", "Where did I go wrong in bringing him up?" "I hope no one notices him play with the dolls, or else they'll ridicule him in school", "He should be playing outside, not sticking to his mother's apron like this", and so on. If children refuse to play the gender roles we assign them, it creates a great deal of anxiety with us. We punish them if they resist. We even take them to counsellors for behavioural therapy. Therefore, accepting a prescribed gender role is not as natural as we would like to believe; it is forced upon us by society. What are the manifestations of such gender norms on Munna and Munni when they grow up? A look at another situation in their lives will throw some more light on this matter.

Situation 7

Munna and Munni are now 20 years old. Munni will soon be married to a boy her father has selected. She knows how to cook and clean, and is good at stitching and mending clothes. She has degree in home science. Her parents have collected money for her dowry. They will give Munna the house and Munni the dowry. Munna has a degree in hotel management and is chef in a good restaurant. He has a decent salary. Munni's fiancé is a dress designer and

designs clothes for boutique. He also has a good annual income. The dowry from Munni's parents will help him put up his own shop. We often say that women are better cooks than men are. Then why are most restaurant owners and world famous chefs men? If men do not mend their own clothes because they do not know how to stitch, then how is it that most tailors are men? What we assume to be 'natural' differences between men and women are actually gendered and based on economic returns. Women cook, clean and mend – mainly for the family, free of cost; but men cook, clean and tailor only when the returns are economic. Even if women are considered excellent cooks, they have no place in the food or hotel industry, where 'masculine' characteristics such as competitiveness, the ability to conduct negotiations, or undertake financial transactions on a large scale are involved. Women's lives thus revolve around the men in their families, obeying fathers or husbands and raising sons who will hopefully provide for them in old age. On their own, they do not own assets, nor will they have adequate access to resources such as education, health care or credit.

The gender roles that we instil within our children in the family are further strengthened through other institutions like education systems, the media, the market, the medical system, the systems of law, jurisprudence, state policy, and of course through religion and culture.

To provide legitimacy to these Norms, certain "social beliefs" are created. For example, men are strong and women are weak. *Sharam* is the *gahena* of women (women are naturally shy), men are brave and courageous; every woman's dream is to become mother, etc.

Through these Social beliefs, different Social Values are created for men and women, which govern our behaviour for example, a good woman always sacrifices for the family, Men should be ready to sacrifice their lives for the honour of Motherland, etc.

These social beliefs and values are strengthened through various Institutions – for example Religion. In every Religion (Hindu, Islam and Christianity) some aspects of man-woman's relationship is mentioned. Consider the example of Eve and Adam or of Vishwamitra and Menka. In both stories, the fall of men from the grace of God or Immortality is attributed to women. In every society, a social belief is that if the 'man' dies to keep the honour of his community or country, he goes straight to Heaven. Or amongst Hindu Community, if woman dies before her husband, she reaches heaven.

Through the institutions of the educational system, these Social values are further strengthened. For example, many text books of North India show girls are tying Rakhee on their brothers, propagating, the belief that men are supposed to protect their sisters as the sisters are incapable of protecting themselves (men are strong, women are weak).

Every community also develops certain symbols for men and women. For example, a married woman must either wear a *mangalsutra* or/and *put kumkum/ sindoor*. Amongst many communities in India maintaining moustache, is a symbol of masculinity (shaving off the moustache is considered as a loss of the man's honour - *mooch katwai*).

Every member of the Community / Society is expected to adhere to these norms and incorporate these Social values into their conduct. For this purpose, something called 'social control' is devised.

What is Social Control?

Social Control refers to ways in which society encourages people to conform to its norms and expectations. Through social mechanisms the community exercises its influence over its members and enforces conformity with its norms.

Social Control is also maintained through institutions such as laws; customs and culture. Social control not only ---- but also results in deep internalisation of the social values and beliefs as individual's own. Through this, society's moral demands and standards become important elements of an individual's personality. Social Control mechanisms ensure that most individuals in most situations like to do things they have to do.

The norms for conduct are different for men and women and therefore they are called Gender Norms. Based on these Norms, Gender Roles are devised.

Evaluate Your Learning

Which of the following Social Beliefs and norms are based on gender:

Social Beliefs and Norms for behaviour	Gender -Yes	Gender -No
1. Whilst eating, one shouldn't speak		
2. Girls shouldn't laugh loudly		
3. The bride's height should be less than the groom		
4. One should wash hands properly before eating		
5. Clothes used during menstruation shouldn't be dried in public		
6. Drinking lots of milk during pregnancy is a good sign		
7. Women should sit down and take a bath		
8. Most of the rape victims enjoy the rape		
9. During pre and post menopause women need extra calcium		
10. Adolescent girls should be barred from eating peanuts and jaggery (raw sugar) during menstruation		
11. When a woman says 'no', she actually means 'yes'		
12. Man's salvation lies in performing <i>Kanyadaan</i>		
13. Violence against woman is not a health issue		

For correct answers, refer page No.12

Do any of the above statements have any affect on the health of individual?

Which statement and what aspects can you relate the concept of social beliefs, gendered norms and social control to your work as a health care provider?

Bear This in Mind:

- Every community/society has a system of social beliefs and values
- Social beliefs are embedded in the socio-eco-political system of the Community / Society
- Social beliefs and values mechanism for social control
- Socialisation of an individual occurs through informal and formal learning
- Every society created institutions to maintain these social beliefs
- Many social beliefs discriminate against women
- A large number of women suffer violence due to these social beliefs
- Because of these social beliefs, women are denied many opportunities
- Our health seeking behaviour is governed by social beliefs
- These beliefs prevent women from seeking health services in time
- Large number of men and women hide the STIs/RTIs due to these Social Beliefs
- A Gender Sensitive Health Service Provider:
 1. Will not accept illness only as a physical condition
 2. Tries to understand what are the social beliefs and gender norms that govern women an men's health seeking behaviour
 3. Uses her/his position to help women and men free themselves from these beliefs through counselling

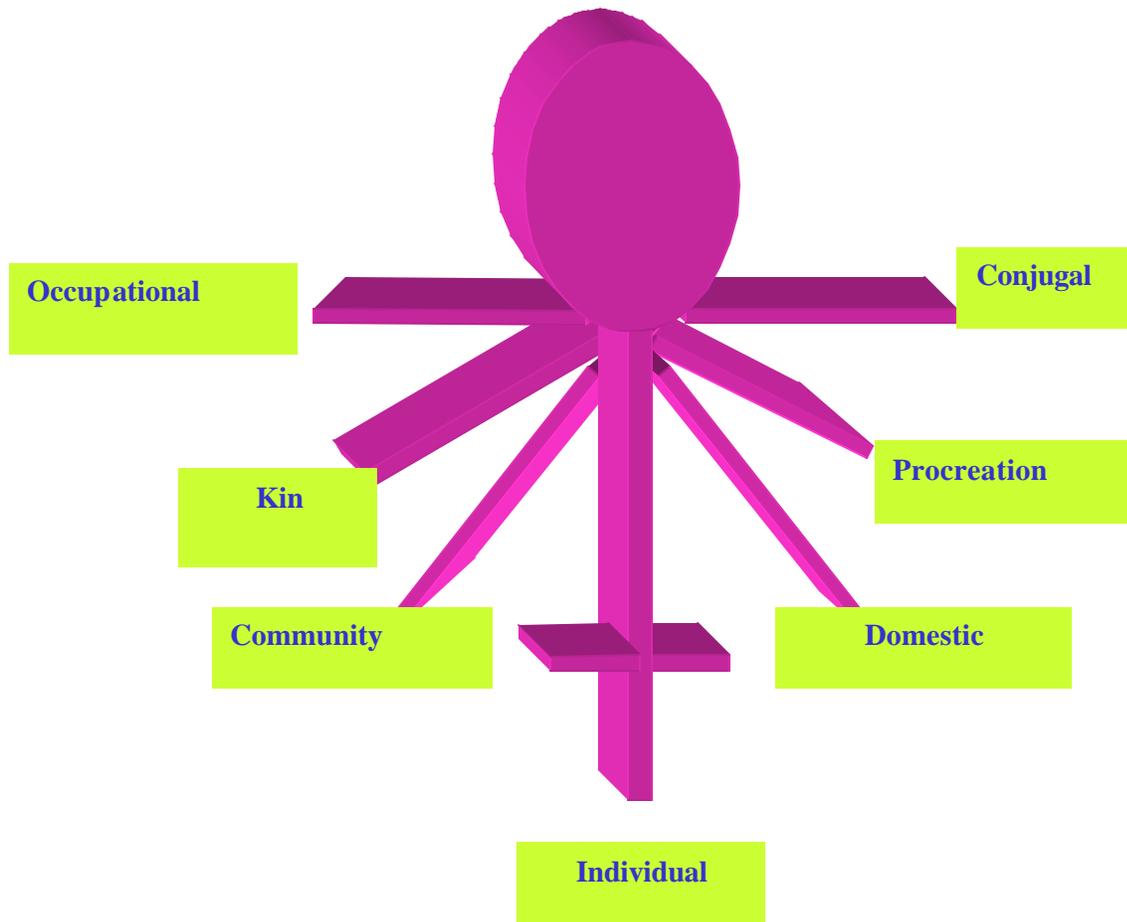
Answers to - Evaluate Your Learning

1. No
2. Yes
3. Yes
4. No
5. Yes
6. No
7. Yes
8. Yes
9. No
10. Yes
11. Yes
12. Yes
13. Yes

Section 3: Gender Roles

Based on social values and Gender Norms, different roles are prescribed for men and women. Typically in Indian Society, women's roles are as follows:

ROLES OF WOMEN



Conjugal: A woman is expected to marry within her caste / *biradari*. A woman, who doesn't do so, is considered as a 'fallen woman' and may be a victim of 'honour killing'.

Procreation: Every married woman is expected to give birth to a child especially to a male child to continue the progeny of her husband. Women who do not give birth to male child are looked down upon, in fact such women, in many communities are socially ostracized.

Domestic: A woman is the keeper of the *izaat* of the family. Her role is to maintain the honour of the family. Her life must also evolve around domestic chores i.e. she is expected to cook, wash utensils, clothes, serve the food to male members, provide nursing services to all the sick male /

elder members of the family, be good at child-care.

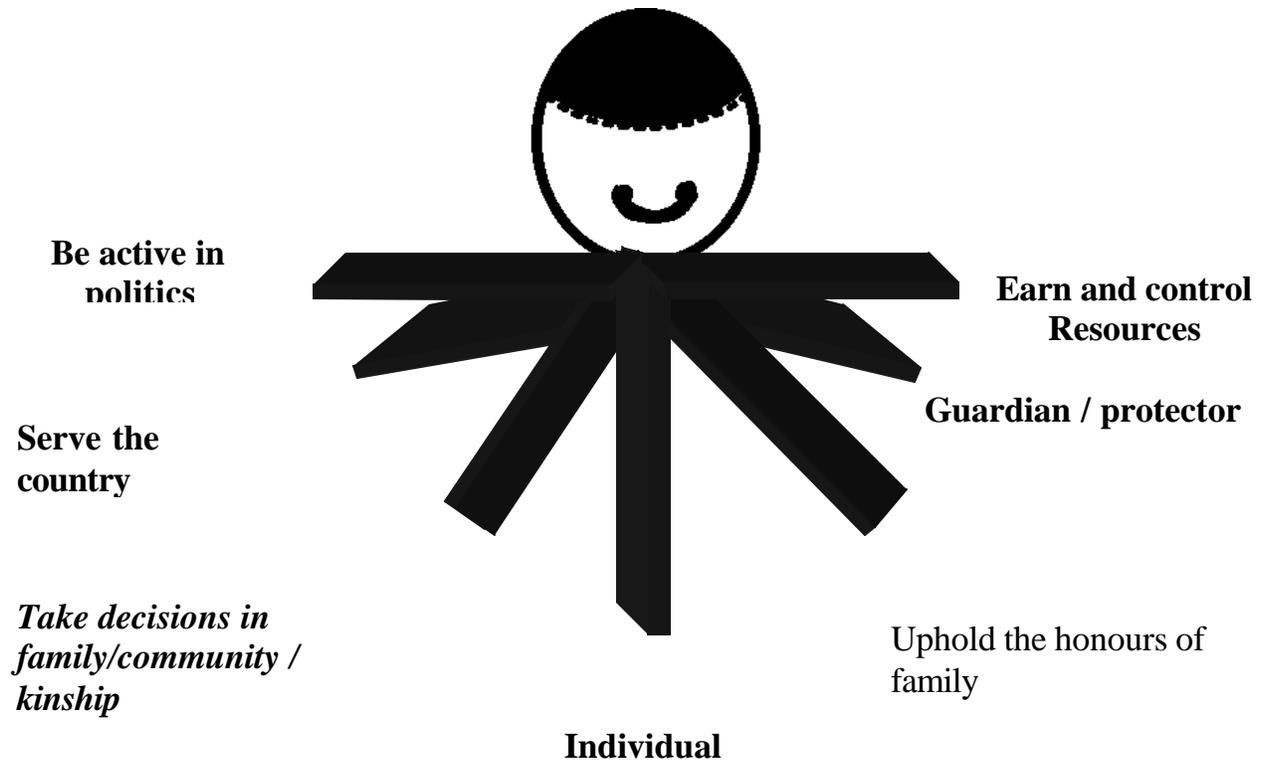
Occupational: Every woman is expected to have certain occupational skills. In an agrarian society, she is expected to have the skills to perform all the basic agricultural activities along with cattle care. In an urban middle class, she is expected to have skills to iron clothes, stitch or embroidery etc. Even if she is able to undertake commercial activities with these skills, her earnings belong to her 'husband' and parent-in-laws.

Kinship: A woman is expected to maintain relationships within her kinship. It is her responsibility to participate in all events that take place within her families; if there is a death in a family, she has to go for condolences, if there is a marriage; she is to go and provide labour.

Community: It is the responsibility of women to participate in all the events that take place within her community – in the galli-mouhalla – be it a marriage or death. Through performing these roles, women have been called as 'custodians and transmitters of culture'.

Individual: In the end if, she has with any energy left, she may do something for herself.

Roles of Men



Earn and control financial resources: Every man is expected to earn enough either through inherited property / business or has own occupation. Boys are socialised and given opportunities for becoming 'financial resource raisers' for the family. For example, a typical farmer would start training his son to use the plough whilst a typical girl child from the farming community would be trained to cut the grass, she would be taught how to plough. Male children are encouraged to undertake professional courses. Men who do not earn enough to take care of their 'family' are looked down in society. In many societies, such men are unable to get married. A man whose wife earns more than him or one who stays at his in-law's place is ridiculed in Indian society.

In a patriarchal society, men are inheritors of parental property. Opportunities are provided to men to be mobile and enhance their information and knowledge base so that they can perform this role satisfactorily.

Guardian /Protector: In a patriarchal society, men are born to head the family and therefore they are expected to be 'protector' and 'Guardians'. A man, who fails to protect his women, children and old parents, is made to feel ashamed. To undertake this role effectively boys are encouraged to build their muscle. A physically weak or delicate man is looked down upon and teased as 'feminine man'. A typical example is when an elder sister wants to meet her friends or relatives; and is chaperoned by her a little brother, who may not be even capable of holding his trousers.

Uphold the honours of

Family: Every man is brought up to uphold the honour of his family. In many societies, the practice of honour killing is based on this concept. When a woman decides to marry outside the '*biradari*', the men of the family are encouraged to undertake killing of this woman. Bollywood films of 60s and 70s depict the *Khandan ki Izzat* theme– showing how men battle to save the *Izzat* of the *Khandan* and how they are applauded by the society. Whilst women are treated as '*izzat*' of the family, its upkeep is left to 'men' and thus as keepers of '*izzat*', the men are allowed to lay norms for women such as wearing *ghunghat*, not sitting on a cot / chair before the men of the family, etc. Men acquire the 'right' to punish any one who breaks these norms in the name of '*izzat*' of the *Khandan*.

Take decisions in family / community / kinship groups: As men have a role to control resources as well as to lay down norms, they acquire the right to take decisions in all the matters pertaining to family, community and kinship groups such as *Jaat-Biradari Panchayat*, *Khaps* etc. As men have acquired more mobility, it is 'presumed' that they have more information and knowledge, which enables them to take decisions. Though women have responsibility to participate in all the events in community and in kinship groups, it is the men who take the decisions.

Serve the country : Theories of civilisation shows that, each member of a clan has been brought up with a value to make supreme sacrifices for the honour of the land under the possession of the clan. Men are taught to be ready to make such sacrifices when their 'land' is attacked and earn a place in heaven! Those who back out or join the 'attackers' go to 'hell'. When the Nation State concept was created, such values became part of construction of masculinity – bravery – to protect the 'motherland'. This was followed by the practice spending time in *akharas* to build their muscles and also having a right to more nutritious food. Women were not expected to perform the patriotic, protector role, so less nutritious food was prescribed for them. This is at the root of the current practice in many of our homes, milk for male children and *lassi (chaj)* for girl children. Male children are encouraged to participate in games, which require high mobility whilst girl children are encouraged to participate in games, which are 'domestic' ones. The result is that, male children are physically fitter than girl children. The 'protector role' is further imbibed amongst the children through the History books – tales of brave Rajas, Sultans and Kings. If a woman performs the same role, she is called '*mardani*' – the one who had performed the role of '*mard*'. Such women are few in history. On the other hand, women putting themselves on the husband' funeral pyre or jumping in the well to save their 'honour' are numerous. Through such tales masculinity and femineity are constructed.

Be active in politics: Control over Resources and freedom of mobility facilitate the role of men in 'politics'. It is expected that men be active in maintaining the political system of the society, be it democracy or dictatorship. This is the reason, why we see few women in active politics in our country and even though reservations are provided for women under 73rd Amendment to the Constitution, the decision making power in Panchayats mostly remains with men.

Evaluate Your Learning

Which of the following statements are based on GENDER and which are based on

BIOLOGY

Mark 'Yes' in appropriate columns:

Sr No.		Based on Gender Construction	Based on Biological construction
01.	Women are best suited to be nurses		
02	Women are more susceptible to STIs		
03.	Women doctors do not undertake post-mortem		
04.	There is higher mortality amongst male infants than female infants		
05	A rape victim must be medically checked by only women doctors		
06	Because women are weak, they can not plough the field		
06	Very few women students opt for surgery		
07	Women have large and strong hips, so they are best suited for tasks which require long periods of sitting on the floor		
08	Women should consume drinks with lesser alcohol content		
09	Men become aggressive of testosterone and Androgen hormones		
10	Men are linear thinkers		

Bear This in Mind

- There are biological differences amongst the men and women
- The processes of socialisation prepare male and female children to perform different Roles. The assignment of roles to men and women depends upon the notions of masculinity and femininity in the community. It has nothing to do with biology.
- Because of specific and different roles expected from men and women, enabling environment is created by providing them different opportunities to learn specific skills to perform these roles. Male child is given an opportunity to learn how to plough the field and the girl child how to cook.
- Male and female children adopt gender Roles to conform to the expectations of family members on whom they depend and later on in life they conform to expectations of peer groups to get accepted.
- Deviation from Gender Roles is treated as delinquent behaviour and is met with harsh punishment – verbal as well as in certain cases physical
- Through proverbs, folksongs and symbols, the Gender Roles are communicated to the boy and the girl child. *Every woman's dream is to become a mother, 'hathon mein churian pehenlee' (to refer to a non-violent man) or 'Bahaadur bache rote nain' (brave boys don't cry)*. Many folk songs are full of bravery of men and sacrifices of women. Listening these songs, the children learn their Gendered Roles.). Through *dress* code, body language is developed to conform to the gendered roles – women's dresses provide them lesser mobility than men's dresses.
- School textbooks also perpetuate the gender stereotypes.
- The important thing to remember here is that all these roles are constructed through the process of socialisation and thus are changeable.

Section 4: Sexual Division of Labour

Once Gender Roles and Responsibilities are prescribed by Society / community, the division of labour takes place.

As we have seen, the major role of women is in the 'domestic sphere.' She has to be trained and equipped with skills that are required to manage the 'home'. Men are expected to be 'controller of resources' therefore they need to be trained and equipped with the skills necessary for this. Greater mobility is allowed to men and their role is in the public sphere.

The process of socialisation starts building skills required for performing these tasks. For example, a girl would start looking after her younger siblings whilst a boy would go out and play with his friends.

This would provide a girl the skills required for bringing up babies whilst the boy would learn how to deal with other 'boys' and how to work in team.

Following are the typical task-charts of women and men in an agrarian society

Woman's Daily Tasks (in an agrarian family)*

- Wake up early to give fodder to cattle
- Clean the house
- Milk the cows / buffalos
- Clean the cowshed, prepare dung-cakes
- Prepare breakfast for the family
- Bring fodder for cattle from farm or from jungle
- Bath and cook afternoon meals
- Serve lunch to all family members,
- Clean the utensils
- Give food to children on return from school
- Go to the farm and do the seasonal work
- Give water and fodder to cattle
- Milk the cows / buffalos
- Prepare dinner for family
- Serve dinner to family
- Prepare beds for all
- Clean utensils
- Do 'sewa' for husband before going to sleep.

**Extracts from a woman's training program.*

Man's Daily Tasks

- Eat breakfast
- Go to the agricultural field and do seasonal work
- On return from field, bathe, have meals and have siesta
- Go back to the field and undertake seasonal work – specially undertake

List the major differences between the two sets of tasks chores given above?
Can you prepare a similar chart for yourself and your spouse?

My daily tasks
1. -----
2. -----
3. -----
4. -----
5. -----
6. -----
7. -----
8. -----
9. -----
10. -----

My spouse's daily tasks
1. -----
2. -----
3. -----
4. -----
5. -----
6. -----
7. -----
8. -----
9. -----
10. -----

Have you observed the following?

1. All the cooks in Restaurants/ Dhabas are male whilst all the cooking at home is done by women
2. Cleaning of utensils at Restaurants/Dhabas is done by men whilst the same work at home is done by women
3. Streets are cleaned by men and to a lesser extent by women whilst the home is cleaned only by women
4. Clothes in the laundry are washed by men but women wash clothes at home
5. Cattle are fed and milked by women whilst milk is sold by men

Now, can you agree to the following statement?

There are no 'natural' or unlearned skills. Skills required to perform every task are part of our learning process. The division of labour based on sex differences is essentially an economic division - All unpaid work is given to women whilst all the paid work goes to men. Work done by women has lower status than work done by men. In addition to this, the sexual division of labour also defines geographical boundaries for men and women - Women are 'assigned' with the tasks that require them to be 'home bound' or have 'limited mobility' whilst men's tasks require wider mobility without any geographical limitations.

The Sexual Division of Labour results in 'information base' of an individual. The one who is 'home bound' tends to have less access to 'information' than the one who has the freedom of mobility.

Does it have any impact on Health Seeking Behaviour of men and women?

Does it have any impact on accessing of Health Services?

What sexual division of labour do you observe within the health care system?

A story of a young doctor:

“ After returning from a Gender Sensitisation Workshop, I decided to provide a helping hand to my mother.

So next morning, when my mother washed the clothes and collected them in a bucket to take upstairs for drying, I decided to do this task. Even though my mother resisted, I carried it to the roof.

When I started hanging the clothes on the clothesline a woman from the neighbourhood saw me and asked:

‘Doctor sahib, is your mama ill?’

I said, ‘No, why?’

‘Oh good, I thought Mama is ill, so you are putting up the clothes’

I was surprised that my neighbour should ever ask me this question.”

A Woman Officer’s Testimony

I work with the Central Government whilst my husband is a State Government employee. My office timings are 9.30 to 5.30p.m. and his timings are 10.00 to 5.00p.m. We have two children.

I wake at 5.00 a.m. drink my tea, finish my toilet and bath by 5.30 a.m.

By 5.30 I am in the kitchen cooking breakfast and lunch.

By 6.30 I wake up the children, help them get ready, pack their lunch boxes, give them breakfast and put them on school bus at 8.00 a.m.

By this time, my husband wakes up; he has to be served tea. I eat my breakfast while he has his second cup of tea. I get ready, make myself presentable and catch the charter bus at 9.00

I return by 6.00 p.m.

My daughter gives me a glass of water and a cup of tea. My son returns from badminton at 6.30. He has to be given a small snack.

By 7.30 p.m. I am in the kitchen, cooking the dinner for 4 of us. My husband returns around 8.30 p.m. and goes for a bath.

We eat our dinner at about 9.00 p.m.

From 9.30 to 11.00 p.m. I help the children with their Homework whilst my husband watches television.

By 11.00 p.m. I am fast asleep, to get up at 5.00 a.m. next morning.

Evaluate your learning:

Complete the following matrix:

(Whilst filling column 3, follow the common observations)

	Tasks / Work	Performer- men/women	Health hazard
1	Cooking on a biomass chulha		
2	Washing clothes		
3	Cutting leaves for fodder		
4	Ploughing the field		
5	Collecting drinking water		
6	Carrying drinking water pots on head		
7	Collecting cattle dung		
8	Travelling in crowded public transport		
9	Weeding in the agriculture farm		
10	Spraying insecticide/pesticide		

Bear This in Mind

- Every task that is expected to be performed by us is a part of our learning and socialization processes
- Most of us are not born with 'natural' skills. We acquire them.
- Seeing a man or woman performing the same tasks from our early childhood, we develop stereotyped notions of men and women. These stereotype images are reinforced in textbooks and media.
- Children are given opportunities to acquire these skills depending upon their 'sex' and not their interests.
- Children through 'peer pressure' or through a desire to get 'group acceptance' acquire typical skills.
- Oral encouragement for performing 'sex based tasks' motivates children to undertake normative learning.
- Once we acquire expertise in certain areas, we feel 'secure' in performing these tasks. This results in not demanding 'change' in learning opportunities.

Differential Tasks and Skills –

Differential Access and Control over **Resources**

We have seen in last chapter, how we are trained to perform 'typical' tasks, which are essentially based on our biological sex and not our aptitude. Let us now find out, how the se tasks are valued differentially and whether this has any connectivity to access and control over resources.

For the survival and growth of Human Society, every human being has to perform essentially

two types of tasks – one that gives direct economic returns whilst another that gives no economic returns. For example, working in a factory shall give a fix salary, which is an economic return for the job/task one performs. Such `tasks` are called ***economic productive activity***.

On the other hand, attending a marriage ceremony is a task we need to perform, but this has no direct economic returns.

Such tasks / jobs are called `***socially productive Activity***`.

This means that, by performing these `Socially Productive Activities` we keep our society healthy and cohesive.

There may be different kinds off returns for performing `non economic tasks`. In some cases, individual get power to make decisions or their social standing is enhanced. For example sitting in a Jaat Biradaari Panchayat is a non-economic activity, but it gives `power` to individuals to take decisions or it enhances their `social standing`.

For effective performance of these activities, we need number of support activities. For example, if a person has to perform effectively as a Factory Worker, he needs to be provided food on time, clean clothes to wear and nursing if he is ill.

If a person has to perform as his duties of Pradhan of Gram Panchayat, he needs to be served food in time, keep his clothes ready, and have tea and snacks ready for visitors. If the Pradhan is to be bothered with the tasks of cooking food, cleaning utensils, washing clothes and preparing tea and snacks for the visitors, then his/her time would go on these activities and he/she shall have no time for tasks to be performed as the Pradhan.

Which are above activities are valued more and who performs which activity?

We have discussed earlier that men are trained to undertake tasks, which require `decision-making` whilst women are trained to perform support activities. Which crop to be planted is decided by men, they plough and sow seeds. But for the healthy growth of crops, weeding is required which women do. Men decide on the match for their sons and daughters while women are assigned the responsibilities to arrange food for the marriage party. This division creates different values to the tasks – decision-making activity is valued more than the support activity. And therefore all the support activities performed by women receive lesser value.

The other way of looking at the different tasks that men and women perform is **Productive and reproductive tasks**.

Men are involved in Productive tasks whilst women are involved in reproductive tasks. Conception, delivery of child and neonatal, childcare are the most essential tasks that women perform, which result in continuation of human society. But do these tasks receive same `value` as that of productive tasks men performs?

The answer to this is a big `NO`.

How much risk women take in delivering a child and how much valuable time women spent in neonatal and child care, doing so how many `opportunities` women have to loose, still the value attached to these tasks lacks the recognition they deserve.

Thus, Gender ascribes different values to the tasks performed by men and women; women's tasks are undervalued. This is part of Gender Based

Discrimination.

To sustain this discrimination, society has evolved certain `rules and regulations', which regulate access to and control over Resources.

It is also true that one whose tasks are considered `more valued' has more access to and control over Resources.

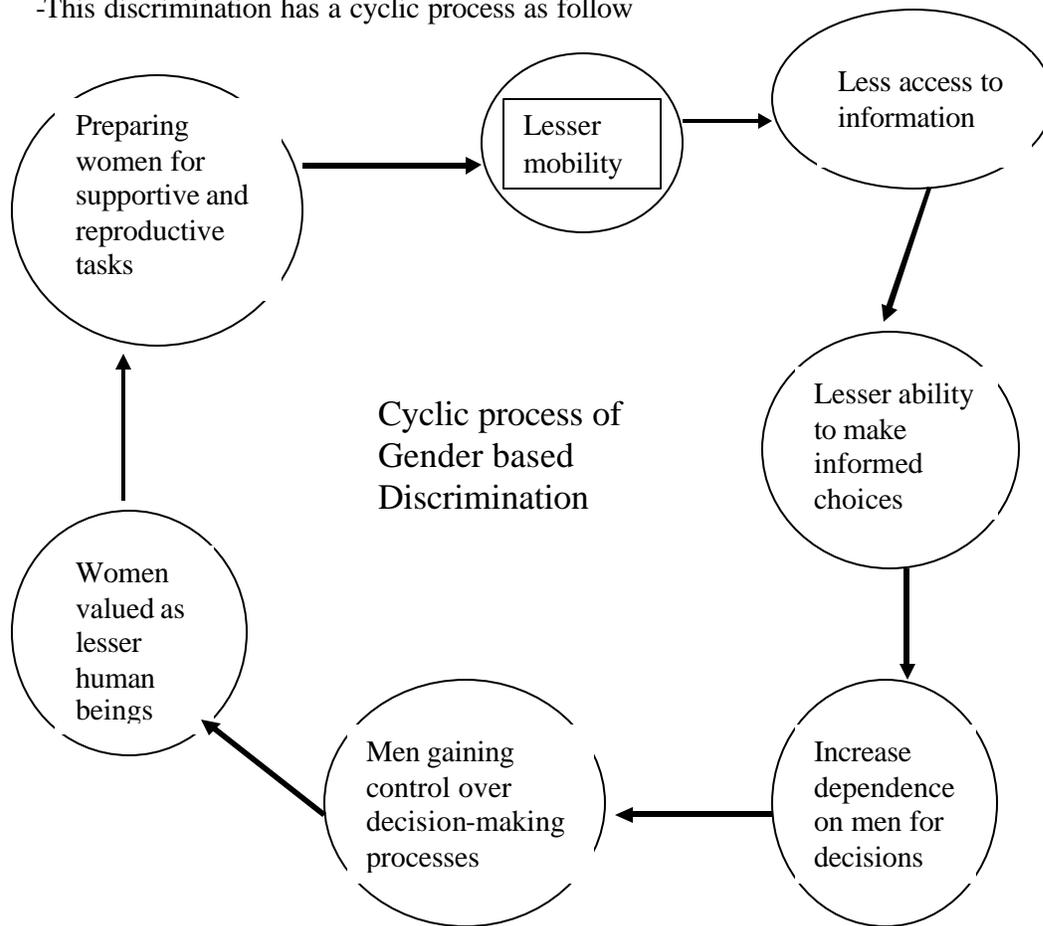
Money, land, technology, knowledge, self-esteem and time-space are the basic resources that require for leading a `healthy' life.

Do, women have access to all these resources at par with men?

Do women control these resources at par with men?

Gender based Discrimination is a discrimination based on biological sex resulting in discriminatory access to opportunities to grow as full human being.

-This discrimination has a cyclic process as follow



This process of creating Women as 'lesser human beings' has also been sanctioned by a number of religions.

Through a process of socialization, this cycle is maintained and thus, large number of women also develop a psyche that they are 'actually' lesser human beings in comparison to men. This results in women 'valuing' themselves less and thus not bothering to take care.

Even if women have access to resources, they rarely use it for their betterment and this is because of their self-perception (built through socialization) as 'lesser human beings'.

It is true that roughly 33% families survive on woman's earnings in India in addition to equal number of families where women's earnings are critical for the family's survival; and still we find large number of women anaemic (52 % women suffer with various anaemia).

Denial of access to and control over resources results in a number of discriminatory practices that become part of our life style. Thus, a small quantity of food eaten by girls is seen as 'natural' whilst the family proudly claims that boys in their family have 'milk' every day. Incomplete immunization for a girl child becomes 'normal'. Not sending girls to schools after class V becomes a part of 'culture'. Repeated abortions in search of a male child become culturally accepted normative behaviour of women.

The fact that, this process of discrimination is seen as a natural way of living is the success of

the system.

Have you noticed that large number of women working as teachers or Gram Sevikas are anaemic?

How many ANMs are anaemic?

Therefore, having access to `money` is not a guarantee that women would spend at least part of this on their own health care or nutrition needs.

But at the same time not having `control` over resources also impends large number of activities which women would like to undertake, but cannot. When user fees were charged in certain PHCs under Health Sector Reform, it was noticed by the Medical Officers that older women stopped visiting PHCs – this was simply because older women had no cash to pay for `parchi`. Large number of women who work on their husband’s small agricultural farm and take care of cattle, are reluctant to visit health care facilities simply because they do not have cash, even though, they perform substantial economic activities (in the form of agriculture work and rearing cattle).

The lack of control over Resources and denial of access to Resources puts women in a disadvantaged position.

What discriminatory Practices have you observed in your own home?

Areas	For boys/male	For girls/women
Food and Nutrition		
PNC		
Education		
Job Opportunities		
Marriages		

Can you think of instances in your work where you have noticed differential access to and control over resources affecting men and women's health?

- (a) -----

- (b) -----

- (c) -----

Bear This in Mind:

- Gender based discrimination like others, is unjust and a violation of Human Rights because our sex is the basis for discrimination.
- Money, land, technology, knowledge, self-esteem and time-space are the basic resources that require for leading a `healthy' life.
- In patriarchal system of governance, men and women have differential access to and control over these resources. Women are kept away from major economic activities
- Gender based discrimination is systemic resulting in women treating themselves as `lesser human beings'.
- Therefore they lack access to and control over resources which prevents women from becoming independent decision maker
- The discriminatory practices deny opportunities to women to develop to their full potential

Section 5: Take Decisions

As we have seen in previous chapter, in a patriarchal society, men have greater access to and control over all types of resources. Men decide how resources can be used. This gives them greater `power`.

`POWER`

What is Power? Various scholars have defined power, in various ways:

- Power is the ability to cause or prevent change (May 1972)
- Power may be defined as the production of intended effects (Russell 1938)
- Power is the ability to satisfy one's wants through the control of preferences and / or opportunities (Kuhn 1963)
- Power is when one's behaviour causes another's (Simon 1957)
- Power is processual relationship between two partners (Schemerhorn 1961)

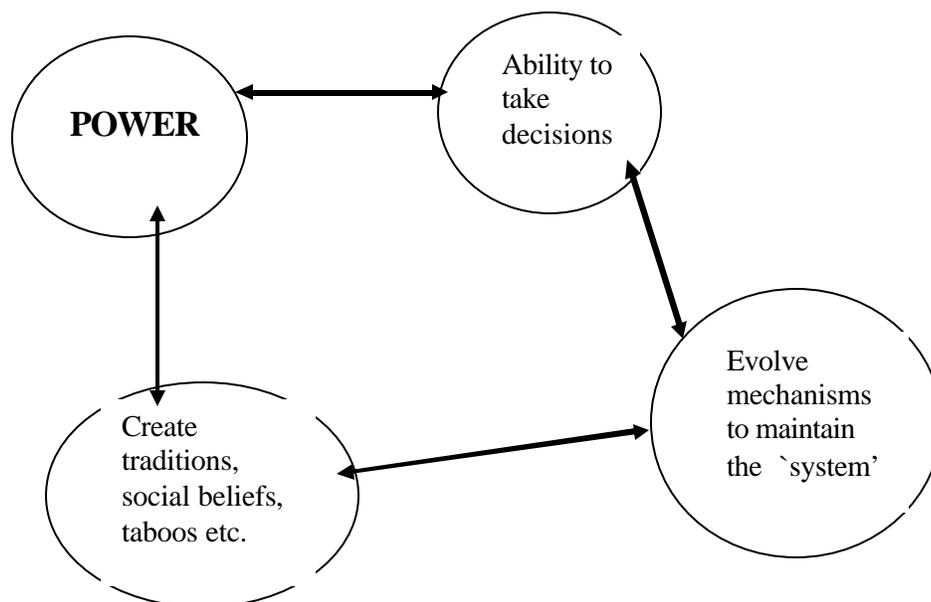
Sources of Power:

Sources of power can be singular or multiple – such as knowledge, information, economic or religious status, family lineage, etc.

But when `power` is conferred on account of `biological sex` then it is due to Gendered system.

In a patriarchal society, power is conferred to a man just because he is biologically a man.

Once the `men` got the `power` they put themselves in the `decision-making` position – they decide what changes to be brought in or what changes to be prevented, what effects to be produced, etc. etc. (You can refer to either May's or Russell's definition to understand this process.). This sets off a cyclic chain of reaction as follow:



Let us understand how this cycle works and how Gendered power Relations work

One can give numerous examples through which we can understand how 'power' bestowed upon 'men' just because they are biologically so, creates a hierarchical relationship between men and women.

Through the process of socialisation, which we have studied, this hierarchical relationship is not only maintained but also strengthened.

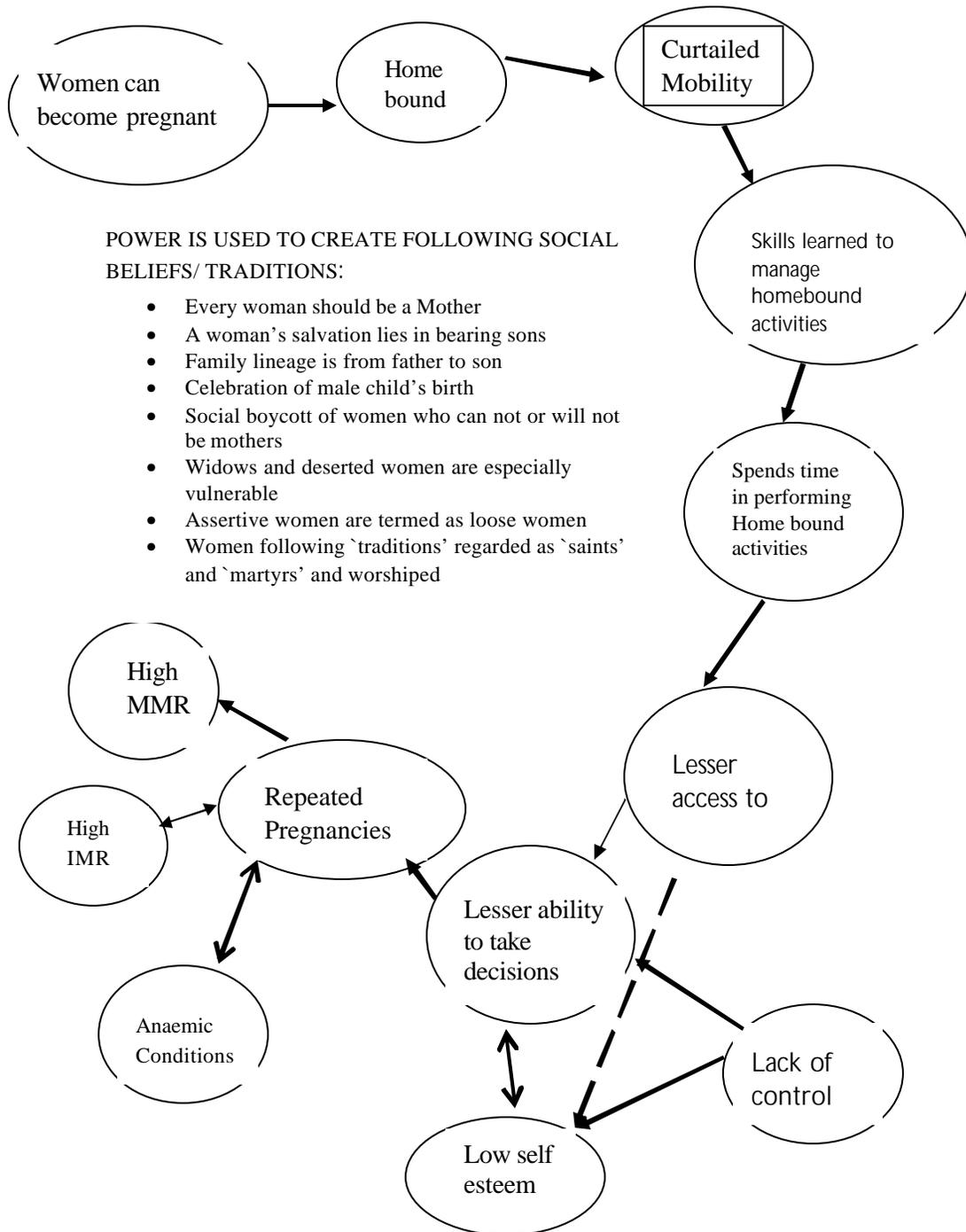
In large number of instances, men 'outsource' the task of maintaining this system to women and such women become 'celebrities' in the society, for example the whole scenario of 'sati worship' that prevails in large part of India. Take another example of this: women coming forward to 'harass' daughter-in-laws for bringing less dowry.

The hierarchical system cannot be carried on without women actually subscribing it and aiding it.

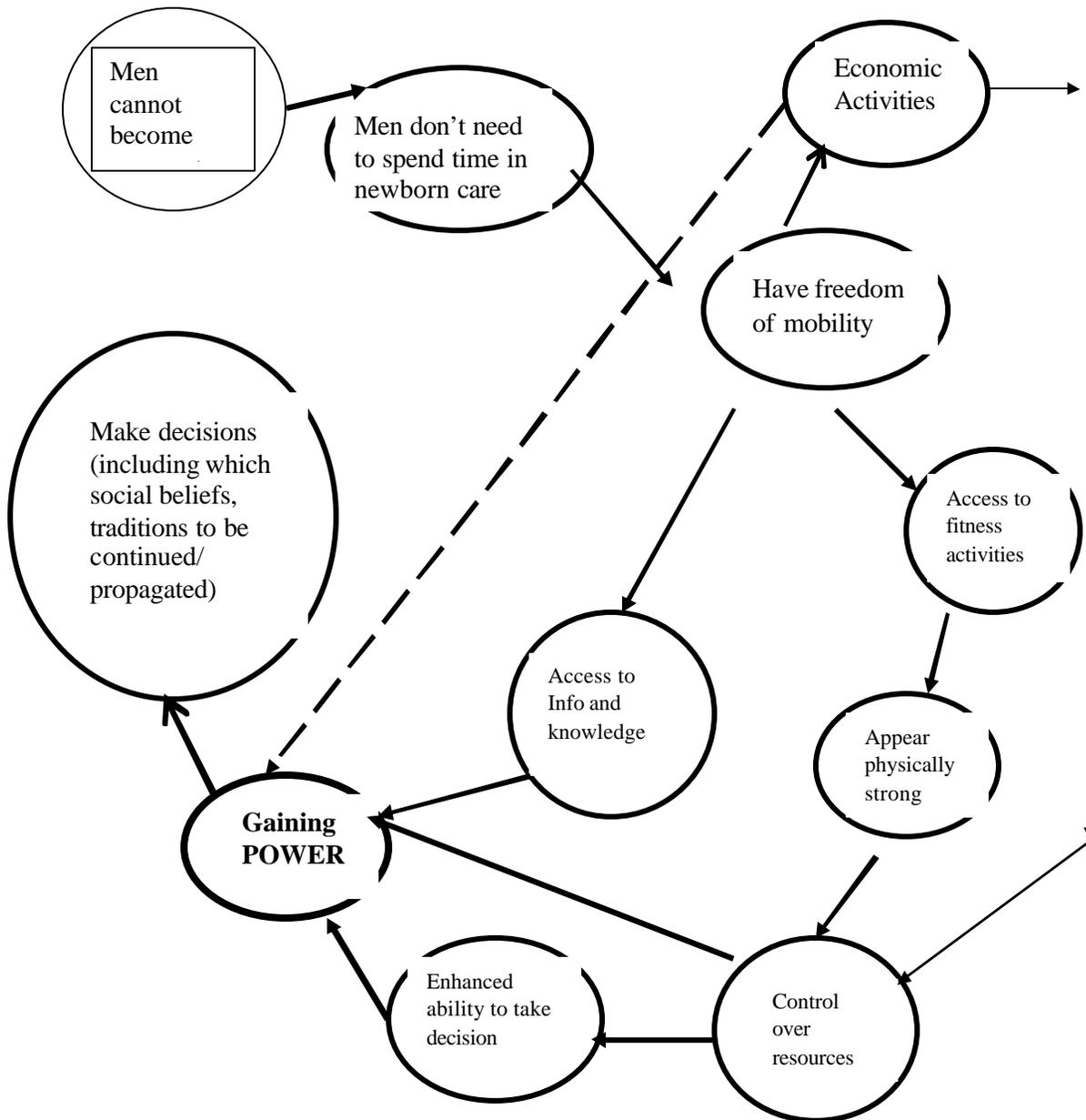
List out the Social beliefs that prevails in your professional service area and Fill up the following Table:

<i>Social beliefs</i>	<i>Impact on Health</i>

Let us understand how 'biology' is used to create following cycle for women:



Let us understand how 'biology' is used to create following cycle for men:



POWER IS USED TO CREATE FOLLOWING SOCIAL BELIEFS/ TRADITIONS:

- Men are strong, women are weak, so they need man's protection (Raksha Bandhan)
- Men are born to Protect their resources – land, village -country
- Women are instruments for continuation of family lineage
- A man's ability lies in how well he controls his wife (wife as a Resource for continuation of Family Lineage - Control Over Resource)
- A man who listens to women or the one who is homebound is a 'lesser man'*
- A man who doesn't marry off his daughter goes to hell, There is no larger Punya than Kanyadaan
- Men need to be 'served' women need to be active in 'support activities'
- A man who has girl children is a lesser man*
- A man who follows / accepts women as 'decision maker' is a fallen man*

* Notions of masculinity

POWER

Power never exists in vacuum it exists in a context.

No person can be powerless forever or visa-versa. Power is also very dynamic.

Take an example of Dalit man is powerless in the presence of a Rajput landlord, but he would not be so in front of his wife. A woman IAS officer is 'powerful' whilst dealing with her junior but she might be 'powerless' in front of her sasoor.

From the following list, underline the one who has more 'power' in relation to other

Retired father	Working son
Jethani who can not conceive	Devrani with a son
Nandand	New Bhabhi
Widowed nandand	Bhabhi
Bahu from poor maika	Bahu from rich maika
Wife of District Collector	Wife of Tahasildar
Dalit woman	Brahmin woman
Father of a bride	Father of a groom
HSP	Client
Doctor	Nurse
MPW	ANM
A dalit woman Pradhan	A Brahmin LHV

Bear This in Mind

- Power is always contextual and dynamic
- Control over resources gives `power' to make decisions
- This control over resources is gained through religion, customs and traditions by using `biology'
- To maintain this `control'; various social beliefs are created so that religious practices, customs and traditions are accepted without question
- Control over resources creates hierarchical relationships between men and women
- The success of this system lies in how well women subscribe to this, thus men `outsource' the task to maintain the system.
- Women who accept hierarchical relationships are `appreciated', and in some instances worshipped
- Men and women who question this, are treated as `deviants' and socially boycotted
- Through a process of socialisation, a psyche amongst women is created that they are `lesser human beings' and so, even though they have access to resources, they refuse to control them
- All this has great impact on health seeking behaviour of men and women

Section 6: Gender based Violence

We have already understood, how gender differences are socially constructed and the kinds of socio-economic systems that have been created to maintain the gender difference. In the following section we shall study how violence is used as a tool for maintaining the system. If anyone deviates from the roles and responsibilities assigned to her / him, violence is used to correct the individual.

For example, if the girl child refuses to learn how to cook, she is either scolded or beaten (punished) so that, next time she dare not refuse to accept the `prescribed learning`.

If an individual physically harms another individual, `law` is used to `punish` the person so that next time she/he dare not repeat her/his behaviour.

The both the examples have violence, but first one is `approved` by the society but not the second one? Why so?

There are various forms of violence that exist in society. Gender based violence is one such form. Let us try to understand what is gender-based violence.

The World Health Organisation and United Nations have defined violence as follow:

The World Health Organization defines violence as:

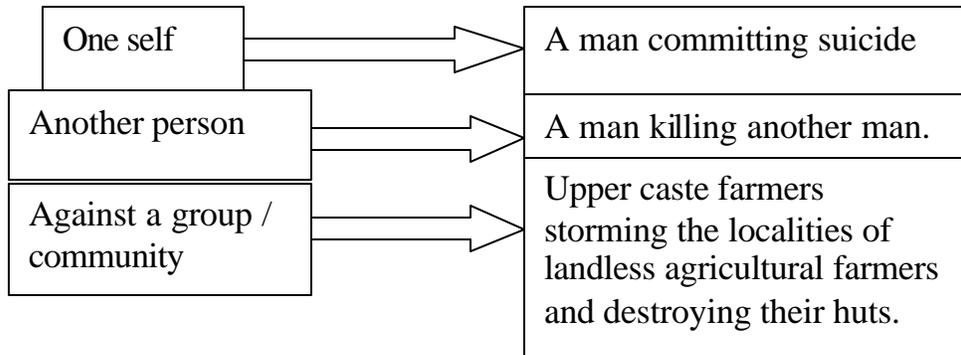
The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation (WHO 2002).

Let us try to understand what this definitions mean:

It states that violence can be against

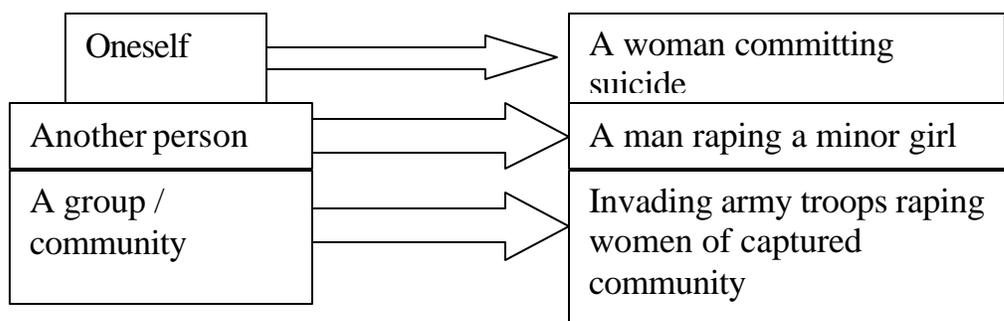
- Oneself
- Another person
- Group / community

Can we find some examples of the above?



Which of the above form of violence are gender based and why? Is each one of them, punishable under the Law of Land?

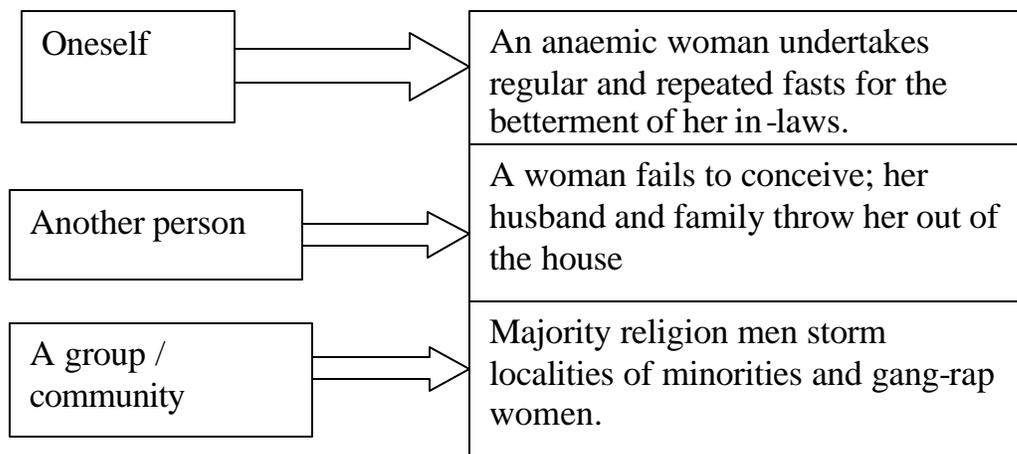
Let us take another set of Violence and see whether they are Gender Based Violence.



Are above forms of violence gender based? And if so, why? Is each one of them, punishable under the Law of Land?

Are we now, able to differentiate between other forms of violence and gender based Violence?

Let us take one more set of violence and see whether they are gender based violence



**Are above forms of violence gender based?
And if so, why? Which one is not punishable
under the Law of Land? And why?**

From the above examples, we can see that, the Society approves some forms of violence and some not. The forms of violence, which are committed so that women do not deviate from the roles and responsibilities given to them [suffer (tyag) for the betterment of in-law's family, pro-creation] are socially approved and are not punishable under the Law of the Land.

Gender based violence is not a violence where a stronger species `harms' the weaker specie.

The Gender based Violence is also not mere class or caste based violence, though it may occur in the context of class and/or caste.

Gender based violence is one that is used as a tool to make individuals follow the Rules and Regulations that Society has created for her /him. The basis of violence is not merely `biology' but also a system supported by various Social Institutions such as Religion, Marriage, etc.

In a patriarchal society, the `power' to commit such violence is usually with men, as they control resources. Therefore, men become perpetuator of violence and women become victims. In number of instances, women who acquire this `power' also become perpetrators of violence, for example, a mother-in-law harassing daughter-in-law.

There are certain forms of violence, which are non-visible such as not giving high caloric

food to girl children. Such forms of violence are called **Gender Based Discriminations**. We encounter such 'discriminations' in our day to day life, number of times, we don't even recognise them as 'discriminations'; for example, not having access to hygienic care during menstruation is one such 'discrimination' or not having complete immunization to the girl children or not feeding baby girl fully, women eating left-overs after feeding all the men and elderly persons in the family, etc. These 'discriminations' are practiced so widely that we forget to recognise them. The society may decry the 'wife beating' but not having complete nutrition for the adolescent girl is hardly decried. These Discriminations have a basis of **Biology** and become part of 'violence', which do not allow girl children to grow into a full human being.

In most cases of Gender Based Violence and Discrimination, the perpetrators are the people whom women trust most and the place where it takes is mostly 'home'.

To understand this, let us have a look at the following table (fill up the blanks)

	Form of Violence/Discrimination	Place	Perpetuators
	Age Group 0 to 12		
01.	Sex determination tests and termination of pregnancy if the foetus is of female child	Hospital	Mother, father, Health Service Providers
02.	If woman gives birth to baby girl, she is hardly given any traditional PNC such as nutritious food etc.	Home, within family	Mother-in-law, sister-in-law, husband etc.
03.	No full immunization	Family / Home	Parents
04.			
05.			
06.			
07.			
08.			
09.			
10.			
	Age Group 13 to 18/20		
01.	Discrimination during menstruation	Family, relatives	Parents
02.	Eve teasing	Home, neighbourhood, schools, streets	Brother, brother's friends, neighbours, teachers, brother-in-laws, etc.

03	Rape	Home, neighbours, school, agriculture fields etc.	Brothers, cousins, neighbours, relatives, in few cases unknown person
04			
05			
06			
07			
	Age-Group 18/20 to 40		
01.	Be in ghoghat	Home	Parent-in-laws
02	Dowry related harassments	Home	Parent-in-laws
03	Under pressure, be ready for sexual intercourse with husband	Home	Husband
04.	Husband not using contraceptives	Home	Husband
05	Repeated pregnancies	Home	Husband,
06	Physical violence during pregnancy	Home	Husband
07	Sexual passes at workplace	Workplace	Colleagues, boss
08			
09			
10			
11			
12.			
13			
14			
	40+ age Group		
01.	Physical beating by husband	Home	Husband
02	Forced sexual intercourse	Home	Husband
03	Husband getting involved with other woman	Home	Husband
04	Widowhood condemnation	Home, society	Male children,
05	Widows not getting full meals	Home	Male children, daughter-in-law

06			
07			
08			
09			
10.			

As Health Service Provider, can you locate the implications of above on the health of women, if so please fill up the following table:

	Form of Violence/Discrimination	Health Implications
	Age Group 0 to 12	
01.	Sex determination tests and termination of pregnancy if the foetus is of female child	
02.	If woman gives birth to baby girl, she is hardly given any traditional PNC such as nutritious food etc.	
03.	No full immunization	
04		
05		
06		
07		
08		
09		
10		
	Age Group 13 to 18/20	
01	Discrimination during menstruation	
02.	Eve teasing	
03	Rape	
04		
05		
06		
07		
	Age-Group 18/20 to 40	
01.	Be in ghonghat	

02	Dowry related harassments	
03	Under pressure, be ready for sexual intercourse with husband	
04.	Husband not using contraceptives	
05	Repeated pregnancies	
06	Physical violence during pregnancy	
08		
09		
10		
11		
12.		
13		
14		
	40+ age Group	
01.	Physical beating by husband	
02	Forced sexual intercourse	
03	Husband getting involved with other woman	
04	Widowhood condemnation	
05	Widows not getting full meals	
06		
07		
08		
09		
10.		

Please Bear in Mind:

- Violence in society has different bases such as class, caste, religion, race and gender
- Gender based violence cuts across the all other forms of violence, for example, a scheduled caste man may be victim of upper caste landlords, but his wife or daughter may also be victim of violence at home.
- Large scale violence against women take place across the world
- Gender based violence mainly uses `biology' as a criterion for perpetrating violence but sometime, its perpetrators are from the same sex, who derive `power' from the system. Such women subscribe to the values propagated by the patriarchy
- Gender based violence is used as a tool to `punish' the deviates; be it women or men (for example, if a man keeps helping his wife in domestic chore, is ridiculed)
- There are some aspects of violence which are accepted even by law such as marital rape
- There are some forms of the violence which are invisible, they are called Gender Based Discrimination
- These discriminations are practiced so widely that most of the time, we forget to recognise them
- Each form of violence and discrimination has health implications
- As health service providers, you must be able to locate such all forms of violence and discriminations within your own homes and work place and develop strategies to deal with them
- A healthy society is the Society which does not discriminate men and women
- Our Constitution has a goal to eliminate all forms of violence and therefore it becomes imperative for all the citizens of India to work towards achieving this goal.

Section 7: Practical Gender Needs Strategic Gender Needs

We have seen how the Gender works as a system. We have also seen how the gender-based violence is used to 'punish' the deviants. We have also understood how the gender-based discrimination becomes part and parcel of our day-to-day life. In short, we have understood that the gendered relations are basically 'power relations'. That is why women find themselves in a position of disadvantage at various levels.

As Health Service Providers, we have understood, by now that gender as a system has various health implications.

Now let us try to understand, what can be done to elevate the situation.

Let us study the following story of a 'Health Service Provider'.

Most of the people visiting my PHC were travelling 25 to 30 kilometres from nearby villages. The buses would reach around 10.00 a.m. and would return to villages around 4.00 p.m. At this PHC, the practice was to ask the patients to collect the results of the tests (urine, stool, blood etc.) the next day. This means, that the patients were forced to undertake one more travel just to collect the results.

To lessen the burden of the villagers, I discussed this with my laboratory staff and suggested that they should do the 'tests' between 11.00 a.m. and 3.00 p.m. and hand over the results to me immediately so that I can advise the patients on required course of action. This would save one visit of the villagers and the laboratory staff would be free for the remaining hours. They readily agreed.

After a few days, I noticed that men would bring the samples of urine, stool immediately and hand them over to the laboratory, but the women would handover the samples to the laboratory next day. This puzzled me a lot. I would insist that the women should bring the samples within 15 to 20 minutes but they rarely followed my instructions. I concluded that, women brainless.

In a Gender Sensitisation Workshop, I narrated my experience. The Trainers were also puzzled and then one of them asked, 'Are there clean toilets for women at the PHC?'

To be honest, I had never checked this.

On my return, I checked this and found that the toilet for women had become a storeroom. I asked the Storekeeper to empty the toilet. He refused saying, 'there is no place to keep the old furniture'.

I approached the Add. District Magistrate (ADM) and requested some funds for the construction a storeroom.

I narrated the whole story to him.

The ADM asked me to send a letter to him with a request for `toilets' as he could give funds only for toilets.

I did that and after receiving the funds, I myself supervised the construction of toilets.

Once the toilets were ready, I made sure that they are kept clean.

The result - women patients hand over their urine and stool to the Laboratory staff and the reports are given to them with advice by 4.00 p.m. on the same day.

They save one trip and a lot of hardship.

I feel that I have done a great job!

MO In-charge, PHC done a great Job by reducing a great job by reducing additional travel in crowded buses for women.

When we undertake various activities to lessen hardships for women and make their life little more comfortable, we address their `Practical Gender Needs'. As Health Service Provider, we can do a lot to address women's practical gender needs and lessen their drudgeries.

We are giving you some situations below and fill up the Action part of the Table:

Situation	Action by H. S. P. /H.S.M.
A woman is agricultural labour. She leaves her home early morning and returns late evening. She has just given birth to a baby girl. How can the HSP ensure complete immunization?	
A woman has received her first ANC. She doesn't turn up for second ANC What can the HSP do?	
A young widow turns up to Sub-Centre with pregnancy. What can the HSP do?	
An adolescent girl turns up to Sub-centre with a problem- she hasn't had her periods for last two months. What can the HSP do?	
An unmarried boy turns up and demands condoms. What should HSP do?	

With above actions, the HSP /HSM can lessen the discomforts that women face due to their

position of disadvantage. But these actions do not effect the `power relations' that prevail between men and women due to gendered relationship.

To transform `power relations' the HSP / HSM will need to develop strategies and implement them.

Let us look at the following story:

Village At the sub-centre in Boregaon Urmila was posted. She was new to the village. Over a period Urmila noticed that large number of women started approaching her with vaginal infections – bacterial as well as fungal. She knew that couple treatment was necessary. She discussed this with her Supervisor. They decided to meet the women representative of Panchayat. A discussion with Kamla (women Representative of Panchayat) resulted in a decision to start meetings of women for Health Education. It was decided that on every second Saturday, Urmila should address a women's meeting. After a few meetings, the women realised that, couples would need to be treated as well as their partners convinced to use condoms, if they had to get rid of infections. The women suggested that Urmila should address the meetings of men folk in the village. Urmila felt hesitant. Along with her Supervisor and Kamla, she approached the MO In-charge of their PHC who agreed to address the men's meeting. During the meeting, the M.O. spoke about various infections and informed the men that unless they go for couple treatment and use condoms, even after that, women would not get cured. A few men agreed. Within a fortnight, Urmila noticed there was an increased demand for condoms. The M.O. informed her that he was getting many more men for `treatme nt'. The meetings went on for about a year. During this period the demand for condom went up four to five times. Urmila organised a RCH Health Check up camp in Boregaon and to her surprise, she found the number of women with infections showed a remarkable decrease. During this year, Urmila also came across a case of bleeding during the 7th month pregnancy of a woman. She referred the case to PHC and along with other women; she met the family members of this woman. Urmila confirmed that the bleeding was an out come of beating. She reported this to her M.O. during the next monthly meeting. The M.O. spoke with the SHO and it was decided that, the SHO would participate in the meeting of the women and give them Legal Knowledge. After this meting, Kamla told Urmila that now there is practically, no wife beating in her locality. Men have started `talking' about women's direct approach to SHO. Urmila was happy.

What did Urmila do?

After understanding the problem, she decided to develop strategies to `empower' women. With the help of Panchayat Representative she organised the women, gave them `information', sought help of her superiors to add weightage to her `messages'. It took time, but then, she did not leave the task unfinished.

Through her efforts, Urmila was able to bring a change in the power relations between men and women of the village. Women who were not able to tell their `husbands' about their problems were able to `talk' with them and the `men' started listening to them and the use of condoms went up.

This is called addressing Strategic Gender Needs.

Strategic Gender Needs are those through which you try to bring change in the power relationships between men and women.

In the situations given below suggest what the HSP can do to address the Strategic Gender Needs

Situation	Action by H.S.P. /H.S.M.
The Birth Registration Record from the PHC area shows continuous decline in number of girls born over a period	
Large number of parents refuse to send their daughters to High School fearing abuse on the way	
Few men in the locality get drunk and beat their wives regularly	
An adolescent girl approaches with pregnancy – she reports that the child belongs to her teacher	

Please Bear this in Mind

- The HSP / HSM are not only service providers, through the provision of services, they can aim for bringing behavioural changes in the community
- It is important to do something, which can lessen the hardships and difficulties women face due to their position of `disadvantage' in society.
- It is also important to understand that these `actions' shall provide great relief to women
- At the same time, it is also important to understand that these `reliefs' however important, are no solutions for bringing changes in the `gendered relationships' between men and women
- To bring `changes' in the gendered relationships, the HSP /HSM must undertake process oriented work with the Community

- Gender Based Violence is very much a Health issue and solution to this is to help women get organised and `feel empowered' to deal with the perpetrators of violence.
- Creating enabling environment for women to undertake such action is a duty that has been enshrined on us by our Constitution.

Section 8: Specific Actions from Health Service Providers

(Source: Report on Mainstreaming Gender in RCH Training, NIHF, 2003)

The provision of quality health care services should promote and establish gender concerns within the community that is to be served, rather than being aimed solely towards 'Population Stabilisation'. The skills of the health service providers (HSPs) need to be enhanced to improve quality of care thereby promoting gender equality.

The health seeking behaviour of people is not governed by clinical approaches alone but also by certain value systems and beliefs that the communities have internalised for generations. As health service providers are also a product of the same cultural milieu as the communities they serve, they carry similar value systems and beliefs. Mere skill improvement does not automatically bring the attitudinal changes that translate into improved quality of health care. For this to happen, understanding of gender equity needs to be inculcated amongst health service providers through the following specific actions that can be initiated at the field level.

In the subsequent pages of this section specific actions for medical officers (MO), female health service providers/female health workers (FHW) (Staff Nurse/ANM/LHV) and male health service providers or Multi Purpose workers (MPW) have been suggested under the following headings.

1. *Management*
2. *Communication*
3. *Maternal Health*
4. *Child Health*
5. *Adolescent Health*

Specific Actions for MO (PHC)

The MO (PHC) is the professional as well as the official leader of the team. Her / his basic duty is to motivate junior colleagues to undertake gender sensitive health services as well as manage the program in a gender sensitive manner. The MO must understand that health seeking behaviour of women is governed by a gendered value system (which includes shyness, domestic life sphere, heavy workload, suffering, self-blame, son preference, and a desire to remain "sada suhagan" that is, to die before the husband and avoid becoming a widow). Gender based discriminations (GBD) and gender-based violence (GBV) always put women in a situation of powerlessness and thus, seeking of help is delayed almost always. Understanding this, s/he should never blame the woman for having brought such a situation to pass.

1. Management

a) Analysis of data:

Sex-disaggregated data needs to be maintained at the PHC level, whenever there is a possibility of being able to identify gender discrimination. Once the teams of LHV / ANM / MPWs complete the health profiles of the respective communities they are serving, s/he should help them analyse the data especially in the context of GBD and GBV in the community.

b) Teamwork within medical set-up

In team formation and team functioning, gender aspects should be considered. E.g. it must be ensured as far as possible that working team and consultative team have roughly equal number of men and women. Work distribution between MPWs and FHWs should be complementary and not duplicated. The concept of Primary Responsibility and Secondary Responsibility should be incorporated. The ANM is heavily burdened with work as compared to any other health functionary. The optimum workload for the ANM needs to be worked out. Reproductive Health is not only a woman's issue, so the working group should have men members also.

It would be useful to delineate job descriptions and reporting relationship of Para medical health service providers specially MPWs (Health Worker and Health assistant). MPWs role has not been seriously considered as having any importance in a gender sensitive RCH programme. Potential of this role for increasing men's responsibilities should be realized.

The MO should help to form a team to evolve strategies to end / minimize incidence of GBD and GBV. The MO should stress upon his team that as long as GBD and GBV exists, they would not be able to achieve meaningful development. It is important for health service providers to understand that they must target issues that create gender disparity rather than sections of communities that require family planning service. Another important role of the MO is to oversee that there is no gender disparity within the team whilst handling job responsibilities or keeping of records.

Since the MO is the manager of PHC it is his duty to see that gendered roles do not exist within the team for example, the women workers always preparing the tea and going into the field whereas the MPWs working as compounders and giving injections at the PHC. The female HSPs bear a much heavier workload as compared to the male worker, or even the MO with respect to RCH. Their contribution must be recognised.

Issues of sexual harassment within the health team also need to be addressed through a proper grievance redressal system.

c) Teamwork with community

Issues emerging from the health profile should be targeted such as less number of girl children, high IMR/CMR amongst girls, high incidences of RTIs / STIs, low self esteem that women carry, violence that they face at all stages of their lives, especially

during pregnancy and adolescence. S/he should help the community to develop appropriate knowledge to deal with beliefs and myths associated with pregnancy, ANC and PNC, sex and sexuality.

2. Communication

The MO should be able to communicate with her / his juniors to provide full feedback and encourage them to share their failures, so that strategies could be worked out to deal with the same. Subordinate staff (especially the LHVs and ANMs should not be made to feel guilty for failing) and at the same time should not be allowed to go scot-free. In the monthly meetings, it is important to create an environment conducive to sharing experiences without fear of blame and punishment. Whilst counselling (Inter Personal Communication) young couples on contraception, proper stress should be laid on men's responsibility in sexual relationships.

3. Maternal Health

a) Ante Natal Care/Post Natal Care

Junior colleagues should be helped to deal with beliefs and myths associated with pregnancy, ANC and PNC. If necessary, the matter may be taken up with community leaders, respected village elders (women and men), panchayat leaders and women representatives. The MOs can use their 'professional image' to inculcate and share modern knowledge with the community. Continuous vigil must be kept on coverage of ANC – if a certain woman who has reported during the first trimester does not report during the second or third trimesters, the matter should be immediately brought to the notice of the concerned LHV and investigated. In case of a miscarriage or abortion the cause and the mishap should be ascertained.

b) Gender Based Violence

If a pregnant woman presents with continuous bleeding, care should be taken to ascertain whether she was a victim of violence, and if so, technical, moral and legal support should be provided. Violence as a public health issue needs to be addressed at the PHC level. The First Referral Units (FRUs) need to be able to handle medico-legal cases, especially burns, suicides, homicide, poisoning and so on. This will help women in violent situations to get immediate help and justice.

4. Child Health

a) Immunisation

The Medical officer must ensure that each and every girl and boy is immunized.

b) Sexual Health

In instances of sexual abuse of girl-child the parents need to be counselled and all information regarding legal support should be provided.

c) **Community Participation**

If higher female mortality is reflected in neonatal deaths, infant mortality rate (IMR) and child mortality rate (CMR), community counselling must be undertaken. The success of the Child Health Program at PHC level is reflected by a healthy girl child sex ratio in the communities served by the PHC.

5. Adolescent Health

a) **Sexuality**

The medical officer must be open and frank with adolescents (girls and boys) regarding sex, sexuality and health without being judgmental. The aim of this information should be to develop a positive attitude towards sexuality that is free of bias, fear or homophobia and to create an environment within which adolescents make responsible choices.

b) **Sexual Health**

The medical officer should provide counselling and guidance regarding legal support in case of sexual abuse in boys and girls. If an adolescent girl seeks MTP, she should be provided services without being judgmental and without personal bias. She should also be counselled regarding contraception.

c) **Social Issues**

In case of incest, all moral support and guidance regarding legal support should be provided to the victim.

Specific Actions for Staff Nurse/ANM / LHV

Most of Staff Nurses/ANMs and LHVs are brought up in the same cultural milieu as the women of the community they serve. It has been noticed that a number of them have internalised patriarchal outlook towards life and often they are overburdened with duties and responsibilities. They are usually not in a position to negotiate with the MPWs (male colleagues) regarding sharing of workload. To achieve gender equity within the community, Staff Nurse/ANMs LHVs should be role models for women in the community, especially in terms of women's empowerment.

1. Management

a) **Teamwork within medical setup**

Women Staff Nurses/ANM/LHV should attempt to work as a team and even though difficult should try and look for ways where they can garner support from male colleagues.

b) **Teamwork with community**

Female health workers should understand and try to resolve the problems faced by women members of the team and the community. They should share the data collected through health profile of the community and sensitise women members of panchayats and the consultative team to act collectively for removing gender based discrimination (GBD) and gender based violence (GBV). They should mobilize women of the community for providing appropriate and adequate nutrition to girl children and speak out against child / early marriage practices if they exist within the community. They should at least try to make sure that *gauna* (*second marriage when the girl goes to her marital home to cohabit with husband*) does not take place unless the girl crosses the age of 18. They should undertake counselling on health and sexuality related issues for members of the community they serve.

Staff Nurse/ANM/LHV should be able to differentiate between felt needs and real needs (and rights) of the community. For example, no community would on its own express the need to arrest the practice of sex selective abortions or better nutrition to women during post delivery period after giving birth to a girl child. These are the real needs as well as basic human rights issues. The Staff Nurse/ANM/LHV should be able to address these rights as the 'felt needs' of the community. They should seek support from their male colleagues to reach-out to men in the community.

2. **Communication**

The Staff Nurse ANM / LHV should evolve strategies to communicate with women in power - at family level as well as at community level. They should have the ability to listen without being judgmental and should be able to communicate with women who are single, widowed or deserted and understand their needs.

3. **Maternal Health**

a) **Ante Natal Care**

The Staff Nurse/LHV / ANM should be aware of the family as well as the obstetric history of the woman. She should know about the order of pregnancy of the woman. If it is the second or third pregnancy, then she must know the sex of previous children. If the sex of previous children is female, then the Staff Nurse/ANM/LHV should take extra care if a second female child is delivered.

It has been noticed that a number of pregnant women who have registered do not turn up for second or third trimester for ANC and the pregnancy is missed. Secondly, if the woman had delivered a low birth weight baby during her previous pregnancies, the LHV / ANM must undertake special counselling to family members on ANC. She should understand the powerlessness of a woman pregnant with her 4th or 5th child and not blame her for producing so many children. She should mobilise male colleagues and panchayat leaders to counsel her partner.

The Staff Nurse/LHV/ANM should dispel myths associated with pregnancy, ANC and PNC (keeping in mind local beliefs and social norms). She must interact with the

community - especially with older women - and develop strategies to deal with myths and misconceptions (for example, relationship of the dark stools that may normally be passed as a result of Iron Folic Acid (IFA) intake, with the complexion of the baby in the womb. The fact is that the colour of the stool is in no way an indication of the skin colour of the baby in the womb).

The Staff Nurse/LHV/ANM should follow-up the nutritional status of pregnant women and in case of poor nutritional status, instead of blaming the woman she should contact and counsel her husband or mother-in-law or whoever is the decision maker in the family.

The occurrences of malaria and TB in pregnant women are quite common. She should seek help of MO to manage these diseases.

b) **Male/Family Participation**

The Staff Nurse/LHV/ANM should ensure that care during pregnancy should be made a family business. The family should be prepared for any emergency (especially in case of the first pregnancy)

c) **Gender Based Violence**

She should treat violence as a public health issue and seek support of her male colleague/s Yuvak Mandal and panchayat leaders to address gender based violence (GBV). Bleeding during pregnancy may be due to violence the woman has faced. Counsel, refer the woman and initiate appropriate action through male colleague or women or men panchayat leaders so that the perpetrator does not repeat the act.

d) **Contraception**

The Staff Nurse/LHV / ANM should inform women regarding the choices available and side effects of female contraception without coercing her for any specific method. She should seek help from the male colleagues to convince the 'husbands' to use male contraception. In case of complications after IUD insertion, she should take up the responsibility and refer the case to MO.

If a woman is seeking abortion - for whatever reasons within first trimester - she should be given adequate advice on after-effects of abortion without being judgmental. If a woman is seeking abortion after the first trimester, it must be ensured that it is not a sex selective abortion under family pressure. If so, male health worker, MO (PHC) and panchayat leaders may be involved to help the woman.

e) **RTIs / STIs**

The Staff Nurse LHV / ANM should seek information from male colleagues regarding men with RH problems and then counsel their sexual partner to take precautions and treatment. She should not be judgmental when a woman approaches her with an RTI / STI problem. This information should be shared with the male colleagues so that he can counsel the woman's partner. She should also attend to RH problems of widows, single and deserted women without being judgmental and always maintain confidentiality.

4. Child Health:

a) **Nutrition**

The Staff Nurse/ANM / LHV needs to be extra vigilant, if a woman has delivered a girl child. She should make sure that the mother and the girl child receive proper nutrition and care. This may require undertaking special visits to counsel the elders/decision makers within the family.

b) **Immunisation**

The Staff Nurse/ANM / LHV must make sure that all the girls and boys in the community are immunized.

c) **Male/Family/Community Participation**

If Staff Nurse/ANM/LHV finds that childhood mortality in the community reflects greater number of female deaths as compared to male deaths, she needs to alert the community and panchayat leaders, her male colleagues and MO (PHC) and seek community action to identify and address the cause. She must seek help from male colleagues and / or community members to reach out to those parents who are unable to find time for immunization of their children due to their work schedule. Instead of blaming these parents, it is important to reach out to them and understand their helplessness. She should undertake regular health check-ups for girl children and give suitable advice to parents for better nutrition and care.

5. Adolescent Health:

a) **Sexuality**

The Staff Nurse/LHV/ANM needs to be open and frank with adolescent girls regarding sex and sexuality. Their queries should not be responded to in a judgmental manner. The aim of this information is to make sure that adolescents develop a positive attitude towards sexuality that is free of bias, fear or homophobia and to create an environment within which adolescents can enter into mutually respectful relationships with the opposite sex. She should provide full and complete information regarding contraception and if asked for, provide the same while maintaining complete confidentiality. She should also make the girls aware about incest and provide them skills to deal with it successfully. If the ANM/LHV comes across any such case, she should provide moral and legal support to the girl.

b) **Sexual Health**

The Staff Nurse/LHV/ANM should provide all information about management of menstruation and hygiene that is needed during this period as well as the need for extra nutrition. She should stress upon the fact that regular menstruation is a sign of 'good health'. She should also help women to get to know about their own menstrual cycles. If an adolescent girl becomes pregnant, she should provide all the necessary medical support for MTP and maintain strict confidentiality.

c) **Social Issues**

The Staff Nurse/LHV/ANM should provide all necessary support to girls and women, if they complain about sexual harassments. She should make efforts to mobilize panchayat leaders to take necessary remedial measures. She should also understand the vulnerability of a girl from lower classes if she complains to her about sexual abuse and provide moral and legal support. She should keep continuous contacts with local health care providers, such as dais, and help them to upgrade their skills as well as educate them so that they do not undertake unsafe abortions of unmarried women / adolescent girls.

Specific Actions for Health Worker/Health Assistant MPW - (Male)

1. **Management**

a) **Team work within medical setup**

Women health service providers including female health workers (FHWs), Anganwadi workers (AWW), etc. face several problems while working in villages. Safety of women workers is an important issue, as is limitation of their mobility. Because of the relatively low status of women in society, their opinions and advice are often not taken seriously. It is the duty of the Male Health Worker, as a colleague, to ensure that female members of the team are respected, their opinion taken seriously and their bodily integrity upheld. In this sense MPWs shall function as role models for other men in the community.

b) **Teamwork with community**

Male Health Worker must understand the problems, faced by women in the community and help them to re-solve the same. He should try to organise the meetings at a time and place convenient to women members of the community. If the meetings are to be held in the evening, it must be ensured that women members of the team are not threatened nor the meeting disrupted due to anti social elements.

2. **Communication**

Male Health Worker must evolve strategies to communicate with men / groups in the power hierarchy. He should be able to 'talk' without hesitation on sexual health, sexuality and, gender equity tactfully and without hurting the sensibilities of the community. Whilst interacting with couples, male health workers must also encourage the woman to speak, without being involved only in a 'man to man' talk.

3. Maternal Health

a) Ante Natal Care/Post Natal Care

Male Health Workers (MPW) should involve men of the family in Ante Natal Care. If the woman seeking Ante Natal Care belongs to a joint / extended family the MPW should motivate and educate the head of the family / eldest man in the family (may be the father in law of the woman) about care to be taken during this period, importance of checks-ups and need for transport at time of delivery. He should counsel the 'husbands' to avoid sexual intercourse for 6 weeks following delivery and seek feedback from ANM regarding the health status of pregnant women in the community. He should counsel the husband or head of the woman's family (Father-in-law /Mother-in-law of woman) regarding nutrition, and providing proper rest during Ante Natal period.

b) MTP

If the couple is seeking abortion due to unwanted pregnancy, the Male Health Worker (MPW) should counsel the husband about safe abortion and use of contraception to prevent such pregnancies in the future.

c) Contraception

The Male Health Worker (MPW) should influence men of the community regarding usage of condoms and also emphasise the use of a new condom during each sexual intercourse to avoid contraceptive failure.

d) RTI / STIs

If a member of the community seeks advice from the Male Health Worker (MPW) regarding RH problems, he should counsel without being judgmental and also ensure confidentiality for the client. He should provide this feedback to his counterpart woman colleague, so that she can interact with the female sexual partner and advise accordingly. He should seek feedback from female colleagues about women seeking advice on RTIs / STIs and take responsibility to interact with their male partners in a confidential manner without being judgmental. It is advisable to reveal the source of this information to avoid interpersonal complications.

e) Gender Based Violence

The Male Health Worker (MPW) should address cases of GBV by mobilising community responses and / or by tactfully interacting with the perpetrator.

4. Child Health

a) Nutrition

The information collected on differential nutritional status of girls and boys should be shared with the male members of the panchayat

b) Immunization:

The Male Health Worker (MPW) should make special efforts to reach out to families who have girl children and encourage and ensure complete immunization of all children in the family. If the parents of young children are not available at home, they should be approached and encouraged to get their children immunised at the work site. Male health workers should constantly interact and hold discussions with fathers, leaders of the Panchayats, and Yuvak Mandals regarding differential rates of immunization (that may be obtained from the records) amongst the male and female children and inspire and motivate them to achieve 100% immunization in the community.

c) Male Participation

The Male Health Worker (MPW) should educate and advice fathers regarding care of children.

5. Adolescent Health

a) Sexuality and Health

The Male Health Worker (MPW) should hold sessions with adolescent boys (school going and/or dropouts) and interact with them regarding sexual health and responsible and caring masculinity. He should dispel misconceptions regarding masturbation and develop interpersonal relationships to unearth sexual abuse of male children. If such cases are encountered he should provide counselling and if necessary, legal action and support.

b) Social Issues

The Male Health Worker (MPW) should involve adolescent boys in promoting proper formal education for girls within their community / family, removal of sexual division of labour, sexual division of availability of nutritional food within the family, etc. He needs to be a role model for adolescent boys of the community.