GHEN News

Issue 5: January 2007

INTRODUCTION

In this fifth issue of *GHEN News* we report on the activities of the Gender and Health Equity Network over the last year, and highlight progress towards some important project milestones. We also outline our plans for 2007, the final year of the project, during which our primary focus will be on documenting and disseminating project activities so far.

UPDATE ON PROJECT ACTIVITIES

In this section we focus on some exciting developments - and challenges - faced by the GHEN India and China project teams. We look at the development of Neighbourhood Groups, a promising mechanism for strengthening accountability relationships between communities and health providers in the project sites in Koppal District, India. We also look at the challenges of extending women's voice and improving accountability on health issues in the context of poor rural China.

Strengthening Accountability for Gender and Health Equity – The Role of Neighbourhood Groups in Koppal, India

Over the last four years, the India Gender and Health Equity project has evolved considerably by responding flexibly to the needs and challenges on the ground. Starting with a broad approach to gender and health, the project has, over time, focused down on the specifics of maternal health, attempted to gather and use information in inclusive ways, and evolved new strategies and processes, including a campaign of 'zero tolerance for maternal and neonatal death'.

The project's main implementation partner, Mahila Samakhya Karnataka (MSK), a Government of India sponsored women's empowerment programme, has been working on issues of women's empowerment for 17 years. Its key strategy to date has been to form village level collectives (*Sanghas*) of low caste (*dalit*) women who are empowered to seek the public services to which they are entitled. In line with gender and health equity project objectives, MSK has adapted its approach to include a focus on whole communities and on government.

There is a tendency within the development community to use participatory approaches as a technical fix. However, these approaches are not always suitable or appropriate in every context. In the India project, a micro-planning approach was used initially as a mechanism for engaging with communities on gender issues. However, it became clear early on in the

process that communities, Village Health Committees (VHCs) and health providers lacked a shared vision that would enable effective dialogue. A further challenge was that the VHCs were dominated by men, and it proved difficult to get gender issues on the agenda in a context where there was a tendency to side-line women's health issues. The response of the project was to 'down-grade' the importance of VHCs, and to focus on creating and supporting institutions that would prove to be a better way of bringing providers and communities together.

The new approach, based on a model used by UNICEF in Karnataka, focused on the creation of Neighbourhood Groups or *Oni Gumpu.* The aim was to engage the entire community. Female representatives from each of 20 households were encouraged to become members of an *Oni Gumpu*. Each group selects a convenor who is invited to attend capacity building sessions provided by MSK, and they are expected to share their knowledge and skills with the rest of the group. Each project village currently has approximately 20-25 active groups.

Oni Gumpu not only act as sources of collective information, but also as catalysts for awareness building. Information is gathered during neighbourhood group meetings on pregnant women, women requiring ante-natal or post-natal care services, high-risk pregnancies, and women requiring immunisations. This information forms the basis of an accountability mechanism linking communities to health providers. Monthly meetings between the staff of primary health care centres and community level health workers provide a feedback system that links communities to providers. The combination of an improved evidence base, plus investment in building stronger community-provider relationships, has enabled some villages to strengthen the links of front-line health staff to communities.

Because of the progress made at community level, there are some positive signs that communities feel more accountable for maternal health and that the local District Health Office is becoming more responsive to gender and health equity needs. For instance, the schedules of health providers working at the lowest level of the health system - Auxiliary Nurse Midwives - have been re-organised to ensure better coverage of villages and to improve the regularity of visits. However, maintaining this level of responsiveness in a context of frequent staff transfers within the district administration is an on-going challenge. Research by the GHEN project team has played a key role in catalysing activities and awareness, ranging from baseline surveys of households and health providers, to on-going assessments, and verbal autopsies of maternal deaths.

Challenges of Developing Women's Voice and Accountability For Better Health in Poor, Rural China

The China GHEN project aims to find ways to increase women's participation in the health planning process, and, in turn, increase accountability to women's health needs. However, the current implementation context is very challenging. Health planning is not sensitive to women's needs at every level of the health system, and little formal accountability exists between health providers and communities. In terms of representation, there are no independent NGOs or mechanisms for civil society participation in rural China, which can provide a channel for voice in relation to government.[1]

Although the Women's Federation is supposed to represent women's interests, in practice it is a top-down, party-led institution, and officers have tightly defined remits, which do not

[1] In contrast urban China is experiencing a significant increase in NGO activity, although efforts to establish mechanisms for civic participation have to go through government, at least initially.

always resonate with local priorities. A survey undertaken by the China GHEN case study team, for instance, looked at women's participation in elections of village Women's Federation cadres. Overall, participation was very low; slightly less than 42% of women never participated, 23% sometimes did, and just over 35% did every time. Because they are subsidised by township governments, Village Committees also lack independence.

Issues of voice, accountability and governance are not currently being addressed in other health sector reform initiatives in rural China, However, there is space for examining these issues in the rural China context. The China project team planned to establish Gender and Governance Groups as a mechanism for increasing women's participation in health planning, and for increasing accountability between providers, policy makers and users of health services in its implementation sites. Membership of the Groups were to comprise women's legitimate representatives (elected by local women), a Women's Federation Representative, Township Health Bureau official, vice Mayor in charge of health, and township health providers. The groups were intended to allow equal participation by their members with incentive funds provided to be used by the groups to deliver services identified by local communities as important for addressing gender disparities in health status and access. Gender and health training tailored to the needs of local officials and Women's Federation cadre has been provided. Instead, the groups have become health promotion groups, addressing a critical need in health services at the community. Local women from demonstration households are educating their neighbours and interfacing with local government and the health system to represent women's needs. While not operating as planned, this is a realistic first step towards greater community involvement in the health planning process.

Considering the difficult implementation context, the actual implementation of the Gender and Governance Groups has been flexible, with necessary changes made in response to experience on the ground, especially the constraints posed by the top down government bureaucratic system and traditions of hierarchical governance. This flexibility is a key characteristic of action research methodologies. The challenge for the China team and its partners has been to find a voice and accountability model that is culturally understandable, technically appropriate and politically viable in the context of poor rural China.

OTHER NETWORK ACTIVITIES

Dissemination Conference, Stockholm, October 2006

A GHEN dissemination conference on *New Findings on Gender and Health Equity in Resource Poor Settings* took place in Stockholm on 6 October 2006. Hosted and funded by *Sida*, the conference was organised around three key questions:

- How can we ensure that gender is on the agenda in resource poor environments?
- What are the tools and approaches for empowering poor people and front-line health providers?
- How can we create a sustainable institutional framework for gender and health equity?

This, the first formal dissemination event held by the GHEN network, was attended by approximately one hundred policy makers, researchers and practitioners. The event took place after a three-day technical advisory meeting of the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health (CSDH) and therefore benefited from the insights gained at that meeting and the inputs of Knowledge Network members (see last page of this newsletter for information on the Women and Gender Equity Knowledge Network).

The Stockholm conference report is available on the GHEN website at www.ids.ac.uk/ghen.

PRIORITIES FOR 2007

Implementation of the three GHEN action research projects will continue throughout 2007. Over the next 12 months emphasis will also be placed on documenting implementation experience so far, and disseminating key lessons learned from the four year action research project to policy makers, practitioners and researchers nationally, regionally and internationally.

Publications

Several publications are in preparation and will be available in the coming months. The current phase of writing will produce a GHEN Working Paper series, with papers based on the country-specific experiences of the three GHEN action research projects. A Gender and Health Equity Policy Briefs series is also planned, with the first set of briefs scheduled to be available in the second half of 2007.

Dissemination

Over the next 12 months, regular updates on publications and upcoming dissemination events will be sent to all those on the *GHEN News* electronic mailing list. Please also refer to the GHEN website for up-to-date news on resources and dissemination events (www.ids.ac.uk/ghen).

NEWS ON OTHER GENDER AND HEALTH EQUITY INITIATIVES

Women and Gender Equity Knowledge Network (WGEKN) Update

The Women and Gender Equity Knowledge Network (WGEKN) of the WHO Commission on Social Determinants of Health analyses and evaluates evidence on the robustness of the associations between gender and health/health equity across different country contexts. It focuses on developing recommendations about the mechanisms, processes and actions that can be taken to reduce gender-based inequities in health. Two meetings have been held, the first in Bangalore, India in April 2006 and the second in Stockholm, Sweden in October 2006. A third meeting is planned to take place in Cairo, Egypt in March 2007. The purpose of the first meeting was to discuss the overall framework, objectives and work plan of the WGEKN, and to move the work forward towards an innovative and solid report that will identify effective policies and mechanisms for their implementation. A critical outcome was the identification 10 research synthesis papers:

1. Intersectionality in Health and Health Care: A Review of Research and Policy (Gita Sen, Piroska Östlin and Aditi Iyer)
2. Gender, Health and Social Justice in Domains of Political Marginalization (Rosalind Petchesky, Ali Miller and Miguel Nunoz)
3. Strategies and Interventions for Changing Gendered Norms at the Community and Household Levels *(*Helen Keleher and Lucinda Franklin)
4. HIV/AIDS and the politics and gendered responses to the crisis (Adrienne Germain)
5. Sex, Gender and Vulnerability: The Gendered Nature of Health Policies (Rachel Snow)
6. Gender and Human Resources for Health (Asha George)

7. Gender Biases and Discrimination: A review of Health Care Interpersonal Interactions (Veloshnee Govender and Loveday Penn-Kekana)
8. Accountability to Citizens on Gender and Health (Ranjani Murthy)
9. Health, Gender and Poverty in Latin America (Karina Batthyany and Sonia Correa)
10. Women's Health Policies and Programmes and Gender Mainstreaming in Health Policies, Programmes and Within the Health Sector (TK Sundari Ravindran and Aarti-Kelkar Khambete)

The purpose of the second meeting was to discuss the draft outlines of commissioned papers, to provide feedback to authors and discuss the further progression of the commissioned papers. The purpose of the third meeting will be to discuss the WGEKN draft final report, including recommendations to the Commissioners.

The most important next steps for the network after finalizing its report will be the production of a *Special Issue of the Journal of Global Public Health* which will include the articles commissioned by the WGEKN and organizing in collaboration with the City of Vienna and the WHO EURO Office a high-level conference in April 2008 in Vienna, where the Final Report of the WGEKN will be launched together with the special issue of the journal.

For more information on the Knowledge Network on Women and Gender Equity contact Piroska Östlin on piroska.ostlin@ki.se or Gita Sen on gita@iimb.ernet.in.

INTRODUCTION TO GHEN

GHEN is an international partnership of individuals and institutions committed to demonstrating through applied research the case for taking gender equity issues into account in health policy and programming. A first phase of network activities resulted in production of state-of-the-art literature reviews of gender issues in a number of technical areas of health. The current phase of network activity is focusing on the implementation of action research projects in Mozambique, India and China. The projects will contribute towards strengthening the evidence base on gender inequalities in health and on the relationship between gender, poverty and health in contexts where very little documented case study material exists.

GHEN OBJECTIVES

- To improve policy implementation with respect to gender and health equity in contexts of high or persisting poverty and inequality
- To enable communities, and particularly poor women and adolescents, to exercise their rights to good health.

By:

- Strengthening capacity among country partners to work with poor communities and service providers on gender and health equity concerns;
- Improving knowledge of gender-related inequalities in health needs and access to services;
- Increasing community health awareness and access to health services;
- Improving the institutional capacity of the health sector to respond to community health needs, particularly of poor women and adolescents;
- Increasing the accountability of sectors within a public health perspective to GE concerns;
- Using action research: working with people to identify problems and needs, develop and test solutions and evaluate their impact.

NETWORK PARTNERS AND FUNDING

Network partners for the action research case studies are:
China: Foreign Loan Office of the Ministry of Health; Yunnan Reproductive Health Research Association; Kennedy School of Government and Department of Social Medicine of HMS, Harvard University; Heller School of Social Policy and Management, Brandeis University. China team members are: Liu Yunguo, Fang Jing, and Joan Kaufman.
India: Indian Institute of Management, Bangalore; Mahila Samakhya, Karnataka; Department of Health and Family Welfare, Karnataka. India team members are: Gita Sen, Asha George, Aditi Iyer, Suchithra Vedanth, Somashekar Hawaldar, Veloshnee Govendar, Priya Patel, Geetha Rani, Vinalini Mathrani, Anasuya Sengupta.
Mozambique: The Ministry of Health (MISAU); The Prime Minister's Office; Gender Institute for Democracy Leadership and Development (GEDLIDE). The Mozambique team member is: Francelina Pinto Romão.
Sweden: National Institute of Public Health (NIPH); Karolinska Institute, Department of Public Health Sciences (IHCAR)

The following organisations have generously funded GHEN activities:
The Ford, Rockefeller and MacArthur Foundations, the Swedish International Development Cooperation Agency (Sida), and the International Development Research Centre (IDRC). Support has also come from the Global Forum for Health Research and the World Health Organization.

CONTACTING US

Network Co-ordination is provided by the Institute of Development Studies, University of Sussex, UK. GHEN's Technical Co-ordinator is Hilary Standing. Email h.standing@ids.ac.uk. Contact details for the individual case study teams can be found on the GHEN website at www.ids.ac.uk/ghen