Report of the

NATIONAL MEETING ON MATERNAL HEALTH AND SAFE ABORTION

(Emphasis on Madhya Pradesh, Chhattisgarh and Vidarbha Region)

CommonHealth[1]: Coalition for Maternal-Neonatal Health and Safe Abortion

In Partnership with

Society for Community Health Awareness Research and Action

(SOCHARA), Bhopal

20- 21 August 2015, Bhopal

This two-day national meeting was inaugurated by Shri Faiz Ahmed Kidwai, MD, NHM Madhya Pradesh. At the outset, Dr. Sharad Iyengar introduced the work of CommonHealth to the audience. Subsequently, information about the fellowship programme of Centre for Public Health and Equity (CPHE), SOCHARA was shared.

On 20th morning, the first session of the meeting focused on the maternal health and safe abortion situation in the local region (Chhattisgarh, Madhya Pradesh, Vidharbha region of Maharashtra). The presentations focused on the broader context of the state including health, various key health indicators, the maternal health situation in the state, the safe abortion scenario especially focusing on availability and access to safe abortion services and also the critical issues emerging that can be taken up for action and advocacy.

Session I- Maternal health in the region- Madhya Pradesh, Chhattisgarh, Maharashtra

Chair person- Dr. Leela Visaria

The session began with the presentations about the status of maternal health in MP. First presentation was by Mr. Ajay Lal, who represented Maternal Health Rights Campaign -(MHRC), Madhya Pradesh. Maternal Health Rights Campaign (MHRC) is a state level autonomous network in the state of Madhya Pradesh (MP). With Centre for Health and Justice (CHSJ) as the key anchor, different groups and Civil Society Organisations (CSOs) of 22 districts of MP are an integral part of this network. Community Based Monitoring (CBM) on maternal health services is being carried out in all these 22 districts under MHRC besides other advocacy initiatives. Total 56 organisations are part of MHRC. The coalition works with disadvantaged/ underprivileged groups and also works for increasing male involvement.

[1] CommonHealth is a project of Action Research & Training for Health (ARTH)

The key findings that emerged from the CBM of maternal health services in 18 districts are as follows-

Only 70 % ANCs are registered in first trimester, whereas 4% ANCs are not registered at all. 95% pregnant women had received TT injection, weight checking was done in 53% ANCs, Hb levels were checked in 78% cases whereas BP was checked in 40% cases. Abdominal examination was done only in 36% and IFA tablets were given in 45% cases. Overall only 9% got full ANC, 2.3 % received no ANC and 88.3% received incomplete ANC. Under JSSK, 83% women availed the service of ambulance to go to hospital. 78% women had received the cash benefit of 1400 rupees under JSSK. 30% complained that they had to pay bribe to receive the cash benefits.

Ajay also shared the initiative in Siddhi and Morena where attempt is done to increase male involvement. Ajay shared that there were three rounds of monitoring, followed by jan samwaad. There was improvement in service delivery after jan samwaad. Similarly PHC monitoring was done which had resulted in improvements in PHC. Ajay also shared about the MHRC news letter. Ajay mentioned that regarding work on safe abortion issues, support from CommonHealth would be required.

Second presentation was about the status of maternal health services by Mr. Govardhan Yadav, who shared work of Prayas, Rajasthan. Govardhanji began his presentation by narrating a case of maternal death. In this case, the woman was residing in a village inside forest. At the time of delivery she was referred several times and finally she was admitted in DH, where the staff again sent her off saying that there is still time for delivery. No vehicle was provided to the woman. Finally she delivered at the main bus stand. She was accompanied by ASHA who took her back to DH. The discharge card notes that the Hb of this woman was 5 gms/dl. After few days when Prayas staff went to investigate the denial of health services, the ANM said that she heard that the woman died, ASHA had reported maternal death but the ANM had not even visited the house. Govardhanji shared that in Jhabua district total 25 maternal deaths were recorded by Prayas, out of which 9 were not reported as maternal deaths. This highlights the gross underreporting of maternal deaths. Lack of PNC was another major issue. He said that the ASHA's role has been limited to taking the pregnant woman to hospital for institutional delivery. He pointed out that the role of dai has been completely ignored.

Presentations about the status of maternal health care situation in Chhattisgarh

First presentation about Chhattisgarh was by Ms. Sharayu Shinde. At the outset, Sharayu briefly spoke about Jan Swasthya Sahyog's work in Bilaspur, Chhattisgarh. Subsequently, Sharayu shared indicators pertaining to women's health situation in Chhattisgarh. Indicators related to the nutritional status depict the prevalence of malnutrition among women as well as men in Chhattisgarh. Sharayu then mentioned about the customs such as choori pehnana and tonhi

which affect women's health. In Chhattisgarh, mostly abortions are conducted by quacks. Legal MTP services are available only at district hospital. In the year 2013, total 77 maternal deaths were recorded, out of them 58 had taken place in Bilaspur and 19 had taken place in Mungeli. Out of these77 deaths, 57 were reviewed using MDR tool. Out of these 57 deaths, 37 women were less than 30 years. Almost 60% deaths had happened in post natal period and around one third had taken place in antenatal period. Sharayu also drew attention of the audience towards the fact that since Baiga is PVTG, women from Baiga tribe are not able to avail the tubal ligation. Another important issue raised was unnecessary hysterectomies under RSBY scheme in Chhattisgarh. Sharayu also spoke about the tribal customs such as after the delivery, mother is not given food for a long time. In terms of access to health care services, it was shared that according to DLHS 3 only 13% pregnant women had received full ANC and the rate of institutional delivery was as low as 18 %.

In the end, Sharayu listed few issues which need urgent attention in the context of Chhattisgarh, such as availability of blood, under-reporting of deaths, problems related to public transport system and such.

After Sharayu, Sanjeeta Gawri presented about the status of maternal health care in Chhattisgarh.

Key points emerging from her presentation are as follows-

About Chhattisgarh-

Total population of Chhattisgarh is around 25.5 Million. One-third of Chhattisgarh population is of tribes, 98% is rural. 60% of its area falls under V^{th} Schedule (of Constitution) which guarantees special provision for protection of Adivasis. 73% of Adivasis live in Schedule area. 44% land cover under Forest, which is 12% of Indian forest. 48% population BPL in Chhattisgarh (Rangrajan committee report, 2014)

80% pop depends on agriculture & allied activities (collection of NTFP etc.) for livelihood. These contribute 40% to the state GDP, while mining contributes just 7.5%. 76% of farmers own less than 2 hectares of land. Only 7.4% of total irrigated land is in Adivasi dominated districts. CG is a mining hotspot contributing to country's share - 17% of coal reserves, 16% of iron ore & 12% of dolomite. The state also produces country's 20% of steel, 15% of cement, 30% of aluminum & 100% of tin. CG shares 13% to the national wealth generated by minerals. Currently mining activities have captured 75,000 ha of forest.

Yet, the access of basic amenities is very poor for the population in Chhattisgarh, cooking gas is still inaccessible to 90% pop. (Eco survey, CG), bringing pressure on fuelwood and 3/4th population doesn't have access to sanitation facilities. (Eco survey, CG)

Some of the health indicators of Chhattisgarh are as follows-

Maternal Mortality Ratio (MMR): 230 per 100,000 live births

Fertility Rate: 3.1

Institutional Deliveries: Less than 50%
Anemia among Women: 56%
Malnutrition: 45% children under three years of age have stunted growth, a reflection of chronic under-nutrition. One-fifth of children (18%) are wasted, indicating acute under-nutrition and 52% are underweight.
Malaria Endemic: The region accounts for 13% of malaria cases, second highest in the country.

State specific problems
No provision of state transport services.
Presence of large informal private sector
Displacement due to dams, wild life, mining and biosphere reserves

There are five PVTGs (Pahari Korwa, Baiga, Birhor, Kamar and Abhujmaria) in Chhattisgarh. 1979 order of undivided MP restricts (Baiga, Pahari Korwa, Birhor, Kamar, Abhujmaria) to be targeted under sterilization. Women who want to plan family are forced to lie their identity. They have to take permission either from BDO/CMO/DC

After Chhattisgarh, there was a presentation regarding Maternal Health in the region of Vidharbha (Maharashtra) by Dr. Satish Gogulwar.
Some of the key points from his presentation are as follows-
Dr. Gogulwar represents the organization Amhi Amchya Arogyasathi (AAA), which is working in Chandrapur & Gadchiroli district for improvement of Maternal & child Health. In Armori & Kurkheda block of Gadchiroli District, AAA is working under community based monitoring part of NHM. In Chamorshi & Ettapalli block of Gadchiroli & Ballarshah block of Chandrapur District AAA working with CSR (Ballarpur Paper Industries) for improvement of Maternal & Child Health.
Dr. Gogulwar presented the following cases of maternal death from Vidarbha region-

Case No. 1:-
Name :- Nilima Gedam Age :- 21 years (first pregnancy)
At post:- Bhamani Ta- Ballarshah Dist- Chandrapur
Delivery date:-21-4-2015
Death :- 24-4-2015 (Hospital)
Neonatal death after delivery
- Only one ANC checkup.
- HB & BP not tested.
- Urine & sugar test not done.
- At sub center Bhamani she did not received Iron –folic acid tablet.

Causes during pregnancy & delivery & postnatal
- HB below 10 gram.
- Swelling on the body.
- Fits during delivery.
- Fever 5 days before delivery.

• Delivered Normal delivery in Medical college, Nagpur

Case No. 2 :-
Name :- Dipali Shedmake
Age :- 19 years first pregnancy
At post:- Visapur Ta- Ballarshah Dist- Chandrapur
LMP—22-4-2014 Delivery date:- 3-4-2015
EDD—29-4-2015 Death :- 5-4-2015 (Hospital)
Child saved
• Only one ANC checkup.
• No regular checkup of HB & B.P, Urine.
• She did not receive Iron –folic acid tablet regularly.
Causes during pregnancy & delivery & postnatal
• Low HB.
• Normal delivery in Govt.district Hospital Yavatmal.
• Heavy bleeding 2 days after delivery.
• Negligence from Doctor.

Dr. Gogulwar talked about the Maternal Death Review system in Gadchiroli District, which is as follows-
1. Any death of women with the age of 15 years to 49 years is informed by Asha/ANM/ AW/ Village leader or any person inform within 24 hrs by phone to the Taluka Health officer (THO).
2. If death of women happens at home, Health centre or during referral, Form- 6 will be filled. Then THO will decide that death is maternal death or not.
3. Within 3 weeks of maternal death, three member team (ANM as one member) discusses with her family members, neighbors and prepare a report.
4. THO sends this information in format to district Nodal officer within 4 weeks.
5. Every month at district level, review is taken about maternal deaths. If it is not maternal death they must convey their relatives. If case is Maternal death then that case is discussed in details, mainly for causes and actions required to prevent these causes.
6. Report of MDR at district level will be sent to state Nodal Officers.

In year 2014 AAA organized two block level workshops with district nodal agency people for ANM/ ASHA/ AW and AAA staff about maternal death review process. He said that regular Community based monitoring is necessary to improve public Health system.
After these presentations, the floor was opened for discussion. Some of the comments from the floor were as follows-

Subhasri asked about the high levels of malnutrition in Chhattisgarh despite universal PDS. Subhash raised questions about exclusion of TBAs, despite the documented evidence regarding their tradition knowledge about natural contraception or resuscitation of blue babies (Jeeva project). He said that since they are not part of target, they are ignored. Similar to Subhasri, Subhash also pointed out that in Chhattisgarh, same political parties win despite poor status of

development. Satish reiterated the poor child indicators in PVTGs. He shared the experience of AAA, where working with dais/ arogyasathis had reduced NMR and IMR. He emphasized the need to integrate neonatal component in SBA training.

Sharayu responded to Subhasri's question about poor nutritional status despite universal PDS saying that in reality PDS doesn't work well on ground, grains are not enough for large families. PDS is not given during monsoon. She also mentioned that open storage of grains is an issue, and the diet is mainly rice based lacking adequate proteins. She informed the group that JSS has tried to train TBAs for conducting safe deliveries at home or in referral centers. Sanjeeta also supported the issues regarding inadequacy of PDS saying that food habits of tribal populations do not match with PDS and population dependent on PDS.

Regarding the role of TBAs, Sharad said that there is a need to separate out the issue of maternal deaths and TBAs. He shared that the TBA training/ midwife should be able to identify women with complications and refer. TBA makes the woman feel comfortable. Gynecologists and anesthetist are not available in remote areas, therefore we need EMoC by trained midwives.

Priya mentioned about the 2012 PVTG's sterilization related planning commission's order. Renu said that considering the depressing health status of women in Chhattisgarh, there is a need to look at longitudinal trends, however, Sharayu mentioned that they could not find enough data. Need to document and learn from good practices of TBAs as well as developing protocols for integrated practice was articulated. Manjiri also raised the question that whether institutional deliveries are actually safe. She said that TBAs have knowledge and training and thus we need to discuss about their role in safe delivery. Syed also corroborated that in Ujjain women approach *dais* first and the *dai* accompanies women.

Regarding the nutritional aspects, Satish mentioned that polished rice is given in PDS, which has low nutritional value than hand pound rice. Satish shared the experience of AAA of using hand pound rice plus pulses in two anaganwadi centres, which had improved nutritional status of the children. He also said that traditional food items such as Mahua and millets have high nutritional value, and these were earlier included in the diet of tribals which has now changed due to PDS.

Subhash also pointed out that Ajay's presentation reveals that it is important to work with elected bodies.

Session II- Challenges in Accessing Safe Abortion Services

This session was chaired by Dr. Suchitra Dalvie.

At the outset, Dr. Suchitra set the tone of the session by providing brief information about the context regarding safe Abortion in India. Some of the key points from her presentation are as follows-

Suchitra began her presentation by stating categorically that abortion is not a right of women in India, in fact IPC 1860 states that,

> 'Whoever voluntarily causes a woman with child to miscarry, shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.'

Today women can avail abortion under Medical Termination of Pregnancy Act 1971. This Act allows the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto. The Act clarifies who can provide, where and for what reasons. It allows termination of pregnancy up to 20 weeks gestation.

However, despite the MTP act, access to safe abortion services and continuing deaths and morbidity from unsafe abortion is a public health problem as well as a rights and social justice issue.

Suchitra said that women should be aware that safe abortion is legal, they should get information about when to seek and where to seek abortion and should get appropriate referrals. Medical and Surgical Abortion should be available in the public health sector with post abortion contraception. Standardized regimen and protocol should be used for MTP. MTP should be available at subsidized costs in private sector. Women should have access to free and non coercive contraception. The providers should be trained and sensitized.

But in reality, women lack the information about legal status of MTP. There is lot of stigma and shame around abortion. There is lack of MTP services in public sector— they are not budgeted, not available, not acceptable. The private sector services are expensive and exploitative, there are increasing denials for fear of PCPNDT implementation. The services available are poor quality services. For e.g. D&C method is still used for conducting MTP. There are no standard regimens used, no pain relief, inadequate information and referrals for emergency care, post abortion contraception.

Suchitra emphasized that it is important to see safe abortion as one component of a spectrum of women's issues. Subsequently, Suchitra also pointed out that sex selection is one of the discriminatory practices and thus she said that we need to talk about dowry, child marriages,

violence against women, access to education, employment, paid maternity leave, equal inheritance of property, political representation, gender sensitive programmes and budgeting among other issues of empowerment.

She concluded by saying that in the current environment, we need to create common ground between the discourse on women's right to safe abortion and the discourse on prevention of sex selection.

After the introductory presentation, Dr. Sharad Iyengar presented the situation regarding access to safe abortion services in the public sector. Key points emerging from his presentation are as follows-

Dr. Sharad began his presentation by saying that most of safe abortion happens outside public sector, which is seen in Rajasthan as well as in other states. He said that the number of abortions have gone down. One of the reasons is there is underreporting of cases. Secondly, there are more number of medical abortions which may not be getting reported. Another discrepancy pointed out by Dr. Sharad was that medical colleges in Rajasthan did not report MTPs using form 2 though they were reporting MTPs in MIS.

Estimates of Abortion incidence

- 636,306 abortions in 2012-13 (MOHFW, Health & FW statistics for India, 2013)

Gross underestimate, excludes all abortions:

  - Provided by certified providers but unreported
  - Provided by uncertified physicians
  - MA drugs dispensed OTC by pharmacists
  - By informal providers

- 6.4 million abortions (national estimates- Abortion assessment project, 2002)
- 75 and 45 abortions / 1000 women (state level studies- AAP-I, 2002)

Dr. Sharad also shared data regarding trends in MTPs reported by Government as well as private facilities. Most of the registered facilities are in private sector. It is necessary that the CHC level facilities are equipped to provide MTP services. It is important that access to safe abortion services is seen as entitlement in public sector. Now there are more providers who have received training for MTP. More facilities providing MTP services are in urban areas than rural areas.

He said that Medical Abortion pills are a revolutionary change. Almost 9 to 10 million mifepristone tablets are sold each year. Almost one third of these tablets are distributed by the pharmacists. Data reveals that up to 6 weeks of pregnancy, almost 78% of abortions were done using MA pills.

Factors Influencing MA enunciated by Dr. Sharad are as follows-

- Does not require hospitalization
- Very Effective
- Non Surgical
- Easy Availability of Service
- Provides Confidence
- Friends/Relatives suggestion
- Confidentiality

Dr. Sharad then cited the study on Medical abortion through pharmacists in Madhya Pradesh (Powell-Jackson, Timothy; Acharya, Rajib; Filippi, Veronique; et al. PLOS ONE) The study reveals that medical abortion was offered to undercover patients by 256 (71.3%) pharmacists. 69% of pharmacists stated that abortion was illegal in India. 39% pharmacists asked clients the timing of LMP. 14 % requested to see a doctor's prescription. 22 % correctly advised patients on the gestational limit for MA. 35% provided correct information on how many and when to take the tablets in a combination pack. 28.4% gave accurate advice on where to seek care in case of complications. However, advice on post-abortion family planning was almost nonexistent.

Recounting barriers to safe, legal, medical abortion in the government sector, Sharad listed the following barriers-

- Legal – the focus on specialist or specially trained doctors
- Cost – opportunity costs, direct costs
- Service delivery related:
    - Method of abortion offered - Govt. providers prefer to offer surgical methods through their institutions, and medical abortion through their home private practice; are skeptical about free MA drugs

- Confidentiality, privacy,
- Consent for MA and for post MA contraception
- Multiple clinic visits

Subsequently, Dr. Sharad shared the findings of the Randomised control trial: Self assessment vs routine follow up after medical abortion. Objectives of this study were assessment of the **efficacy** of home assessment as compared to the routine clinic follow up and evaluating women's **experiences and acceptability** of home assessment after MA as compared to clinic follow up.

Regarding the role of community health workers in providing safe abortion services, Dr. Sharad cited the study, 'How well can Community Health Workers (like ASHAs) assess eligibility and follow up care for early medical abortion? *A multi-country study*'. In India, the assessment of the eligibility for MA pills by the health workers was 84% accurate, when compared with the eligibility assessed by the doctors.

Important conclusions of the study were that-

- Even minimally trained CHWs with basic middle school education can use simple checklists, gestational age wheel and assess women's eligibility to a reasonable extent
- CHWs have a potential to play an effective role in timely referrals to 'appropriate' health providers:
    - Identifying women with unwanted pregnancy
    - Confirming pregnancy & counseling
    - Assess eligibility for MA and guide to safe facilities
    - If not eligible for MA, then guide to surgical abortion facilities
    - Reduce the need for follow-up

Current role of ASHAs in helping women to access abortion is limited as women with unwanted pregnancy have apprehensions about contacting ASHAs. ASHAs are not adequately trained to play role in facilitating safe abortion. Appropriate training & unbiased counseling by ASHAs could improve women's access to safe abortion.

Sharad pointed out that beyond service provision, role of government is also in enabling safe abortion access in India.

For providing an enabling legal environment, it is necessary that the Government clarifies the intersection between PC-PNDT and MTP Acts as well as between MTP Act and Drugs & Cosmetics Act, POCSO, etc. Government needs to invest in quality improvement. There should be adequate budgetary allocations for provision of abortion services which also includes monitoring the quality of these services.

Dr. Sharad concluded his presentation by enlisting the challenges for setting an Indian agenda on safe abortion. These are as follows-

There is considerable awareness of the need to ensure safe abortion access, with governments at central and state levels, some of it driven by a population control agenda

There also are latent + active anti-abortion groups in the country, exercising social, religious and political clout

The organized effort to preserve and expand safe abortion access is driven by:

Government / NHM interventions

Market dynamics – drug procurement, packaging, marketing (including social marketing)

Foreign funded interventions through multinational NGOs (more) and Indian NGOs (less) or a combination of the two

In the current scenario, the safe abortion agenda is rather vulnerable to political opposition and derailment.

After the challenges in public sector, Anand Pawar talked about the challenges in accessing safe abortion services in private sector. Anand said that this presentation is specific to Maharashtra. The background of the study was that Samyak was working in small towns, during their work, they realized that women are not getting SA services. It was also felt that the NGOs not talking to each other on these issues. In this situation, Samyak considered it necessary to dialogue with private doctors on the issue of access to safe abortion.

Key points from this presentation are as follows-

Private sector providers are the primary source of health care for the majority of households in urban (70%) as well as rural areas (63%). (National Family Health Survey (NFHS) III, this is largely unregulated sector, doctors harbor pro-life and patriarchal attitudes and thus it is necessary to research this sector. Subsequently, Anand mentioned about the challenges faced in working with private sector providers. The doctors have knowledge of MTP Act and PCPNDT act but often they confuse that the PCPNDT does not mention anything abortion. The doctors are fearful about the stringent implementation of PCPNDT Act. Several doctors also report about

the corruption and harassment by Appropriate Authorities of PCPNDT Act. The doctors say that the information given by the patients is false which creates difficulties for the provider. Regarding the knowledge and views on the MTP Act, he mentioned that the doctors had received information on the MTP Act during undergraduate and post-graduate curriculum; however they did not have adequate knowledge of the history and origins of the MTP Act. One respondent with 20 years' practice mistakenly believed the MTP Act had been "converted into the PCPNDT Act in 1994". It was found that the doctors were compromising with confidentiality of patients due to strict monitoring environment and pressure from the government authorities. It was observed that under PcPNDT Act, due to fear of authorities, there were several irrational behaviors and extra-legal procedures. Associations of private providers had taken collective decisions to not to provide abortion services under ANY circumstances, some doctors were asking patients to seek permission from the president of the association or *Taluka Arogya Adhikari* (Block Health Officer). The cost of abortion was increased by the doctors as they perceived risk with providing abortion service. Some of the doctors were referring cases to public facility despite of having registered MTP centre – adding to efforts, costs, delays for women – rejection by public hospital – unsafe abortion.

Doctors say that they face difficulties and challenges while following recording guidelines as different procedures are expected by different Appropriate Authorities. It is seen that the Appropriate Authorities do not have adequate knowledge of about PcPNDT and MTP Acts. Doctors also question the utility of the data collected through form F under PcPNDT Act. Another important problem in implementation of PCPNDT act is that the Appropriate Authorities lack medical knowledge, sometimes they also treat doctors disrespectfully. There is lack of efficient communication channels between AAs and private providers which adds to the confusion on this issue. Even the doctors among their groups share inaccurate information regarding rules and procedures.

Another important hurdle in provision of safe abortion services is the patriarchal attitudes of private practitioners. Anand shared the following quote-

"Two months are complete. Why are you doing this now? It is a sin to kill your child in the womb. In our religion we do not even kill an ant and you want to kill your child? Abortion is a big sin. If you don't want a child you should have thought of it earlier. I will not commit this sin."

Anand also shared following opinions expressed in a meeting with private providers-

Government should compel every couple to have at least one girl child. If a couple has first boy child then for the next pregnancy government should ask the couple to go for sex determination and if it is a female fetus then they should be allowed to continue with

pregnancy. But if it is a male fetus it should be aborted. This is how we could maintain the balance in sex ratio.

Sex determination should be done for every pregnancy and then the government should track those who are having female fetus and what they do next.

To conclude the presentation, Anand said that there is growing inaccessibility of safe abortion services, especially during second trimester, which is linked with the private medical practitioners' fear regarding PCPNDT Authorities. Doctors denying abortion services to keep themselves "safe" – collective decisions are being made to deny abortion services. Confidentiality is taking back seat. There is a need that the PCPNDT authorities should deal with the providers sensitively. There is also an urgent need to train private medical practitioners about Gender, the MTP and PCPNDT Acts to emphasise that they are very distinct in content and address two completely different elements.

Comments from the floor-

Surabhi asked whether the medical abortion is reinforcing the stigma around abortion.

Nilangi raised the issues related to commercial interests of doctors in denying abortion. Since MTP is not a very lucrative service, there is a possibility that doctors find it easier to stop performing MTPs and focus on other services which yield more money.

Regarding implementation of PCPNDT, it was pointed out that instead of monitoring USG clinics, women who undergo MTP are being tracked. Because those women who go for sex determination using ultrasound, who are told that the fetus is male go home happily and are not caught, though they too have violated the PCPNDT act. Hence, it is important to monitor USG centers and not hamper access to MTP services under this act. It was also pointed out that the sex selection is one of the issues of gender discrimination ensuing from patriarchal system, hence merely chasing technology will not be enough to counter patriarchy.

Privacy with MA pills- MA pills avoid exposure to health facility, we have to give information about the privacy with medical abortion pills

Doctors said that everybody knows who is doing sex selection, but they have political protection

Subhash- there are malpractices in private sector that need to be accepted, technically legally there is no connection between MTP and PCPNDT. Case in Himachal Pradesh- women from far off areas and all with pregnancy less than 10 weeks coming to MTP in a particular centre raises doubts. He shared about the study on families who accepted terminal methods- 10 years from HP, sample size 1,20,000. Small family norm is reason for sex selection. In the study, 25%

families- no girl child, 36% families- one girl, one boy, there were merely 0.2 % who had only girl child.

Medha- regarding link between SA services and JSSK, Medha informed that GOI sees SA as management of pregnancy complications under JSSK. States say that it is not explicit so we will not go overboard in some states, vacuum aspiration kit etc bought under JSSK

It was pointed out that the Doctors say that under PCPNDT, there is criminal offence for doctors and not the family. Within civil society, there are camps of people who work on PCPNDT and MTP actually women's health activists should look at both these issues in balanced way and keep women's rights at centre stage

It was emphasized that the term *stree-bhrun hatya* shouldn't be used as it poses abortion as killing the fetus. PCPNDT only talks about sex determination and not about sex selective abortions, only sex determination is illegal and we need to be careful about language

After these two presentations about access to safe abortion services in public and private sector, there was presentation by Ragini Pant about Beti Bachao Beti Padhao campaign.

About Beti Bachao Beti Padhao campaign (http://vikaspedia.in/social-welfare/women-and-child-development/girl-child-welfare/beti-bachao-beti-padhao)

This campaign has been launched to address the issue of declining sex ratio. Overall goal of the campaign is to celebrate the girl child & enable her education.

Objectives of the BBBP campaign are to

- Prevent gender biased sex selective elimination
- Ensure survival & protection of the girl child
- Ensure education of the girl child

Strategies

Implement a sustained Social Mobilization and Communication Campaign to create equal value for the girl child & promote her education.
Place the issue of decline in CSR/SRB in public discourse, improvement of which would be a indicator for good governance.
Focus on Gender Critical Districts and Cities low on CSR for intensive & integrated action.
Mobilize & Train Panchayati Raj Institutions/Urban local bodies/ Grassroot workers as catalysts for social change, in partnership with local community/women's/youth groups.
Ensure service delivery structures/schemes & programmes are sufficiently responsive to issues of gender and children's rights.
Enable Inter-sectoral and inter-institutional convergence at District/Block/Grassroot levels.

Components

Mass Communication Campaign on Beti Bachao-Beti Padhao

The programme is initiated with the launch of ***"Beti Bachao, Beti Padhao",*** a nation-wide campaign to increase awareness on celebrating the Girl Child & enabling her education. The campaign is aimed at ensuring girls are born, nurtured and educated without discrimination to become empowered citizens of this country with equal rights. The Campaign interlinks National, State and District level interventions with community level action in 100 districts, bringing together different stakeholders for accelerated impact.

Multi-Sectoral interventions in 100 Gender Critical Districts covering all States/UTs low on CSR

Project Implementation

The Ministry of Women and Child Development is responsible for budgetary control and administration of the scheme from the Centre. At the State level, the Secretary, Department of Women and Child Development will be responsible for overall direction and implementation of the scheme. The Structure of the proposed Scheme is as follows:

At the National level

A National Task Force for ***Beti Bachao, Beti Padhao*** headed by Secretary, WCD with representation from concerned ministries namely Ministry of Health & Family Welfare, Ministry of Human Resource Development, National Legal Services Authority, Department of Disability Affairs and Ministry of Information & Broadcasting; Gender Experts and Civil Society representatives. The Task Force will provide guidance and support; finalize training content; review state plans and monitor effective implementation.

At the State level

The States shall form a State Task Force (STF) with representation of concerned Departments (Health & Family Welfare; Education; Panchayati Raj/ Rural Development) including State Level Services Authority and Department of Disability Affairs for ***Beti Bachao, Beti Padhao*** to coordinate the implementation of the Scheme. As the issue requires convergence & coordination between Departments, the Task Force would be headed by the Chief Secretary. In UTs the Task Force would be headed by Administrator, UT Administration. Some States/UTs have their own mechanism at the State/UT level for Women's Empowerment, Gender and Child related issues which may be considered and/or strengthened as State/UT Task Force. Principal Secretary, WCD/Social Welfare will be the convener of this body. Department of Women & Child Development will have the responsibility of coordinating all the activities related to implementation of the Plan in the State/UTs through the Directorate of ICDS.

At the District level

A District Task Force (DTF) led by the District Collector/Deputy Commissioner with representation of concerned departments (Health & Family Welfare; Appropriate Authority (PC&PNDT); Education; Panchayati Raj/ Rural Development, Police) including District legal Services Authority (DLSA) will be responsible for effective implementation, monitoring & supervision of the District Action Plan. Technical support and guidance for the implementation of Action Plan in the district would be provided by District Programme Officer (DPO) in the District ICDS Office for formulation of District Action Plan using the Block level Action Plans. A Gender expert/CSO member may also be included in the task force.

At the Block level

A Block level Committee is to be set up under the Chairpersonship of the Sub Divisional Magistrate/Sub Divisional Officer/Block Development Officer (as may be decided by the concerned State Governments) to provide support in effective implementation, monitoring & supervision of the Block Action Plan.

At the Gram Panchayat/Ward level

The respective Panchayat Samiti/Ward Samiti (as may be decided by concerned State Governments) having jurisdiction over the concerned Gram Panchayat/Ward would be responsible for the overall coordination & supervision for effectively carrying out activities under the Plan.

At Village level

Village Health Sanitation and Nutrition Committees, (recognized as sub committees of panchayats) will guide and support village level implementation and monitoring of the plan. Frontline workers (AWWs, ASHAs & ANMs) will catalyze action on ground by creating awareness on the issue of CSR, collecting data, dissemination of information about schemes/programmes related to girl child & their families etc.

Budget

A budgetary allocation of 100 Cr. has been made under the budget announcement for ***Beti Bachao, Beti Padhao*** campaign and 100 Cr. will be mobilized from Plan Outlay of the Planned scheme 'Care and Protection of Girl Child - A Multi Sectoral Action Plan' for the 12th Plan. Additional resources can be mobilized through Corporate Social Responsibility at National & State levels.

Ragini's presentation specifically focused on her experience of BBBP campaign in Jhajjar district. This campaign has a target driven approach towards women's health. The target is to increase CSR increase by 10 points. The Anganwadis have been given the target 100 % registration therefore they are tracking women. Ragini reported that police are being involved, Red Cross society has been included as NGO. Under this campaign, government is tracking pregnancies of individual women and claiming that CSR is improved.

During the discussion, specific question was asked about beti should be saved from whom and for whom. Subhash informed that he is a member of national task force, but no meeting has yet happened. States are expected to submit plans "girls count", however, no state has given budgets. It was raised that tracking is violation of human rights. Manisha also reported that she is a member of task force of district committee of BBBP. There have been two meetings as of now. The discussions in the meeting focus more on beti bachao rather than padhao. Girls need to be retained in school. The committee is not clear about the goals of the project. Anganwadi worker and ASHA are doing the tracking. She said that the issue of tracking was discussed in women's gram sabha but the officials insist on tracking.

During discussion on this issue, Renu pointed out the contradiction that on one hand, tracking is violating woman's rights over her body, confidentiality and privacy, however, on the other hand, we also want to monitor the quality of ANC care- how do we balance this? It is seen that in some areas, signs are being put up on the doors of pregnant women. In a way it is good to involve men and community in caring women during pregnancy, yet there is a need to keep women's autonomy intact.

It was also emphasized that it is not just enough to look at sex ratio at birth, neglect of girl child also needs to be addressed through such programmes.

After the presentation on BBBP, Surabhi presented about the CREA- CommonHealth project, '**Creating Champions to Address Sex Selection and Improve Access to Safe Abortion'.**

Brief information about this project is as follows-

Goal

Build capacity to advocate and to foster a common understanding and solidarity among individuals/organizations working on sex selection/declining sex ratio and safe abortion in selected states in India to work towards the larger shared goal of gender justice and equality.

Focus States

Punjab, Haryana, Delhi, Uttar Pradesh and Maharashtra

Stakeholders

NGOs, academics, healthcare providers, grassroots health activists, women's rights advocates, human rights activists, lawyers, media, coalitions and campaigns working on gender justice with a focus on issue of ex selection/declining sex ratio and/or safe abortion in the 5 focus states

Strategy and Activities

- **Gender and Rights Institute (Focus on Sex Selection and Safe Abortion)**: 5-day intensive training on increasing knowledge and understanding of participants about various aspects and dimensions of the issue of sex selection and safe abortion in India.
- **Support for Follow Up and State-Level Advocacy**: As part of the Institute one full day will be devoted to state level action planning by participants. CommonHealth and CREA will provide relevant support to the participating organisations to operationalise the action plan at the state level.

Expected Outcomes

- Participants demonstrate increased understanding of gender and rights with respect to the issue of sex selection/declining sex ratio and safe abortion
- Participants advocate against sex selection in a nuanced manner that also asserts every woman's access to safe abortion
- Participants incorporate a rights-based approach in their own work on sex selection and safe abortion at the organizational level
- Participating organizations build (informal) networks and coalitions at the state-level to to further the collective goal of improving access to safe abortion and addressing sex selection
- Expand the pool of trainers and facilitators at the state and national levels to conduct similar trainings.

Subsequently Surabhi shared about the CREA, Youth ki Awaz campaign. She said that the issue of abortion and conversation surrounding it are both highly stigmatized. Thus open discussion about abortion is necessary for making progress toward reproductive justice. CREA and Youth Ki Awaaz through #AbortTheStigma have taken a step toward creating a space for these conversations that will contribute to breaking the stigma and shame attached to abortion. A short film on this issue was screened during the session.

In her presentation, Surabhi reiterated that gender biased sex selection is an issue of gender justice. She shared the process of mapping the field undertaken as part of the CREA-CH project. She said that very little work has been done on safe abortion. There should not be hierarchy between sex selection and safe abortion

Regarding abortion, she said that lot more than health it is control, autonomy, sexuality related issue. She also mentioned that there is confusion about EC pills and MA pills.

In this process, they are gathering personal narratives about women undergoing abortion.

The excerpts of the discussion that ensued after the screening of the film is are as follows-

Sanjeeta said that the film shows the perspectives of what some of us grew with, even I related sex selection and safe abortion, it's not their fault overall youth is ignorant about several issues such as RTI, NREGA. She said that the popular TV serials show that bad women go for abortion, with disclaimer that the channel does not support abortion, they show gender violence, there are disclaimers about tobacco consumption but GBV is normalized

Subhash- HP- state women's commission chairperson said that abortion should not be done

Anand- how will we address EC?

Renu said that we need to acknowledge that there are different positions on the issue of abortion. The banner of the meeting does not contain the word, safe abortion reveals that there is dissonance and discomfort around abortion.

Manjari appreciated the presentations. She said that we work in tribal areas, the discussions here are more focused on urban areas, we need to talk about what are the adolescents in rural areas thinking? Are they talking about these issues, there was a 13 year old girl, who was pregnant, she wasn't allowed to step out of the house. After delivery the infant was killed and the girl also died.

Sushil said that the presentations depicted the real situation, quacks charge more money for abortions, severe infection is seen, women don't disclose about abortions, sometimes the situation becomes serious.

Nupur- narratives on women who had abortion- video required

Manisha- while working with youth, they spoke about contraceptives and also that they use these contraceptives. Need to establish rapport with them, women need abortion services but there is stigma around it.

Pushing abortions in popular culture- use images that are not stereotypical

Why are we not talking about preventing unwanted pregnancies so that less abortions become necessary

We should explain the adolescents what are problems with MTP

Suchitra- there are several health programmes so that women can fulfill their role as mother, also programmes to save girls so that they become wives, but it is assumed that the one who does abortion is bad woman, even a mother goes for abortion, its women's right, we need to talk about sexuality and sexual rights, abortion as part of life cycle. Need to normalize abortion, also there is a need to talk to doctors

In the evening there was a session by the group , "Video Volunteers"

Objective of this session was to know more about the work of the video volunteers.

Nupur started by saying that the program initiated with a belief that effective monitoring is possible only when the community does it and video is an effective medium for advocacy.

There are 200 correspondents in 18 states who have undergone a two to three days training where they have been sensitized on various issues ranging from gender discrimination to violence against women , eviction , caste discrimination etc., trained to use cameras and other life skill aspects such as critical thinking etc. 70% are women correspondents. Correspondents are mostly from marginalized communities.

Their system of functioning is very decentralized with about 200 correspondents spread across 18 states having 3to 4 Mentors and a State Coordinator for each state. The Goa Unit acts as the Central Unit

25 videos have been made in the last six months. After screening some videos graphed by correspondents, the floor was open for discussion.

Talking about the impact of these videos, the Video volunteer said that in every 4 videos, one has made an impact. Officials have started working. It has the effect just like that of a Jan Samwad. They have also made informational videos. Many of these videos have come into the mainstream. They are put on the U tube. It is a challenge to put 200 videos in mainstream. But

there are pickups by the National or State Media. There is a good response for maternal health videos. A magazine 'Lady' Fingers' has reviewed all videos. Channelizing them to relevant channels is going on.

Talking about the challenges and threats, the volunteer agreed that there are challenges. The head office in Goa keeps a constant touch with all the correspondents all over. These correspondents are usually from the social networks / social movements. So they have a backing. If there is threat, the correspondents name is not released, only his or her voice is in the videos. For issues like untouchability and water, there have been pressures from political affluent. The female correspondents receive physical threats. The IB and the CID come and ask 19 questions on whether this group is associated with any media or correspondents.

When asked if different videos under one theme can be compiled to make it into a big documentary to know what works and what does not, put together a larger picture, the Video Volunteer replied that it can be possible,. But some videos are extremely scattered. Maternal health itself is such a vast topic. It is difficult to put it as one video. Videos for a large level can be used to design a campaign. But it requires a capital.

When asked what it would entail in cost if CH wants to take it, the Video Volunteer said that existing network does not cost anything. Training will cost. Also depends on what is the need.

Video volunteers put forth what CH can do in collaboration with V.V.

- State and district specific videos, can be used by CH and its members for advocacy
- Can produce videos documentaries from respective states, can be used for advocating with policy makers in public health dialogues, use in media and for awareness on entitlements for community screenings.
- Video audits on maternal health.
- Going beyond plain figures and digits – stories and visuals.
- Nuances of what violation means or why the violation happened in the first place?
- Audit ideal for advocating with policy makers to make them understand what is happening.
- Demonstrate for C Cs created impact each video identifies issues, features concerned authority and how CC resolved the issues by meeting with him. Camera gives sense of being watched for not doing your job. This fear gets duty bearers to do their job, ensuring that the issue highlighted in the video is resolved.

Support of VV

- Train members
- Campaign design workshops

Support from CH

- Recruiting CCs from within social movements.
- Cases of violation which can be duly documented by CCs and used as evidence for advocacy.
- Identify call to act and scale up advocacy at the State/ National level

DAY 2

Session: Rights-based contraceptive services
Facilitator – Renu Khanna

At the very outset, Renu Khanna shared that the session aims to introduce the participants to the advocates' guide for Rights-based contraceptive services prepared under the aegis of CommonHealth and Sahaj supported by Asia-Pacific Resource and Research Centre for Women (ARROW). The guide was seen as a tool for planning future work around advocacy for rights based contraceptives. She also urged participants to provide inputs and feedback on the translated guide.

To commence the discussion around the guide and the issue of contraception, Renu Khanna made a presentation on the global processes affecting access, availability and use of contraception. She shared that CommonHealth has been consistently critical of the coercive nature of most 'family planning' methods promoted nationally and internationally. At the same time, she contended that CH's engagement with the issues around contraception have been inadequate. She asserted the need to recognise that contraception is not limited to traditional families but also relevant for those who are unmarried, young adults or adolescents etc. The use of the term 'family planning' is detrimental to the larger cause of access and availability of contraceptives. She historically traced the trajectory of contraceptives to population control policies initiated in/by the West. There was local and international resistance to these policies. After the International Conference on Population and Development (ICPD) held in 1994 in Cairo called for a rejection of targeting in contraceptive programmes, locally targets were relaxed in national programmes. However, since then they have resurfaced with full force in contraception-related programmes.

Renu Khanna then briefly discussed the London Summit on Family Planning organised in 2012 by the UK government and Bill and Melinda Gates Foundation (BMGF), in partnership with UNFPA where more than 20 governments came together to work towards improved access to contraception information, services and supplies. Family Planning 2020 or FP2020 a global partnership was envisaged and launched at the London Summit. As part of the partnership, 2.8

billion dollars were pledged by donors for the cause of contraceptives across the world. Renu drew the attention of the participants to the large sums of money being directed towards family planning. She asked them to reflect on how will this partnership affect their work and ultimately influence the provision of contraceptive. Women's groups across the world have raised questions related to how safe are these contraceptives, are they controlled by women and do they maintain women's bodily integrity. She pointed out that these international developments are crucial to our work.

Within the FP2020, there is a Working Group on Rights-based contraceptives and ARROW is a member of this working group. At the behest of ARROW, Dr. T K Sundari Ravindran developed a global guide on Rights-based contraception. The guide is prepared with the view to contextualise the World Health Organisation's principles and recommendations for contraception for the Indian setting. Later, Renu Khanna prepared the Advocates' Guide for the Indian context. A consultation was held in Mumbai in September 2014 to review the draft guide. The tools developed as part of the guide were field tested as well. Subsequently, Renu Khanna gave a brief overview of the contents of the guide. She informed the participants that the guide is available in both Hindi and English. She then asked the members to suggest ways in which the guide can be put to use in their field areas and urging them to use the tool widely. She asked them to share what they would like to monitor from the basket of contraceptives.

The members made the following observations and suggestions:

- It was suggested by one of the participants that as the guide is an exhaustive tool for monitoring contraceptive services, supplies and information, it could be tested in the field through the members. She shared that similar to the Dead Women Talking exercise, the guide/tool can be used to gather key information related to access and availability concerns in different parts of the country.

- A participant observed that in many states Postpartum Intrauterine Contraceptive Devices (PPIUCDs) are being promoted and pushed among rural women. She highlighted that often this promotion is coercive with an absence of informed consent and proper follow-up. She suggested that monitoring of PPIUCD can be undertaken using the guide in different areas to then consolidate the information collected at the national level.

- One of the observations was that only sterilisation is carried out in the name of contraception and there are many who opt for the limiting method. She recommended that more attention should be paid to IUCDs as it is a relatively newer contraceptive method. A checklist on IUCD should be put together and administered in the different areas to collect data regarding the use of the method, its acceptance, access etc.

PPIUCD is being promoted with a lot of gusto as BMGF has provided a large number of PPIUCD which is why it is being distributed.

- There was also a suggestion to firstly map out the current status of availability and access to contraceptives in different areas. She shared that there is a need to clearly identify what has been the engagement with issues related to contraceptives, so far.
- Another participant shared that in Jharkhand, JHPEIGO is actively involved in the promotion of PPIUCD in the state. At present, there is an estimated 8% adoption of the method in the state. She shared that the organisation is aware of the issues around informed consent in the adoption of PPIUCD. She suggested that they could be approached for work related to PPIUCD in Jharkhand.
- A participant from Odisha shared that although tribal women would be willing to adopt contraceptive methods, one finds that there is a lack of information and very limited or no access to contraceptives in their areas. Additionally, these matters are not openly discussed in the villages.
- Another observation was that RMNCH+A approach has a major component related to contraceptives.
- There was also a suggestion that the extent of unmet need should properly tracked and documented. It is important that we clearly identify how to ensure access, consent, choice. This must be built into the engagement at the ground level.
- Conducting Focused Group Discussions (FGDs) were recommended to document the status of access to contraception in the community. It was observed that although, ASHAs have supplies of contraceptive pills they are not regularly and consistently provided to those in need. Also, a field observation was that there is no choice in contraceptives as women are mostly advised to get a permanent method.
- Research related to the training of the health personnel regarding PPIUCD was also recommended.
- It was observed that information provided in the field depends entirely on who is providing the information and what h/she understands or thinks is best for the patient. For example, An ANM provides information and services based on her understanding of what is best. It was observed that ANMs in Gujarat would suggest CuT to women if they had already had one child.

- The use of contraceptives among older women and newly married women must be captured. It was observed that the younger generation is often not willing to adopt permanent methods.

- It was observed that ANMs are able to provide only those methods which are available. Their hands are tied owing to the system's failure in ensuring availability of different methods.

- Counselling in rural areas is important as occasional cases of bleeding owing to CuT can deter them from adopting the method.

- It was shared that targeting in provision of contraception continues till now. Often, consent for PPIUCD was taken at the time of delivery.

- There is an information gap as ANMs and ASHAs are embarrassed to talk about contraception. In Madhya Pradesh, the participant shared that in ASHA and ANM meetings they encouraged the personnel to openly talk about the issues. She also shared that contraceptives do not reach the villages from the CHCs. It was observed that women with 1 or 2 children are targeted but little attention is paid to the contraceptive needs of those who have multiple children.

- Participants from Maharashtra shared that as migration is very high in the area marriages take place at a very young age. Most couples have children immediately after their marriage. There is very little conversation about contraception among them. Additionally, ANMs are reluctant to discuss these issues while ASHAs do not discuss this at all. In her field area, it is the private gynaecologists who are consulted for contraception.

- Another observation was that on the one hand ASHAs and ANMs are embarrassed to discuss contraceptives while on the other hand there are incentives for the promotion of certain methods. A question was raised whether an incentive of Rs. 100/200 can influence the adoption of a method. Another point shared was that in Chambal sterilisation incentives include motorcycles and gun licenses.

At the end of the discussion, Dr. Nilangi Sardeshpanse asked the members whether they would be interested in a training programme for the use of a tool to collect information related to contraceptive use in their respective areas. Most members expressed interest in such an exercise. Dr. Subha Sri shared that the training would be held over two days. The tool would need to be field tested before initiating data collection in different areas.

Renu Khanna wrapped up the session stating that all the members who attend the training workshop (to be held tentatively in January 2016) should go through the guide thoroughly to be able to actively participate in the process.

Session: Anaemia and Blood Availability
Chair – Renu Khanna
Presenters – Dr. Ramani, Dr. Vandana Prasad and Dr. Subha Sri

Dr. Vandana Prasad commenced the session with her presentation on Anaemia. The objective of the session was to build an understanding of the systemic issues related to Anaemia and identify ways of engaging strategically to address the concerns. The presentation was based on Government of India document on the Iron Plus Initiative. The work shared in the presentation was culled out from Jan Swasthya Abhiyan's (JSA) engagement on nutrition issues in tribal areas of Bihar, Jharkhand and Chhatisgarh.

At the outset, Dr. Vandana explained the condition of anaemia, its symptoms and prevalence. As per NFHS-2 and NFHS-3, an increase in anaemia figures is seen among children. Although there may be some methodological issues in the collection of data, experts confirmed that the data may not be entirely incorrect. Dr. Vandana shared that anaemia adversely affects women and their general well-being. She shared that anaemia among pregnant women can lead to [a] premature deliveries, [b] perinatal mortality and [c] increased risk of death in delivery and postpartum. As the problem largely lies in the realm of lack of food security, the Right to Food Campaign and JSA have been working together on this issue. Anaemia cannot be addressed without working on concerns related to food security and also local food practices. She also stressed the social and gendered determinants of women's health. Her presentation highlighted food related determinants such as poverty and food security, lack of food diversity, gender related cultural/behavioural practices such as giving away expensive food to men etc. Social determinants of infections such as malaria, hookworms, were also highlighted. Dr. Vandana identified crosscutting factors such as availability and access to food, water, sanitation, investigations, drugs etc. along with early/frequent pregnancies and gendered access to health services among others. Before concluding her session she pointed to public health systems failure in providing adequate information, ensuring community participation and ensuring anaemia related services. Additionally, treatment of women with anaemia was also identified as near absent. Mere distribution of iron tablets was understood to be an inadequate intervention to address this widespread condition. The solutions for dealing with anaemia would have to be as complex as the determinants of the problem. It was pointed out that iron-rich food is not available in the PDS, there are no maternity entitlements for supporting exclusive breast feeding, across all schemes and programmes – access, quality, targeting and corruption are major problems. Community based models such as DHAN in Tamil

Nadu, PHRN-PRADAN's FAAM programme in Odisha and Jharkhand, AAM project in Odisha, Jharkhand, Chhatisgarh and Bihar etc were shared.

Following this, Dr. Ramani Atkuri presented the clinical aspects of anaemia in some detail. Her presentation explained what occurs in the body when a person is anaemic. She explained the role of red blood cells in a normal body. In anaemia, the lack of either iron or protein reduces the oxygen absorption capacity of red blood cells in the system. As a result of low oxygen absorption, blood looks pale and the affected person feels exhausted easily. Factors leading to anaemia were identified as – lack of iron or protein in the body owing to harmful food habits/inadequate intake, destruction of red blood cells as seen in malaria and sickle cell anaemia, high blood loss and frequent pregnancies. Anaemia in pregnancy increases the possibility of maternal deaths as excessive bleeding during delivery can result in the woman's death. Anaemia can also lead to pre-term or low birth weight babies. Anaemia in pregnant woman is seen to adversely affect the presence of iron in the foetus, which in turn can lead to developmental issues after birth. She then discussed the symptoms such as pale tongue and hands, swelling in legs etc. Dr. Ramani presented DLHS 2004 data to highlight that in Madhya Pradesh 33% of adolescent girls have severe anaemia while 99% have mild anaemia. Similarly, 54% pregnant women were found to be severely anaemic and 97% had mild anaemia. The strategies for prevention and control of iron deficiency shared were – dietary diversification, food fortification, iron supplementation and improved health services and sanitation. Treatment of anaemia included – proper diagnosis of factors leading to anaemia, deworming of children in every six months, administering iron tablets and syrup, blood transfusion in case of breathlessness and swelling, increased protein intake. Dr. Ramani shared different food sources of iron and concluded her presentation with a look at the Weekly Iron and Folic Acid Supplementation (WIFS) programme and follow-up by ANMs of anaemic children.

The session was then opened for clarification and discussion by Renu Khanna who was the chairperson.

- A participant linked the session's presentations with the previous day's presentation on the status of maternal health in Chhatisgarh. Although the PDS is functioning well in Chhatisgarh, one finds that the BMI levels of men and women are rather low. Also, she pointed out that considering PDS does not provide any form of protein to the beneficiaries, intake of protein required to prevent anaemia among poor population is very low.

- A question put before the presenters was whether they were aware of any Ayurvedic medicines for anaemia. The participant who asked the question shared that in her knowledge although there are effective Ayurvedic medicines for anaemia, they are

somehow not made available. Additionally, she questioned the logic of providing weekly iron tablets in the Weekly Iron Folic Supplementation programme (WIFS).

- One of the participants shared that in Uttar Pradesh blood tests of adolescent girls is not taking place and there is shortage of Iron tablets in the state.

- Aami Aamchya Arogyasathi's experience of using Ayurvedic medicines for Anaemia in their field areas was shared. The ayurvedic medicine was administered in the form of *laddoos* and *churan* among the community.

The presenters responded to each of the questions and comments. Dr. Vandana shared that the logic for weekly iron supplementation is not clear. She agreed that the ration provided in the PDS is not adequate for addressing the protein requirements for preventing anaemia among rural and poor populations. She shared that although there are AYUSH doctors in the system, they do not have access to Ayurvedic medicines. Often, they prescribe allopathic medicines owing to the shortage of Ayurvedic medicines. In Chhatisgarh, Raigarh Ambikapur Health Association (RAHA) is working on herbal medicines. She again highlighted that the treatment or case management of anaemia has largely been left out in programmes and policies which concentrate on prevention of the condition. Food diversity is critical to addressing these concerns. She also contended that to tackle anaemia the Tamil Nadu model could be implemented in other states, but the government has not taken adequate steps for this. There is clearly a lack of political will owing to a variety of factors. In Tamil Nadu, ANMs were provided an Ayurvedic drug kit several years ago. Anecdotal experience showed that the medicines were more effective than IFA tablets. This could be explored further to identify the medicines and to provide them in other parts of the country.

- A question related to the combination of Iron and Calcium affecting the absorption of iron in the system was raised. A participant asked whether local/common dishes which combined the two nutrients should be avoided in case of anaemia.

- One of the participants shared some details of Nutrition Rehabilitation Centres (NRCs) set up in Satna district in Madhya Pradhesh. Locally available and procured food such as jaggery, peanuts etc. were provided to children at the NRCs. This was seen to be effective in addressing malnutrition among the children.

- One of the participants observed that policies were largely distribution-oriented with little or no attention to counselling. Additionally, it was observed that the Iron Plus Initiative does not look at the ICDS programme which is mainly responsible for nutrition related services. The lack of coordination between different departments was seen to be adversely affecting the implementation of nutrition related programmes.

- There was a query regarding the details of nutrition project models shared by Dr. Vandana.
- Another question raised was related to how to ensure availability of protein-rich food in the field. Also, a participant enquired whether ANMs and ASHAs have IEC materials related to good food practices.
- One of the participants highlighted the need for Folic Acid along with Iron.

Dr. Ramani in response to the above questions shared that for long term solutions for Anaemia, hygiene and sanitation on the ground must be ensured. She claimed that although at the top level there is a lack of coordination between the Health and ICDS departments, at the district or field level there is convergence to some extent. She also suggested that the Education Department must be brought into the discussion related to Anaemia. She urged participants to taste the Iron syrup provided in the field to understand that often adolescent girls and women are averse to taking the medicine owing to its metallic taste. Dr. Vandana recommended intake of a diverse range of foods that are nutrient-rich instead of labouring over each, separate micronutrient and its sources. She shared that the nutrition-related models cited in her presentation were largely community mobilisation and participation oriented. The focus in each of the models was to mobilise local communities for effective systems and action. The projects also look at community management of malnutrition to some extent. With regard to fortification, Dr. Vandana asserted that there is little evidence of the effectiveness of fortification in addressing nutritional concerns. Although promising results were seen in African countries immediately after implementation, she contended that the fortification programme was ceased as the results were not sustained over a period of time.

Blood availability as a health systems issue

Dr. Subha Sri made a presentation regarding the problem of blood availability as a health system issue. The presentation was prepared based on related discussions which took place at the National Consultation on Maternal Health held in Delhi in January 2015. Presentations made by Dr. Yogesh Jain and Dr. Latha Jagannathan along with discussions led by Dr. Sridhar formed the base of Dr. Subha Sri's presentation on blood availability. Priya John helped in putting the presentation together. Dr. Subha Sri commenced with a look at the need for blood in the country. Research and experiences at the ground evince one percent of all pregnancies require blood. Additionally, the need for blood must be understood as the need for free access to safe blood, access to different blood groups, blood components and for immediate/emergency purposes. Within maternal health, she shared that cases of anaemia and postpartum haemorrhage require blood. A WHO 2008 study identified that 10 million units of blood are required for a one billion population. As per the study, there is a shortage of 6 million

units of blood in India. Also, a study conducted in Maharashtra and Gujarat in 2009, revealed that government blood banks are able to provide only 31% and 13% of blood in Maharashtra and Gujarat, respectively. In terms of government policies on the availability of blood, National Blood Policy, standards for blood banks and blood transfusion services and guidelines for setting up blood storage facilities were formulated in 2007. Dr. Subha Sri shared that the regulations laid down in these policies are often too stringent for the blood banks to fulfil.

Subsequently, she presented the state of affairs on the ground with regard to blood banks and blood storage centres. She highlighted that – [a] the numbers of blood banks is inadequate, [b] regulations being too stringent one finds that safety often takes precedence leaving supply rather low, [c] blood donation has taken a backseat over the years etc. She pointed to the equally poor state of blood storage centres in the country. With this background, she put before the participants the alternative of Unbanked and Directed Blood Transfusion (UDBT). She asked of the participants whether UDBT could be considered a viable option to improve availability of blood in the country. At present, UDBT is illegal across the country except for the Indian armed forces. Primary concern with regard to UDBT is the need to regulate blood safety to prevent HIV transmission. Dr. Subha Sri asserted that the demand for blood banks and storage units must be sustained. She asked the participants whether UDBT could be advocated for as an interim short-term option for specific areas with strict regulation? She asked the participants to reflect on the UDBT-related issues for which we need further information and what should be CommonHealth's advocacy agenda. Before concluding she shared the recommendations from the January consultation which included – encourage voluntary donations, establishment of blood storage units and blood banks, revision of regulations related to blood banks etc.

At the end of the presentation, the floor was open for clarifications and discussions.

- A clarification was sought regarding profession donors and the implications of the presence of such donors in the system. Also, a participant asked whether the presence of alcohol in the blood stream of a donor disqualifies him or her.

- An observation shared by a participant was that often relatives of female patients do not come forward to help them when there is a need for blood.

- A clarification regarding the reversible infections at the time of blood transfusion was sought. The participant also observed the need for further analysis of the risks involved in UDBT and the demand for revision of standards.

Dr. Ravi D'Souza joined Dr. Subha Sri as a discussant for the session. In response to the clarifications and discussions, the discussant and presenter clarified that professional donors

should not be encouraged in any way and in case of alcohol consumption then the donor is not allowed to donate blood as per the government guidelines. They also shared that blood must be tested for infections before UDBT is undertaken and it is not advisable for close relatives to donate blood for patients. It was also pointed out that well-functioning blood banks maintain blood donors' database which can be accessed when there is a need. The Chair, Renu Khanna, shared that the most recent Comptroller and Auditor General (CAG)'s report on Gujarat has revealed that blood was being sold to pharmaceutical companies. It was pointed out that as blood bank policies omit the issue of sale of blood commercial interests are bound to make an appearance in the system. With regard to setting up blood storage units, the undue delay is issuance of licenses was highlighted.

Before the conclusion of the session, the participants were asked to share their recommendations vis-à-vis blood availability. The recommendations were as follows:

- It was proposed that a blood availability infrastructure, equipment and services related checklist and corresponding format should be prepared to be filled by CH members. The information collected from different parts could be used firstly as a stock-taking exercise and as evidence for advocacy purposes.
- The implementation of the National Blood Policy should be ensured and monitored.
- There is need to encourage voluntary blood donation instead of replacement donation.
- Blood related policies and guidelines must be promotive in nature rather than preventive.
- If we are seeking revisions in the guidelines and policies, then we need to clearly specific the extent to which these revisions should be applied.
- Association of Rural surgeons of India who are already involved in advocacy on the issue of UDBT must be engaged in this process.
- There is a need for realistic standards in blood related policies and guidelines.

Session: Future steps
Facilitator – Dr. Nilangi Sardeshpande

Dr. Nilangi Sardeshpande facilitated this session which focussed on future steps for CH. She urged the participants to reflect on the discussions over the two days of the national meeting to identify practical steps that can be taken on different issues. She asked the participants to think

about the next phase of CH and what concrete programme can be undertaken in the next one year. All the participants were then asked to write their recommendations and suggestions on a piece of paper and hand it over to the facilitator. The suggestions and recommendations that poured in have been categorised below as 'issues' and 'strategies':

S.no.	Issues
1	Quality ANC and PNC services
2	Improved blood availability through blood banks and blood storage units
3	Contraception
4	Safe Abortion
5	PCPNDT Act
6	Maternal Health Services & Accountability
7	Violence against women
8	Awareness about health services
9	Awareness on birth spacing methods
10	Shortage of drugs e.g. IFA tablets

S. no.	Future strategies and activities
1	Need for a renewed look at ICPD strategies with the changing time
2	Build linkages between the 73rd and 74th Constitutional Amendment related to Panchayats and Municipalities and Reproductive Health
3	Community-based management of anaemia and nutrition status especially in adolescent girls.
4	For contraception issues - summarising tool for monitoring family planning programme; field testing of tool
5	Better adolescent health outcomes and training of youth
6	Strengthen Village Health and Nutrition Days to improve status of anaemia, postnatal care and malnutrition
7	Take forward abort the stigma campaign
8	For anaemia – review of ARSH, RKSK and need for more research
9	Study on status of Maternal and Adolescent health in tribal of areas of MP
10	Perinatal mortality review
11	Sex education for adolescents
12	Bust myths and superstitions surrounding health related issues with sensitivity to the culture of the community
13	Support from Video Volunteers on making videos/training/advocacy
14	Work with marginalised communities – SC/ST/DNT
15	Community wise Disaggregated data related to maternal/infant/child mortality

16	IEC material on safe abortion
17	Sustainable Development Goals
18	Position paper on Traditional Birth Attendants
19	Within Dead Women Talking exercise – near miss cases and postnatal death audits
20	Study on essential drugs

Following this exercise, there was a brief discussion regarding anaemia and its link with poverty. In response to an observation of a participant regarding the anaemia among the poor, Dr. Vandana Prasad reasserted that anaemia is clearly a symptom of poverty. She pointed out that the millets, green leafy vegetables and meat that the poor used to eat at one time have become a fad among the rich in the country. She threw light on some of the debates around and issues related to importing foodgrains and exporting local produce. Another claim was that although there is high food production in the country, one sees huge number of starvation deaths as well. Dr. Vandana argued that this is no longer the case in the country as the number of starvation deaths is not very high yet there is ever-increasing inequality between the rich and the poor. She urged the participants to think of food security as a complex issue.

An observation from the field was that historically, local foods such corn, millets etc. were found to be filling and adequate by the village community. However, at present foods such as rice/wheat procured from the PDS shop are considered inadequate by local communities vis-à-vis the amount of work done. Also, there is a higher incidence of sickness among the rural populace. Dr. Vandana shared that corn continues to be grown in rural areas and so, a strategy could be to encourage its consumption and introduction in the PDS. She concluded the discussion with the suggestion that experts, local communities and mediators (such as CH, JSA, RTF) must engage in dialogue. It is essential that our discussions are taken to the grassroots to chalk out the way forward.

At the end of the session, Dr. Nilangi shared a timeline for CH's work in the coming months. She shared that [a] suggestions and feedback for the SDGs' advocacy guide would be sought in September first week, [b] Perinatal death and near-miss audits would be initiated in November and [c] Rights-based contraceptive workshop would be organised in January or February.

The National Meeting on Maternal Health and Safe Abortion was concluded with a vote of thanks by Dr. Subha Sri. She thanked all the participants, presenters and organisers for their support and active participation in the meeting and SOCHARA for partnering with CH in this event.