Report of the Fifth General Body Meeting, CommonHealth

March 22-23, 2013 at Hotel Savshanti, Vadodara

The meeting was attended by 48 participants, 31 came from different parts of India either as representatives of their organization or as individual members and 17 participants came from local NGOs based in Gujarat and Vadodara. Several participants could not get train reservations till the end and had to cancel their programme. This is a learning that we need to decide on the dates and venue well in advance to make it possible for members to be able to travel comfortably. Please see Annexure 1 for Agenda and Annexure 2 for participants' list. All the presentations are on the CommonHealth website www.commonhealth.in.

WELCOME AND INTRODUCTION TO COMMONHEALTH – DR. SUNDARI RAVINDRAN

Dr. Ravindran as chairperson of the Coalition welcomed the participants and gave an introduction to CH. CommonHealth, a multi-state level coalition built on rights-based and gender sensitive perspective, has 17 institutional and 85 individual members. CH foregrounds women's rights to the highest attainable standards of maternal health and care.

Three regional meetings have been held in the past 12 months in Jharkhand, Rajasthan and Nagpur. At present, the Chairperson is Dr. Sundari Ravindran and Renu Khanna is the Financial Advisor.

Dr. Sundari talked about the benefits of membership like: support for members from each other in their regional agendas or issues of concern, opportunity to become resource persons for capacity building workshops, opportunity to contribute from their experiences to the huge repository of data on maternal and neo-natal health. She showed the CH website with its valuable resources of statewise data, classic readings on the three themes, new addition of Hindi resources and films on maternal health.

After the general introduction, the three Theme Leaders introduced the work done on the focal themes of CommonHealth.

MATERNAL HEALTH – DR. SUBHASRI

The objectives of the CH comprise ensuring high quality, accessible maternal health services. Its goals resonate with those of the ICPD 1994, which highlights the need for a human rights-based approach to healthcare, and expands the time-frame of women's reproductive health to include her entire life cycle. The objectives of the CH are also in opposition to the target-oriented approaches provisioned in the Millennium Development Goals of 2000

which reduce the ambit of the ICPD agenda to technical solutions. As a corrective to this narrow, technocentric paradigm, the current challenges of the CH include 1) refocusing reproductive and maternal health as an important component of healthcare 2) repoliticising maternal health to include socio-political determinants. Within this, the strategies include centre-staging safe delivery, focusing on abortion, highlighting the continuum between reproductive health and other health concerns.

Foregrounding safe delivery is a crucial component of addressing maternal health issues. A comprehensive definition of safe delivery has evolved through conversations with activists, academics, civil society members, and women at the grassroots, and is used as a premise for healthcare monitoring. The definition of safe delivery includes:

- Absence of morbidity and mortality
- Technical quality of care
- Continuum of care through antenatal, intrapartum and postpartum period and through the life cycle of the woman
- Adequate support facilities at place of delivery like electricity, running water, toilets, cleanliness
- Enabling environment promoting physical and emotional health of the woman including nutrition, family support, social support
- Presence of a birth companion
- Safe contraception and safe abortion services
- Autonomy and decision making of the woman
- Dignity of the woman and absence of abuse and violence
- Absence of discrimination
- Special needs of marginalized groups to be addressed
- Accountability to the woman and to the community
- Absence of corruption.
- Safety at work places, maternity benefits and welfare schemes like crèches, child care facilities.

The 26 maternal deaths in 8 months in 2010, in the Barwani District Hospital, are an important illustration of the significance of safe deliveries within maternal healthcare. Members of the CH went as a fact-finding team to investigate how the maternal health policy played out in Barwani. Their findings point to the lack of good quality maternal health services and outcomes despite NRHM's investment in health systems. Other issues include poor quality of care, apathy from professionals, frequent flouting of ethical principles of care, dereliction of duty, absence of grievance redressal systems, the absence of maternal death reviews despite a prescribed mandate and corruption. In sum, poor governance and a lack of accountability are important reasons behind the abysmal state of the maternal

health services. (See for further details http://www.commonhealth.in/CH-publications-Reports.html#1.)

A CH-published document, 'Policy critique of maternal health policy' discusses these issues in detail, highlighting the need to centre-stage the lived experiences of women and their families, avoid a reductive indicator-oriented approach, address the lack of accountability within healthcare systems.

Other civil society groups also documented maternal deaths in Tamil Nadu and Kerala. These region-based investigations culminated in 'Dead Women Talking', a meeting that aired different experiences of maternal healthcare. It also led to a project titled 'Enabling Community Action for Promoting Accountability for Maternal Health' in Gujarat with an emphasis on monitoring the quality of maternal health, ensuring maternal death reviews are implemented by involving the community, ensuring that these maternal reviews are placed in the public domain, and are inclusive of social determinants.

Strategies and solutions include

Increasing Accountability for Maternal Health

- Strengthening maternal death reviews by a) including social determinants 2) increasing community involvement
- Monitoring QoC based on safe delivery indicators

Building Capacities for Maternal Health

- Making 'Pregnancy Safer' courses
- Gender and rights-based understanding of maternal health
- Including civil society organizations
- Including and addressing the health system – district health officials and programme managers

After the presentation there was a discussion on quality of care and how the private sector does not come under the scanner for quality of care. Also, how to monitor the unqualified sector like the RMPs. Dr. Sundari talked about a CH member – Lindsay Barnes - training RMPs in Jharkhand about quality of care for maternal health. CH has also produced Fact sheets about dos and don'ts about medicines administered during and after labour.

MATERNAL HEALTH- NEONATAL CONTINUUM: PROGRESS AND DIRECTIONS – DR. SHARAD IYENGAR

The size of the problem

- More than 10 million children die each year from preventable diseases. 27,000 deaths per day.

- About **6 million children die** per year worldwide, aged 1 month to 5 years
- About **4 million newborn die** in first month of life (40 % of all child deaths).
- The Millennium Development Goals 4 call for a two-third reduction in death rates for children under age of five by 2015. Almost 40 percent of these deaths occur in neonatal period.
- India has 24 percent of the world's neonatal deaths.
- More than 100 neonatal deaths every hour in India, where the total births - 26 million (2.6 crore) and the neonatal deaths - 0.94 million (9.4 lakh) are the highest in the world.

Various spaces where neonatal healthcare is accessed are

level	**Type of facility**	**Specificities**
Village-based clinics	Subcentre	closed by design, few or no drugs
	village practitioner	open for long hours, provider resides next door
Occasional clinical services	health camps (eg. swasthya chetna yatra	
	mobile clinics	
Health-centres and hospitals	institutional delivery services	crowded, focused on childbirth
	outpatient care	
	hospital for children - inpatient care	

Family expectations from an institutional delivery of a new born include a live newborn who breathes and feeds well, who is not weak or jaundiced, who is warm and active and passes urine and stools. However, the delivery often results in stillbirths and early neonatal deaths. Some of the risky practices after an institutional delivery include referrals for asphyxia, not weighing newborns, discharging women and the newborns without adequate neonatal assessment.

The CH (2009) Strategies for Neonatal Health

The CH recognizes and emphasizes that maternal and neonatal health are interlinked issues, extensions of one another, and hence it is important to highlight the continuum between the two.

- Promoting labour monitoring for the neonate within a quality of care framework for maternal-newborn care: observing deliveries, interviewing women that have delivered, communicating with families planning deliveries, contact providers (Foetal Heart Sound monitoring, use of a partograph, referral arrangements in the event of fetal distress).

- Promoting maternal and newborn assessment before discharge: counting stillbirth and early neonatal deaths for a defined community and time period, working with a health facility to review numbers of stillbirths/ intrauterine deaths or 'IUDs' occurring over the past 6 month – year, advocating facility-based perinatal death count or audit in a busy govt health facility – DH or CHC, auditing neonatal deaths – develop or adapt instruments, train data collectors, involving the VHSC in inquiring into perinatal deaths in the community, linking it to utilization of available services.
- Generating and disseminating information on newborn health.
- Newborn deaths: burden, social, gender and economic determinants
- Newborn care approaches
- Community and home based approaches
- Facility-based routine care
- Referral arrangements
- Facility based sick newborn care
- Generate interest and action
- Promote accountability

Articulating right to life for the newborn would include: Women's right to prenatal care – pregnancy, labour care and referrals. Right to health of the newborn, right to routine care that meets basic standards, right to special care when the newborn has Low Birth Weight, asphyxia, and jaundice infections.

Nonetheless, this raises a controversy over whether the newborn has a right to be breastfeed, does the woman then, have a right or a duty to breastfeed. How may breastfeeding then, be promoted and enabled (See Handout 1 on Neo Natal Health in India for details of government strategies for preventing neonatal deaths, NBSUs, and Navjeevan in Rajasthan).

SAFE ABORTION (IN THE ABSENCE OF DR. SUCHITRA DALVIE, THE THEME LEADER, RENU KHANNA MADE THIS PRESENTATION)

In collaboration with CEHAT, CH launched the National Campaign on Safe Abortion (NCSA) in 2008. Through this campaign, a meeting of different civil society organizations was held to discuss the challenges to safe abortion services posed by the backlash against sex-selective abortions. Consequently, a national advocacy strategy has evolved to advocate for urgent policy and programmatic attention to safe abortion services. A working group was formed by ANS, ARTH, CEHAT, CMNHSA, CHSJ/ Health Watch Forum and MASUM.

A timeline on the work done safe abortion issues

February 2009: A workshop for NGO functionaries in Rajasthan, organized by ARTH and CH.
April-December 2009: Community-based advocacy projects on promoting access to safe abortion were implemented in Bihar, Orissa and Uttar Pradesh
Women's Voices workshop for rural women held in Tamil Nadu by RUWSEC on sex selection and safe abortion.
April 2009: The 'Sex-selection and Safe Abortion: Creating Common Ground' course was conducted. CH's Steering Committee members supported an initiative by a participant in Rajasthan as a follow-up of the workshop.
September 2009: Common Ground workshop for Rajasthan PCPNDT cell members was held.
November 2009: A media workshop was held with journalists from nine states in India on 'Safe and Legal Abortion in India: Every Women's Right'. Several articles appeared in local newspapers talking about the rights of reproductive rights of women in general, after the workshop.
2009-2010: Published factsheets on abortion, discussing features such as the cost of abortion, abortion as a women's health and rights issue and FAQs on abortion.
2010-11: Community-based information and advocacy projects in Nabarangpur and Mayurbhanj districts, Odisha. VHSCs, SHG women, ANMs and ASHAs in a cluster of 20 villages.
June 2010: Safe abortion workshop for medical professionals in Guwhati organized by ASAP and CH.
January 2011: Gender, sex selection and safe abortion workshops organized by SWATI, SAHAJ and CH in collaboration with the Government of Gujarat.
2011: Conducted a study of PIPs for assessing policy commitments to abortion services. It was completed in December and published in 2012
2012: Published an abortion access working paper ('Many a slip between the cup and the lip') by Dr. Sundari Ravindran and Renu Khanna.
January 2013: Participated in an IPAS meeting and became part of Campaign on Gender Equality and Safe Abortion.
February 2013: A dialogue meeting in Maharashtra, a four day Common Ground Workshop kit draft prepared.
April 2013: In the process of translating factsheets into Hindi.

CONCERNS OF PARTICIPANTS: OPEN DISCUSSION CHAIRED BY DR. SUNIL KAUL

In this session, participants introduced themselves and shared their concerns related to Maternal-Neonatal Health and Safe Abortion.

Devika Biswas talked about denial of services in Bihar while Dr. Behara (SODA) talked about the situation in Mayurbanj district in Odisha. Alka Barua raised concerns about the involvement of private - public sector in Gujarat.

Sarita Baripanda from CHSJ talked about her concerns about quality of sterilizations and felt that national level policies/guidelines and state level practices are totally different and the need to bridge the gap between the two. Dr. Suresh Patel, former Additional Director, Dept. of Health and Family Welfare also talked about sterilization services and distributing bogus IUDs. He also mentioned that women felt that oral pills lead to sterility and was of the opinion that unless basic family planning services were provided, no safe abortion possible.

Gayatri Giri works as an independent researcher and talked about her experiences of doing Maternal death Reviews in Bihar. Dhananjay Kakade from OXFAM talked about his work on maternal health with social determinants approach in states like Bihar, Jharkhand, Rajasthan and Orissa. Nilangi talked about her work in SATHI where they coordinated community monitoring of NRHM including maternal health.

Dr.Subhasri described her work in RUWSEC where they work at grass roots level on issues of gender and reproductive health. Dr. Rahul Bawankule works in Gadchiroli. Maharashtra. In some of the districts, the MMR is very high and problems are compounded because the area is infested with naxals and public facilities are not used. Mr. Ajay from Integrated Health and Development Agency, Odisha works in a tribal area which is again a naxal area and safe delivery is a major problem there. Shweta Krishnan – ASAP – is a doctor turned advocate for safe abortion and a filmaker. She was attending this meeting in order to film interviews with CH members and make a short film on the issues of concern and the members' perspectives.

Sangeeta from SAHAJ said that in Vadodara city, home deliveries were still continuing to be conducted. The Municipal Corporation Link Workers are given targets and work for incentives – this creates problems in the bastis where SAHAJ works because the health workers from SAHAJ who do not work for incentives. Leela Visaria, demographer from GIDR said that her years of research experience showed that cultural practices and anaemia are responsible for poor health of women.

This round of introductions and articulation of concerns provided a good platform for discussions for the remainder of the meeting.

TECHNICAL SESSION 1 – NEONATAL HEALTH – CHAIR: DR.SUNDARI RAVINDRAN

The SEWA Rural experience demonstrating the maternal-neonatal care continuum

Dr. Pankaj Shah (SEWA Rural)

SEWA Rural provides maternal and neonatal care to poor, rural and tribal community in Bharuch district, Gujarat, for over three decades in 168 villages of Jhagadia Block. It has a hundred-bed charitable general hospital (approved as First Referral Unit) providing Comprehensive EmOC services. It ensures complete enumeration of all pregnancies and a thorough follow-up by village-based cadre of front-line health volunteers, supported by the field staff. It follows a 'life cycle approach' by involving stake-holders and continuing healthcare services from pregnancy, delivery to post-partum care for mothers and neonates. The organization extends its services to children up till two years. It also involves adolescents, young people, and newlyweds in the health programs. The hospital uses mobile phones to keep track of information on the status of each mother and child. Some of their results include: 85 percent of the women of Jhagadia receive complete ANC care, 85 percent reduction in maternal mortality, 40 percent reduction in neonatal mortality rate in one year.

Perspective from Bihar: maternal and neonatal health

Dr. S Sridhar (Technical Director, IFHI Project CARE Bihar)

Most newborns would survive if front-line functionaries are trained adequately. Such training must include using tools for identifying maternal complications, for planning and tracking pregnancies. Neonatal deaths may also be prevented if the frontline workers can provide key messages about: Antenatal care, Asphyxia management, initiation of Breast Feeding in the labour room, timing of first visit by front line workers. Frontline workers also need to be supervised on these aspects.

Perspective from Rajasthan: maternal and neonatal health

Dr. Sharad Iyengar (ARTH)

The overriding concern among birth attendants in Rajasthan is the inability of the woman to deliver. The birth attendants say that healthy and strong women are able to generate sufficient *taakat* (strength) to deliver the baby. Yet, most women are weak. The perceived lack of strength in women is compensated by external agents such as injections that generate heat in the body to help expel the baby. Commercial or workload related reasons, however may also be responsible for hastening labour. Deliveries may also be hastened through strong fundal pressure and IV drips during the delivery. Fundal pressure is nearly universal, prevalent in home and facility deliveries. It is also known as *haath dena* (giving a

hand), *jor lagaana taakat lagana*, *thela dena*, or *halkiya.* The attendant gives it by sitting behind a woman, kneeling /standing and pushing while woman is supine, standing on footstep and pushing while woman is supine where pressure maybe applied even in early phases of labor *(See POWERPOINT 2 on Maternal-Neonatal Continuum for details)*. These frontline health workers remain unconcerned by the deleterious effects of oxytocin injections and expediting labour in general, on the fetus and the newborn. Medical practices after delivery, interval between institutional discharge and delivery, management by nurse-midwives of the range of the deliveries, reasons for refusal to comply with referral advice (only two thirds complied) and the type of treatment given to them, are elaborated in Handout 2 on Maternal-Neonatal Health Continuum.

The discussion following this panel brought out the importance of training local women in their own language and idiom and the need to document success stories of advocacy with the government.

TECHNICAL SESSION 2 – THE DECLINING SEX RATIO, SEX SELECTION AND SAFE ABORTION DEBATE

Calculating the Sex Ratio

Leela Visaria(GIDR)

Two methods of calculating the sex-ratios were explained. India has historically calculated the ratio as number of girls per thousand boys, in order to highlight the girls' deficit. Age has always been an important criterion in categorizing populations in the Indian census since 1881. The anomaly in sex-ratios had also been noted by British demographers who examined, conjectured and commented upon the gender disparities in populations. Listed reasons behind the lopsided sex ratio include sociological reasons such as misreporting ages and sex-selective migration. Analysis has shown that higher mortality rates are observed across all ages amongst women. Previously, this severely affected the life expectancy of women, who had shorter lives than men. However, this has changed. Women now, on an average, live two years more than men.

There is also the need for comprehensive birth registrations for an accurate calculation of the sex-ratio at birth. Within India, Kerala and Tamil Nadu have better registration rates. Dr Visaria examined the decline of the juvenile sex-ratio (the age group 0 to 6 years). This age group was treated with significant concern in 1981 when the Government realised that the country had not made enough progress in terms of its literacy rates. Dr Visaria went onto discuss the sex decline in the recent years. She showed that 10 states have dipped below the 910 mark in 2011 as opposed to 7 states in 2001. She attributes this decline to the

advent of new technologies, such as the portable sonogram, which has made it easier to detect the sex of the foetus. Studies have shown that the second and third girl child is at a greater risk of being aborted. Studies have also shown that among the educated, landed and higher caste, the deficit of girls is even higher.

Dr. Visaria went on to explain the legal measures undertaken to counter the decline. The campaign against prenatal diagnostic techniques, for instance, led first to a ban on such tests in Maharashtra in 1986. This in turn led to the enactment of the PNDT Act, whose enforcement continues to be ineffective. Nonetheless, persistent lobbying, through several public interest litigations led to an expansion of powers within Act in 2003-2004. Advocacy at various levels has led the MoHFW to set up a multi-pronged approach at different levels to deal with the issue. Central and state level advisory boards have been set up, appropriate advocacy and communication strategies have been designed. The media too, has helped disseminate and circulate relevant discourse on the issue. The Act, other measures by the government, and interventions by the media, have helped keep the issue alive in public consciousness. And yet, underground acts of prenatal sex detection and selection have also intensified. Consequently, it is difficult to get accurate data on sex-selective abortion.

Several challenges remain for people attempting to address the intertwined issues of safe abortion and gender. Advanced developments in medical technology such as simple maternal blood tests which detect the sex of the foetus, enable sex-selective abortions. Other challenges include the blurred boundary between abortion and sex-selective abortion and the associated need to differentiate between a physiologically abnormal foetus and a sociologically undesirable one. Perceived financial costs of a girl child and the absence of systematic evaluation on the effectiveness of advocacy measures impacting the sex ratio are also factors that need consideration. Important ways in which the complex nature of abortion in India may be addressed, is by debating the consequences of a 'womenless' society, working with members of the IMA and FOGSI, and addressing society's ingrained attitudes towards women.

Introducing the Campaign for Gender Equality and Safe Abortion

Medha Gandhi (IPAS: Health, Access Rights)

According to the Census of India 2011, child sex-ratio dropped to the lowest since Independence. This finding has generated an alarm and led to a shift in focus in terms of public discourse and state-level policies. Some examples of newspaper headlines highlighting the issue include: 'India counts its missing daughters as illegal abortion continues', 'Sex selective abortions rise in India', 'Govt looks to tighten abortion norms.'

At the state level: ‘State wants to ban sale of abortion pills’, ‘Surya clinics license is hanging by the thread’, ‘Treat abortion as murder: Maharashtra govt to Centre.’ The backlash is indicated in headlines such as: ‘Doctors wary of conducting abortion after 12 weeks’, ‘Chemists in city refuse to stock abortion pills’, ‘Abortion may go underground’.

Different stakeholders implicated in the issue have also responded variously. At the policy-level, there is a need to meet the demands of making the law restrictive. The bureaucrats deploy arbitrary measures to restrict access to abortion. While they may be in agreement on the importance of access to safe abortion at the bureaucratic level, the emphasis in enforcement is on regulating abortion, not on sex-determination. The providers are reluctant to provide abortion services, or provision services go unrecorded and hidden. The media presents abortion as the primary problem, the complicated contextual relationship between sex determination and socio-economic structures remains underexplored. At the community-level, there is an increased misconception that abortion is illegal. This further intensifies the stigma against abortions.

The biggest challenge therefore is to preserve access to safe abortion while addressing sex selection in India. For this, it is important to demystify the issue, pin-point and elucidate the stakeholders, identify allies and facilitators.

Medha Gandhi referred to a consultation supported by Packard Foundation, attended by 22 different organizations. The organizations included donors, coalitions, international NGOs, NGOs, professional associations, and advocates against sex selection. The objective of the meeting was to find a common ground amongst different organizations over seemingly disparate issues. For instance, access to safe abortion and sex-selective abortion, are deeply intertwined issues and must be addressed together. The meeting ended by recognizing 1) the need for collective action to work on both issues simultaneously 2) the need for a loose network to work on these issues 3) key areas for campaigning.

The key areas for campaigning included 1) positioning abortion and sex selection as women’s issues 2) creating a gender equality and rights approach 3) strategic priorities for the campaign 4) public messages on legal abortion and gender equality 5) Clarification of the Acts impacting safe abortion and sex selective procedures, namely the PCPNDT Act, the MTP Act and the Drugs and Cosmetics Act. Once again, the PCPNDT Act has been the most complex, in its implementation. The groups’ analysis on themes revealed that Medical Abortions are permitted in public facilities, but drugs like Misoprostol and mifepristone are not easily available despite the state PIP budgets allocating enough money for its procurement. While these drugs are supposed to be available with private chemists as well, they have declined over time due to fears of crackdown. A dip-stick study in Maharashtra has shown that over 50 percent of the pharmacies in the state did not keep abortion medicines. According to the chemists, the FDI inspection bodies often raise questions on

prescriptions, the names of doctors prescribing the medicines, the dosage of the drug, and so on, verging on harassment. 6) Introduce Medical Abortion for First Trimester in public health facilities 7) Expand allies among development partners.

On the basis of these findings, the groups decided that they would work together as a campaign. A campaign was preferred over an institutional organization because it offered flexibility, a flat structure of a consortium or a network, the absence of a chair, strength in numbers, where the secretariat is not the sole representative of the members. It was also a targeted intervention with a defined goal and a fixed time frame of three years, against which it would measure its achievements, revise its goals according to the changes in trends.

The next steps included finalizing the ToRs for the campaign and four working groups, campaign branding, launching strategy and launching date, possibly 28th May, meeting to finalize the immediate next steps.

Through questions in this CH meeting, it was identified that pharma companies have a 17 percent stake in anti-abortion drugs, and that it is important to engage with them, especially in the current climate when the FDI is clamping down on pharmacies. The IPAS campaign has not worked with them, but is willing to take up the suggestion.

Breakthrough's work towards addressing Sex Selective Elimination

Veenu Kakkar (Breakthrough)

Breakthrough, as an organization, did not view issues of safe abortion and sex selective elimination as competing ones. In their work against gender discrimination, they have held meetings with government officials, doctors and have worked with the youth.

Their research in four districts of Haryana viz. Panipat, Sonipat, Rohtak and Jhajjar revealed very low sex ratios and child sex ratios with marginal improvement since 2011.

The multi-stakeholder approach deployed by them included Phase 1: Agenda setting: a) Develop draft routes b) assessing stakeholder understanding of the issue. Phase 2: Developing action plan a) Prioritizing route b) Developing action plans. Phase 3: Finalizing communication strategy a) identifying effectiveness of stakeholders b) developing strategy for stakeholders.

Some of the main challenges that threaten the issues of sex selective abortion issues include the vocabulary deployed when discussing and highlighting the issue, slow uptake of ideas, poor translation of ideas at the ground level. Breakthrough also found that the crackdown on the doctors and chemists had negative repercussions.

S.no	Target groups	Challenges	Status
1.	Youth	Lack organizing, really want to do something	Do number of activities, not sustained with little impact
2.	PRI and other influencers	They have no clear message, do not know what to do	Can be effective but do not take up the issue actively
3.	Media	Deep analytic work is missing; reports largely on events	Know their roles and responsibilities and are willing to help within the framework
4.	Government	Too many responsibilities ; willing to give monetary incentives and create policies	Willing to be part of campaigns and initiatives and willing to support better implementation policies like SABLA , NREGA
5.	NGOs, frontline worker, SHG	Lack will, motivation, capacity, and tools	Carrying out programs and already doing work to address many of these issues
6.	Educationists	Unable to conduct inter-generational conversations; no tools; no time	Very limited participation and not sure how to address the issue directly
7.	Medical professionals	Don't know what messages to give and how	Feel defensive and blamed for SSE
8.	Corporates	Not sure if they can be part of this issue and how	Minimal involvement

Media Initiatives on Abortion

Mercy Barla (Population First)

On analyzing media initiatives that frame sex-selective abortion as a 'save the girl child' issue, Population First notes that media images communicate shock and gore, playing on themes of guilt and fear when it comes to the aborting a female foetus. Advertisements rely on the rationales behind having sons and daughters. The terminology used is that of the unborn child, female foeticide and foeticide. Women too get stereotyped as mothers of brave sons. This also resonates with knee-jerk reactions from the government, such as tracking pregnancy, restricting sale of abortion drugs, restrictions on service providers. The 'Ladli' ad, sponsored through a SUN group corporate social responsibility venture, illustrates the problems ridden in the ways in which ideas on sex selective abortion are conceptualized and disseminated.

The ad features a young couple and mother-in-law at a hospital as they prepare to meet a doctor to abort the pregnancy. While the husband remains silent and subservient, the mother-in-law tells the young woman that she should go ahead with the abortion since it is a girl child, The conversations are being overheard by a hospital sweeper and many others present at the clinic. The young woman appears conflicted and reluctant, and suddenly everyone in the room hears the voice of a little girl pleading for her life and expressing her desire to live, and that her parents' would not have to worry about her education, as she would use her brother's books, or her dowry because she would live with her parents and look after them in their old age. The mother-in-law, after the plaintive cries of the illusive little girl are heard, has a change of heart, and tells the young woman that she should no longer go in for the abortion and the family walks away happily. The on-lookers are touched by the scene and appreciate the move by the family.

This advertisement is hinged on idea of the right to life, and slides over the crucial issue of sex-selective abortion. After protests by several activists, mainstream television stopped airing the advertisement. And yet, it is difficult to monitor and regulate the images that flood public spaces. While there is a need to use communication effectively to circulate ideas, this must be done delicately. Advocacy through information, education and communication is critical. Population First has also created a repository of campaign materials developed by different agencies. This information is provided on a **www.creative-excellence.org** as an open source.

Some Conclusions and Reflections

- Members reflected on the dilemma that practitioners might face in delivering and restricting abortion services based on sex selection. Socio-cultural, familial, and

individual economic pressures must necessarily be taken into account while thinking about, and addressing sex-selective abortion.

- The public discourse on the thinking about abortion must not attach and extend personhood to the foetus. Phrases like the girl child and baby girl must be avoided altogether.
- Public discourse on abortion must also avoid emotionally charged vocabulary.
- Access to abortion must not be restricted, and efforts must be made to extend it beyond 12-15 weeks or the first trimester abortions.

TECHNICAL SESSION 3: MATERNAL HEALTH – CHAIR: DR. NILANGI SARDESPANDE

Health System Challenges to Maternal Health Care

Dr. Dilip Mavalankar IIPHG

Dr. Mavalankar began with a quote by Dr. Abdul Kalam "India is a country of 1 billion but thinks like 1 million". This gets reflected in the way our health systems also function. One of the main bottlenecks with regards to the health systems is that management capacity is very limited. He gave the example of how at the national level there were maybe three people at the Director level to manage Maternal Health. The same situation repeats at the state levels too where there are insufficient number of technical and management competent persons. Dr. Dilip contrasted the situation between the British NHS and the Indian Public Health System - at the primary care level, the former had 1 General Practitioner per 1000 population and in India, the ratio is 1 PHC Medical Officer for 20-30,000 population. India also lags behind with respect to other staffing. The point is not to compare UK and India as many people would point out, but to bring to the forefront that India as a country is yet to revise historical PHC norms and Human Resource norms. Even the public provisioning of health budgets is more towards staff salaries than actual programmes. In effect, the system is under-resourced in every way.

Dr. Dilip also brought up the absence of accountability and linking it to action. The World Bank had undertaken an extensive study to analyse absenteeism. The issues of corruption, labour rights etc. are all part of the accountability discourse. But this was the last study to do so. With respect to NRHM, though there is a mandate for all Public Health facilities, especially the PHC to display the citizens' charter, not many do so. He also warned the group about the flip side of accountability. If patients start accessing public health facilities more regularly, the patient load will increase. In India there are no standards on the physician time per patient. In the UK, doctors are only permitted to see six patients per hour. In India, there is lot of resistance in adopting such guidelines. Sweden has similar norms for their midwives. The midwives there have to spend an hour witha pregnant lady for the first appointment and half an hour in subsequent meetings.

Dr. Dilip described some of the major challenges to explain the continuing apathy towards public health. To begin with, there is no top-level political debate, creating a favourable environment to do so is a challenge. Secondly, data is missing. There is lack of administrative capacity at national, state and district level to report demographic information on a more regular basis. Thirdly, creating accountability mechanisms continue to be a challenge. Dr. Dilip concluded his presentation by stating that "We are not ready to address the key and deep rooted issues and still tinkering at the margins"

The Contribution of the ASHA Programme to Maternal Health and Some Challenges

Dr. Rajani Ved NHSRC

Dr. Rajani elaborated on the original vision of roles that an ASHA was supposed to fulfill and how the concept has evolved; as well as the inherent challenges and opportunities. Over a period of time, it has become a practice to heap additional responsibilities on the ASHA. Originally conceived as a facilitator, volunteer- activist and a community level provider, she is now being projected as an extension of government health services system. Other challenges include continuous training, need for support structures and mentorship, availability of drug supplies, equipments and the need for a performance monitoring system.

As per data and observations, Rajani noted that the High- Focus States did much better with respect to their ASHA performance. Each state continues to adapt their training, management and payment structures for their ASHAs. She then went on to explain the role of the ASHA for maternal Health

1. Home visits
2. Mobilizing pregnant women
3. Supporting Institutional Delivery
4. PNC as a part of HBNC
5. Family Planning Counselling

Based on concurrent evaluations and various other monitoring reports, Rajani pointed out that ASHAs are conducting more home visits than ANMs, but then too they end up leaving behind the most marginalised groups in their villages. Rajani classified the various resistances that the ASHA movement faces - mainly from the medical fraternity, industry (private) and from Civil Society itself. Politically as well, with India entering the G20 club, there are questions as to whether a CHW has a role to play in health care services. According to her, the time has now come to pilot new types of training and broadening the scope of the ASHA's work to Non Communicable Diseases in states like Kerala where it may

be more required than others. Also, there is a need to stabilise security for ASHAs by introducing certifications through Open Universities and promoting Brazil's Community Health Nurse Model.

Improving Accountability for Maternal Health

Dr. B. Subhasri - RUWSEC

Subhasri's presentation focused on CommonHealth's work on improving accountability for Maternal Health. She explained in details the groups work over the years –particularly focusing on the Barwani fact-finding visit/report, development and implementation of the social autopsy tool. Subhasri described the processes, methods, findings and how these evolved into more concrete outputs, especially advocacy material. She closed her presentation by listing few areas that CommonHealth could explore as part of its work on MCH continuum

1. Maternal morbidity
2. Perinatal Outcomes
3. Processes like referrals
4. Quality of Care-(Respectful care)

Enabling Community Action to Promote Accountability for Maternal Health in Gujarat

Renu Khanna SAHAJ

Renu's presentation explained the context and framework of Accountability. The Gujarat project has borrowed many ideas from the Community Based Monitoring framework for NRHM. She explained the step by step approach undertaken under the project including selection of districts, using pathways of community engagement, understanding women's perceptions on Quality of Care, development of tools and various other processes that SAHAJ implemented in order to undertake the exercise.

A tool has been developed for collecting information on maternal deaths: 'social autopsy' with an emphasis on social determinants and rights. Social autopsy offers a critique to the official maternal death reviews in which social determinants and indirect causes are not recorded and only health systems personnel are involved. Social autopsies, instead, are designed to document system- related and social factors alongside scientific, technical factors. They also actively record rights violations. Community-based organizations have been trained to use this tool (*See Handout on Enabling Community Action to Promote Accountability for Maternal Health-Gujarat*, *for tools, monitoring maternal health and further explorations).*

Renu concluded her presentation with some of the key lessons that SAHAJ and partners have learnt from the MH Accountability and Social Audit process.

1. There is an acute need to make women aware of their entitlements
2. The importance of continuous dialoguing with Health system personnel

An Enquiry into Maternal Deaths: Parijat Project - ARTH

Dr. Rajesh - ARTH

Dr. Rajesh started his presentation with idea behind Project Parijat-An inquiry of Maternal Deaths in 10 districts of Rajasthan. He outlined the objectives, key steps undertaken and various indicators that emerged through the processes documentation during course of the project.

Some key findings that emerged from the study field area were:

1. The Health System/District Civil Registration system had only captured and investigated a small percentage of the maternal deaths in the community
2. Around 50% of the deaths are post-partum
3. Around 44% of the women died in an institution
4. Six major causes of death were identified - Anemia and PPH were among the most major causes of death

The study is nearing completion. Currently, an expert panel is reviewing the cause of death for all the cases.

Discussion

a. FOGSI can play a big role when it comes to sex selective abortions and offering safe abortion services. Health Systems have a huge role to play when it comes to sex determination and Maternal Death Review. We should make conscious attempts to liaison with these stakeholders. It was also brought to the attention of the house that most of our work is disconnected from the political system. We also need to engage with the local political systems
b. The term Data Triangulation needs to be cautiously interpreted and understood. Words may change in various contexts. For example. What does ‘delivery’ mean to different persons? We asked women, who conducted their delivery and they would

reply that their mother-in-laws did. But when the ANM (who actually conducted the delivery) asked the women the same question, they clarified that actually the ANM caught the baby, but their mother-in-law did all the cleaning work and other preparatory work.

c. In relation to Dr. Mavalankar's talk, a participant remarked that there is a difference in the efficiency levels of permanent and contractual workers. The efficiency of the permanent staff is worrisomely low. Dr. Mavalankar responded that labour laws and salaries are major issues. One worrisome issue is that once people become permanent, they do not have an incentive to work. At the same time, we need to be cognizant of the issue of rights and entitlements of health workers – there are doctors and nurses who are over-worked, even contracting malaria and other diseases as they work. These issues arise when the system is too centralised and there in no work measurement.
d. Do we need to explore for a *suo moto* declaration –i.e pro-active displaying of critical data to the public, so that they do not need to resort to the RTI mechanism every time. What are the specific things that ought to be displayed? Dr. Mavalankar stated that there is a lack of accountability when it comes to publishable data. He gave an example of his being commissioned by the government to prepare a report on the capacity of various stakeholders to implement Immunization Programs. The report was never made public - the response was that this was a GOI's funded project and they owned the data and they did not feel it needed to be shared. With respect to pro-active disclosure, he suggested that we could work closely with the medical administration to develop a menu card of the information that each Health Centre should display.
e. Community Based Monitoring heavily concentrates on frontline workers like the ANM, MPW, ASHA and not higher –up. *Community Action presupposes that the onus of reporting and auditing lies with the Public. The* VHSCs require continuous support, training and budgetary investments. Experience of CBM shows that VHSCs take around 3 years to actually start functioning. It takes around 3-5 years for monitoring culture to get rooted. If we hasten things or expect quick results in a short time, it will be mere tokenism. We need to strengthen the management capacity at various levels and set standards of accountability.

ADMINISTRATIVE AND ORGANIZATIONAL ISSUES

- **On registering CH:** CH is an unregistered body. On the question of registering CH, several opinions were aired, its pros and cons discussed. Dr. Visaria said that she was a member of HealthWatch which had undergone a similar problem. Its members had

decided to register it. However, a proper secretariat was not created and after 1994, the organization became completely dormant. She suggested that registration would be a positive step if CH had a concrete vision of what it wanted to accomplish in the next 10-15 years. Supporting a secretariat involves establishing an office and hiring staff. Sarita Barpanda said that everybody must commit themselves to nurturing the organization. Gayatri Giri said that registration would detract attention from substantive issues towards administrative ones. Some of the members also argued that funding, an important reason behind registering the organization, was inevitably constraining, and came with its own baggage. Medha Gandhi argued that the current structure of the CH was flexible and open, this gave it strength in terms of numbers, and hence, it did not matter if it was unregistered. Renu Khanna was also against registering the coalition; she added that a lot had been achieved in the last seven years. The discussion was consequently closed without any conclusive decisions. It was decided that the Steering Committee should consider the General Body's views and take a decision.

The election process: The coalition has a steering committee that plans and manages all activities. According to CommonHealth's rules for SC functioning, SC members are to be rotated off after a maximum of six years in office. This implied that several persons who had been SC members since the formation of CommonHealth needed to be rotated off in the immediate future. In the SC meeting held on the day previous to this General Body Meeting, it was decided that taking into account requests to step down from various SC members while also ensuring continuity, the following SC members were to be rotated off: Abhijit Das, Sunita Singh and Lindsay Barnes.

In order to facilitate rotating off more members in the next SC meeting, the SC meeting also decided that in addition to electing three new SC members, three 'special invitees' will be inducted who will be on the SC for one year, and would become full members in the next election unless they are for some reason unwilling/unable to do so or if during the year of being special invitee, do not engage in CH activities to the extent expected of an SC member.

. Dr. Subhasri, Sangeeta Mcwan and Gayatri Giri were elected as new SC memebrs. Dr Shobha Mishra, , Ajay Kumar Das and Dr. Nilangi Sardeshpande who were nominated for the SC election by members presentwere asked to be special invitees.

There was also discussion on electing new office bearers in place of Sundari (Chair) and Renu (financial advisor). Only two SC members were eligible for becoming office bearers – Suchitra Dalvie and B Subhasri, because the others are in the queue for being rotated off. Since Suchitra was not present, a decision was made that both Suchitra and Subhasri would

become vice-chairs for a period of six months. After six months, Sundari and Renu will be rotated off and vice chairs will become office-bearers.

PLANNING AND PRIORITISATION FOR THE NEXT YEAR

Participants worked in groups and identified priority issues in each of the Theme areas. They were asked to discuss the following questions:

1. What are some priority issues that we should address, to make pregnancies safer for women?
2. What are the most important action steps we need to ensure to prevent avoidable newborn mortality?
3. What actions would we take to prevent sex selection without compromising access to safe abortion?

The table below gives the outcome of the group discussions.

	Research	Advocacy	IEC Production of materials
Neonatal	• Quality of newborn care • Position paper (maternal and neonatal continuum) • Existing referrals systems to be studied	• Home based new born care by ASHA • Audits of new born deaths/counting of perinatal deaths • Increase in the number of nursing staff • Specialised services at PHC/CHC level • Advocacy for integrated intensive new born care set up at district hospitals **(may be even at lower levels if yes then what kind of services to be advocated at lower levels??)**	• Checklist of quality of care/discharge checklist • Appropriate use of oxytocin • How to identify danger signs • Define new and practical standards of referrals • Breastfeeding practices for mother

Maternal	• Position paper on referrals • Evidence building around JSSK • Going beyond descriptive status documentation to explaining why	• Advocacy for maternal death reviews with reports being published at state and national level (Available in the public domain • Maternal health monitoring tools/need to be incorporated within CBM tools • Referrals audits • Advocacy for the state to address anaemia /iron sucrose • Advocacy to increase and have a cadre of nurse-midwives and maternal health officers • Advocacy to make institutions compliance with IPHS • Labour room facilities • Training of link workers on gender and rights • Advocacy on investment of technology for detecting anaemia at the community level • Maternal death insurance	• IEC materials on a range of topics
Safe Abortion	• Content analysis of IEC materials regarding sex selection prevention and safe abortion • Research on knowledge, attitudes, behaviour and practices on safe abortion and MTP	• Advocate for ASHAs for IEC materials on safe abortion and MTPs • Common ground workshops and alliance building • Sessions on a whole range of stakeholders • PCPNDT Act to be monitored • State level advocacy on production of MTP reports (public disclosure) • Work with men and boys on gender equality • Task shifting towards suitable nursing cadres providing safe abortion services	• Educating communities • Differences between PCPNDT ACT and MTP Act • Repository site for IEC materials

The meeting end with a vote of thanks to all participants, resource persons, the SAHAJ team for organising the logistics, Sunanda, Sapna, Nilangi for rapporteuring. The report has been compiled by Chandana and Renu.