Report of the CommonHealth Regional Meeting

23rd and 24th September 2013

BAIF, Pune

On 23rd and 24th September 2013, a two days regional meeting was organized in Pune. This meeting was attended by around 35 participants from five states viz Maharashtra, MP, Gujarat, Goa and Chattisgarh. The participants were mainly grass root level representatives of different organizations from these states.

During the regional meeting, following sessions were organized-

1. An introduction to CommonHealth –vision, mission, highlights of activities
2. Maternal Health situation in the five states
3. Maternal Death Reviews: the strategy and tools and processes
4. MDR: Sharing experiences from the field
5. Neglected issues in maternal health
6. Brainstorming session on bringing Maternal Health into Community Based Monitoring and accountability
7. Current situation and challenges in safe abortion access
8. Medical Abortion pills—Technical update
9. PCPNDT and access to safe abortion services
10. Strategies for Common Ground discussions among key stakeholders

Given below is the summary of the important issues which were discussed during this regional meeting.

Session 1: An introduction to CommonHealth –vision, mission, highlights of activities

At the outset, Nilangi welcomed all the participants on behalf of the CommonHealth. She shared that CH mainly works on three areas viz maternal health, neonatal health, and safe abortion. However, in the regional workshop, the discussions would mainly revolve around on two themes i.e. maternal health and safe-abortion.

All the participants then introduced themselves and spoke about the work of their organizations in brief. For the detailed information of the participants, please refer to **Annexure-I.**

After this brief session of introductions, Suchitra gave a short presentation about CommonHealth and its activities. The participants were shown the CH website and the different resources available on the website.

The Coalition for Maternal-Neonatal Health and Safe Abortion is a membership based network of Individuals and organisations from across the country.

The **goal** of CommonHealth is to advocate for better access to and quality of **maternal-neonatal health and safe abortion** services. We engage with issues of gender and reproductive health and rights through a broad-based advocacy strategy to identify significant gaps that exist in maternal-neonatal health and safe abortion in terms of health outcomes and women's rights.

Why do we do this ?

Because in India: One woman dies every 7 minutes from complications of pregnancy, childbirth or unsafe abortion.

What do we do ?

Maternal- Neonatal Health : Quality of care in Maternal Health, Gender and Rights training, Community Monitoring, Mobilization for accountability, Maternal Death Reviews, Fact sheets, Fact finding studies, policy documents

Safe Abortion: Advocacy for improving access to safe abortion services, women's right to safe abortion, sex determination issues impacting safe abortion

How do we do this ?

Through the active involvement of the membership:

- Regional meetings for advocacy
- Capacity building
- Documentation and testimonies
- Forum for experience sharing
- Peer support and mentoring
- Online platforms and print material

In the same session, Renu shared with participants that some of the awareness material originally written in English has been translated in other languages like Hindi and Oriya. She encouraged participants to share their material, which can be displayed on the CH website. She encouraged participants to share stories, experiences, photos of their work. Participants were also requested to translate the relevant material in their regional language.

A short film named "Voices from the ground" was screened and feedback of participants was sought. Some of the important comments by the participants are as follows:

- It would be good if testimonies of woman can be included.
- Need to incorporate issues related to the implementation of schemes such as JSY and JSSK, and stories about services provided by private sector
- One of the participants suggested that there should be Hindi subtitles where there are English narrations in the film. Visuals in the film were appreciated
- It was suggested that the name of the local organization in Badwani, MP should be mentioned in the film,

Session 2: Maternal Health Situation in the five states Maharashtra, Goa, Gujarat, Madhya Pradesh, and Chattisgarh: Facilitator-Shobha Mishra

In the beginning of the session, Dr. Shobha Misra shared framework for the discussion on maternal health. She asked the participants to discuss following issues pertaining to the maternal health situation in the respective states-

1. Discuss status of maternal health in your state

2. Identify one issue related to ill health of mothers

3. What are the barriers for this health problem?

4. Suggest possible solutions to overcome the barriers

Participants were given half an hour to discuss in the state wise groups. After the discussions, each group made presentations about the issues discussed. Key issues related to maternal health presented by the state groups were as follows-

Since there were more participants from the state of Maharashtra, they were divided into two groups.

Maharashtra Group 1:

Important issues raised by first group were as follows- anemia, malnutrition, early marriages**,** two child norm, restricted access to contraceptives for certain groups such as Muslim women, social cultural determinants of unwanted pregnancy, poor quality of ANC, disparities in Urban and rural areas, privatization of health care and its impact on women. Within the urban areas, women residing in slums are the worst affected as there are hardly any maternal health services available for them. The dominance of private sector is evident even in the small cities.

The group shared that due to community based monitoring in Maharashtra, there is certainly some improvements where CBM is being implemented. Lack of political will was articulated as the most important barrier for the delivery of good quality maternal health services.

Solution given was pro-people advocacy

Urban health issues: In Pune city, some of the area comes under the jurisdiction of military. This has led to difficulty in accessing health care as the civilians face discrimination in military hospitals. Lack of health care for migrant population was also enunciated as one of the problems in Maharashtra.

Maharashtra Group 2:

Second group from Maharashtra articulated that MMR is reducing. Concern was raised over lack of information regarding abortion related deaths. Women in tribal areas are in worse situation than other parts of the state, as, in tribal areas there are neither private healthcare facilities nor is the public sector effective. Even today, 75% deliveries take place at home.

Solutions proposed by this group were that people should be made aware about their rights, rights to get health services, awareness on health issues. Both service providers in private and public sector should be sensitized about the rights and should be made accountable.

Chhattisgarh and Madhya Pradesh:

Key concerns related to maternal health were as follows-

High MMR, malnutrition and high prevalence of anaemia. Lack of physical access to health services due to dense forest and infiltration of extremist groups in certain areas. Social exclusion of dalits, tribals and muslims was also mentioned as one of the issues

Most of the deliveries are conducted by untrained personnel. TBAs are missing from the villages and in pressure of institutional delivery ASHAs conducting home delivery. Home deliveries are registered as institutional deliveries. Quality of health care in institutional deliveries is very poor

High out of pocket expenditure incurred on travelling and purchase of medicines. Long distances between PHCs and villages is one of the important barriers. CBM program should be strengthened. Public health system is not providing services at community level, people do not want to use public health services

Government is not willing to accept low institutional deliveries. In pursuit of institutional deliveries, government has abandoned Dai programme. There is reduction in space for NGOs in the right wing government

Private providers reaching to community are mostly quacks and they are exploiting community.

Mitanin progamme of Chhattisgarh though very successful, now the mitanins want to be taken as government employee, when they were actually people's representatives.

Solutions proposed were: TBA training should be restarted-TBAs should be trained and provided support to conduct safe home delivery. There is a need to give information to community about identifying high risk signs. Irregularities in receiving JSY incentives was also pointed out as one of the problems

Goa:

Key issues pertaining to maternal health in Goa were as follows:

Unsafe abortion related deaths was mentioned as one of the important problems

No help is given for home deliveries, however, institutional deliveries are high in number

Among the residents, there are high levels of literacy however the situation is not so good for the migrant workforce in the state

Untrained nurses in the private sector is one of the problems in delivering good quality health services, private doctors do not take the responsibility if there are any complications, patients are then referred to the public hospitals

Issues: survivors of rape are not able to reach health institution due to discrimination.

Solutions proposed were creating awareness about delivery, safe abortion, spacing methods.

Gujarat:

MMR in Gujarat is 148.

Issues enlisted by the group were unwed pregnancy, indirect maternal death, early pregnancy related deaths, concerns of migrant population, hard to reach areas, facility based maternal deaths in other wards away be missed.

MDR format of public and private should be same. Monitoring for MDR there is scope for improvement. PPP-CY scheme earlier it was good now focus is shifted to promoted institutional delivery at public health system. Other hand public health systems are not equipped, referral back up support required. /E-Mamta good programme but sustainable, quality, utilization of the same, review and feedback not effective**.**

Mamata clinic-ANM stopped visiting field, PNC poor/done by ASHA. JSY, JSK issues of certification earlier sarpanch was empowered now they have to get from higher authority-hence, there is corruption and the women/family has to suffer.

Declining sex ratio '*Beti Bachao*' vs. '*Beti Badhao*'

So many cadres at community level so conflict of interest, confusion. At *Mamta* day, there were eight health functionary and beneficiary few.

Solutions given were- increasing community awareness for rights, community monitoring, universal health coverage, free medicine to be made available, sensitization, commitment and enabling environment is required.

Priority issues:

Community level: awareness for the rights and own health and health related issues. Attitudinal change required, awareness-required for organizing and empowering community. ANC, screening for HR factor. Local service provider should create awareness in community about their guaranteed health services and rights. Community based research for advocacy and how to make private sector responsible for.

Renu Khanna summarized key issues emerging from the presentations of five states and the discussion.

Key problems related to maternal health from the presentations and discussion were-

Under-reporting of maternal deaths, poor quality of ANC, PNC, unsafe abortions, inequities in access to health services especially for tribals and residents in naxal affected areas and migrants.

Lack of public health infrastructure in urban areas, urban poor are most vulnerable groups.

Private sector is unregulated

Strong emphasis on institutional delivery is problematic

Need to restart training of TBAs

JSY corruption, blood bank availability issues, government schemes are good JSY, JSK, RSBY etc. Implementation is huge issues.

Concern of declining sex ratio, confusion between '*beti bacho*' and abortion services

Session 3: Maternal Death Reviews: the strategy, tools, and processes

Facilitator-Renu Khanna

Renu Khanna shared CommonHealth's work in area of social autopsy of maternal deaths. CH uses SSSR framework for Maternal Death review.

S- system related issues

S- social factors

S- science i.e. technical factors

R- rights violation

CH work on this issue is complimentary to existing MDR review done by Government functionaries.

Our aim is to make good quality maternal health services available, accessible and affordable. It was shared that women's struggle for reproductive rights was unfortunately narrowed down in MDGs. Globally comprehensive maternal health was confined to maternal deaths and further narrowed to SBA and institutional delivery.

Challenge is to put maternal health in reproductive framework and to include social political determinants.

CH position is to challenge the concept that only institutional delivery is considered safe delivery and to ensure that safe delivery includes respect, privacy, freedom from labour room abuse etc. from women's perspective and indicators.

MH=ANC, INC, PNC while contraception, safe abortion, maternal morbidities should be part of Comprehensive maternal health.

Sharing of experience of CH and MDR: Barwani experience, review of medical records, gender issues, rights violation, and health system issues. Despite huge financial investment public health service delivery remains poor. District hospitals are referring emergency cases to the private sector. Felt need to work on accountability.

Many people working on Maternal Death issues organized a meeting in July 2012 on 'Dead Women Talking'. MDs are under reported. NGOs and CBOs are closer to the community and they are able to identify MD and can improve under reported of maternal deaths.

Develop methodology and guidelines so that we can use it. Framework of analysis was developed.

There are ethical guidelines how to use the framework how to approach family, how to probe, and about maintaining confidentiality.

CH has conducted five training programmes, which included training on methodology, framework, and now doing Social autopsy of maternal deaths.

In the end Renu shared that in January there would be a three day workshop in Mumbai to collate the data from different exercises of maternal deaths review and to review the findings emerging. Also the need for validation of the tool was enunciated. CH would prepare a shadow report on maternal death review cases.

Session 4: Maternal Death Reviews: sharing experiences from the field:

Facilitator-Arun Gadre

In this session, experiences regarding gathering information related to maternal deaths were shared by the participants.

Santkumar, Bilaspur, Chhattisgarh Using RTI, data regarding maternal deaths from January to May 2013 was sought. According to this, there were only two maternal deaths recorded in this period. In the previous year, there were 8 to 10 recorded deaths. However, during community meeting, they could elicit information about 42 deaths, which shows huge under-recording. Four deaths had taken place at Apollo hospital. It was revealed that the Apollo hospital doesn't come under the jurisdiction of RTI and hence those deaths were not accounted for. Most of the women

go to natal house for the delivery so for one MD review they have to visit minimum two villages. They do not go to family of deceased immediately after the MD but after 10-15 days. Along with last rights families throw/burn all records of deceased. AWW are denying the information. Government organized meeting but out of four, there were no minutes for two meetings. MDR conducted but the guidelines for the review are not followed. Out of 25 MD, one third were poor, backward caste and resided in isolated place in village. Major challenge is getting information about abortion-related deaths due to the stigma associated with it.

Feedback on CH framework: Need to increase space for summary writing.

RK suggested doing listing of all deaths in reproductive age group first and then verifying whether it was maternal death or non-maternal deaths.

Bhavna, Amhi Amchya Arogya Sathi, Maharastra (Oxfam supported programme): Exercise on documenting maternal deaths was done in two blocks, 35 villages. Last one year 12 MD were founded and none of them were recorded by government. The organization has done nine MDR. Sickle cell anaemia is common and related maternal deaths are high. Publicly only two maternal deaths was reported on the probe another nine deaths were identified. Community level workers are also not aware about definition of maternal death. So need to work on these aspects too.

Vijayalaxmi on 13th Sept, 2013 did review for one MD. That woman was admitted to RH, was kept for 24 hours, and then referred to sub district hospital. Family was asked to show at sub district hospital but family decided to take patient to the DH but woman died on the way to the hospital. Underlying cause of maternal death was GBV. Family was not willing to provide any information. Only 46 MDs reported by government while assumption is that it must be much more then reported.

RK: There should be civil society representation in the MDR committee at district/state level and MD should be reviewed through social autopsy framework.

Organization has developed strategy to strengthening the VH&SC especially to deal with GBV issues.

Dr. Shobha, SEWA-Rural: Dr. Shobha also raised the issue regarding deaths during abortion especially if the girl is unmarried, such cases are never reported and the ANM is not aware if these come under maternal deaths or not. She voiced the importance of doing MDR and highlighting underlying social determinants of death.

MDR form: difficulty to get information whether woman is SHG member, toilet availability, form is lengthy, how we are going to use this information.

RK: As soon as, we establish MD they sent SMS to PHC staff informing them and feeding back to the public health system. Therefore, MDR information filled form sent to PHC. MH is not only government's responsibility there are many stakeholders and wasted interest.

Session 5: Neglected issues in maternal health-

Facilitator- Gayatri Giri

Suchitra presented PPTs on indirect causes of maternal deaths and spoke in detail about four conditions

Anaemia: more than 70% adolescent girls are anaemic. Explained about sickle cell trait and disease. Dehydration, fever, low oxygen, in labor if woman sweats etc. aggravates problem.

Malaria: general population risk, pregnant women are more vulnerable as immunity suppressed during pregnancy so is more at risk. If P. Falciparum malaria then risk increases more.

HIV/AIDS/STIs: Human immune deficiency virus. Four route of HIV infection. Unprotected sex, infected blood transfusion, single needle injection multiple user (drug users), Blood Mother to child transmission-One of the risk vaginal delivery-vaginal fluid. Screening during pregnancy about HIV, importance of counseling and timely and continue ART.

TB: Low immunity, TB, women having TB gender issues late identification, late treatment and if woman is pregnant she is can have IUGR, pre term labour.

8 by 8 rule. A person with active TB can infect anyone within an 8 feet distance in 8 minutes. In India, 2.3 million TB cases in comparison of total 8.8 million TB patients globally.

The participants suggested including other conditions such as Jaundice, Rheumatoid Heart Disease (RHD) and Gender based violence (GBV).

Session 6: Bringing Maternal Health into Community based monitoring and accountability:

Facilitator-Nilangi Sardeshpande

Hema shared Maharashtra experience of CBM which was started in 2007 in five districts. In each block, there were three PHCs and in each PHC, five villages selected. This was done in support with GoM. Purpose was to ensure that millions of rupees spent on the services under NRHM should reach to the people. [Funds were released for infrastructure, material, supply and miscellaneous].

Village Health &Sanitation Committees (VHSC) were organized and empowered for monitoring at community level. Tools are developed for the monitoring. A committee was formed to monitor PHCs. Public hearing held once in a year where all concerned public health functionaries were invited. The process is not fault finding but solving problem of public health functionaries. There were significant improvements seen due to this processes i.e. people became aware about their entitlements in PHC and the functions of PHC staff.

Some of the positive outcomes of CBM were such that earlier women were not getting JSY money which is Rs.700/- and ANM was giving only Rs.300/-. Now payment is done through cheque. During Jan Sunwai, Nurses and beneficiaries both are present. Families shared that they have not received full amount. In the public hearing, some of the ANMs returned the money to respective families, which was earlier pocketed by them.

CBM platform works like a pressure group. Earlier people could not confront doctors now they create pressure on doctor to come in time. People created pressure on health functionaries to provide services at community level. Earlier patients were given prescriptions to purchase medicines now they are provided medicines. In one village, it was noticed that ANM had written same Hb levels for all women. It was pointed out by the monitoring committee and then the ANM corrected her practice. In this process, media is involved strategically.

After the experience sharing of CBM in Maharashtra, MP experience of CBM was shared. CBM in MP focused on two components VH&ND, JSY, and JSKK. Started doing study, developed format etc. People were not aware about their basic rights. Women monitored VH&S day and filled up forms. Next session ANM came with all equipment, medicines etc. Women were surprised to see that as they saw all those equipment for the first time. Due to small steps, few changes happened.

In MP, currently SATHI, Sochara, CHSJ and 35 other NGOs are involved in monitoring. It was seen that women's health is not communities' health concern but it is also not families concern. There was no cooperation from the service providers. Most of the time ASHAs were victimized. Now there is slight improvement in the relationship between community and the ANM and ASHAs. MDs were identified, RTIs filed for the same.

Day II

24th September, 2013

Session 1: Overview of current situation and challenges in Safe abortion access:

PCPNDT: In Maharashtra, sex ratio was declining significantly hence sting operations done to check abortions. This has also affected access to safe abortion services.

In MP tribal areas, quacks perform illegal abortions. If people come to city, they go to particular service providers and illegal abortions are performed. In market, many medicines are available in open market. Women access it and use it, which has side effects. Concern was raised that safe legal abortion services should be available so that women's rights, health be protected and can be free from financial exploitations.

A case was shared of unmarried girl who became pregnant and was denied abortion services by public health service providers.

Goa: The Church is against abortion, illicit relationships are common. They have shelter to keep pregnant unmarried girls for short duration. In government hospitals, every day three to four women come for the MTP.

Gujarat: USG machine registration is mandatory, one has to send MTP reports, medical abortion kit people are using. They take history and if a woman with two daughters is asking for MTP the nurse suspects sex selection. Earlier in tribal area, roots were used for abortion mainly in unmarried girls. Two to three cases of maternal deaths were occurring due to sepsis. Now that practice is reducing.

ASHA and AWW have network with RHP and they do illegal abortion. ASHAs/AWWs paid Rs.1000/-.

In Maharashtra at civil hospital, one married woman was denied abortion/MTP so she went to private provider. Her abortion was done but she faced some complication and in six month, she has to undergo hysterectomy to get rid of those complications.

MP: 98% girls come all alone for the MTP; men do not come. They do not get actively involved in health issues of their wife or family. Dalit and tribal women are more vulnerable. They need special attention. There are lots of myths and misconceptions.

Maharashtra: one of the participants shared her experience when women come to hospital, her husband provides all details, and woman does not speak anything.

Bihar: Husband is not required legally but they call husband and take his consent so that later they should not make noise about it. All abortion cases are diverted to the districts hospitals which are not equipped and safe.

There is so much information available about PCPNDT but there is no awareness generation for MTP. In Pune 96 PHCs were studied. They should be providing MTP services upto three months of pregnancy but they are not.

Abortion is not treated as health issues, women's rights issues but considered as 'pap ka kam' and everything is done '*chori chupi se'*.

Many girls are not aware about menstruation etc. and they come at four or five months of pregnancy. Then it is very late and service provider is helpless.

There is a lack of body knowledge/conception/pregnancy/rights/MTP etc.

RHPs are accessible, close to home, keeps confidential hence, women go to them.

CG/JK: Mission hospital does not provide abortion services but provides post abortion complication services. So in routine it became practice that RHP provides partial abortion services and post abortion/complication services women go to mission hospital.

Marie Stopes clinic failed in Bihar because they failed to keep information confidential.

In Yavatmal and Gadhchiroli the tribal communities do not have any taboo for premarital sex, unmarried pregnancy etc. so abortion is not problem. Fertility and contraception is not an issue. ANMs given target so 23 year old women get TL done.

Goa: Hindus go for MTP and use contraception while Catholics do not.

Suchitra: The MTP Act does not state that safe abortion is a woman's right. It is conditional in order to protect the provider and the woman from the IPC which still criminalizes abortion.

Session on Medical abortion pills-Technical update:

ipill (only progesterone) used as an emergency and as prevention. There are no medical complications. ipill is not barrier method so does not give prevention from the HIV infection.

Vacuum Aspiration: Manual vacuum aspiration/ electrical vacuum aspiration. D&C dilatation and curettage is harmful so discouraged to do it.

SD shared observation of a study from South India that quacks realize MA is safe and they are doing MA while qualified doctors are still performing D&C. There is a need to sensitize/trained medical fraternity for MA.

She then spoke in detail about medical abortion using the 2 drugs Mifepristone +Misoprostol. Mifepristone stops blood supply to fetus. Ideally, after taking one Mifepristone has to give two to four tablet of Misoprostol, which causes uterine contraction. This is like natural miscarriage. This is used until 9 weeks of gestation and does not cause more bleeding than a natural miscarriage. Minor and self-limiting complications include nausea, vomiting, shivering. Combipack of pills is now available in the market and contains one tablet of Mifepristone and four tablet of Misoprostol. Reduces chances of sepsis as nothing is inserted in uterus.

Session 2: PCPNDT and access to safe abortion services-presentation and discussion on findings of the study conducted by Samyak: Facilitator-Kajal Jain:

Anand: Samyak works in gender, masculinity issues women's health and violence against women. Focus work area is among urban poor women in small cities.

They worked with 16 nagar parishads and started studying their health budget which was almost nil. They contacted people who were working on health issues and organized them to work for urban poor women's health right forum.

Preet: shared details of their study conducted in Maharashtra on studying the impact of PCPNDT implementation on safe abortion services.

Due to the strict enforcement of PCPNDT the private sector is denying abortion services to women so they have started going to the public institutions or to unsafe providers.

PCPNDT act was made to prevent sex determination. Identification of fetal sex is illegal. One has to see whether this is prevented. ? Another point was sex ratio is declining we need to find out what is the reason-is only sex selective abortion is the problem?

Anand: if 80% abortion services are provided by the private providers and if they have confusion then we are not able to address need/rights of women for medical/safe abortions. If private sector denies for abortion then woman has to go far of the place to the public sector to avail medical/safe abortion but has to suffer a lot (travel time, money etc.). We need to sensitize government functionaries for women's rights.

Session 3: Strategies for common ground discussions among key stakeholders: (facilitator-Suchitra Dalvie):

Group work state wise to outline strategies for

(i) CBM for MDR

(ii) Sex selection and its impact on women's access to safe abortion services.

The purpose is that if proposals of organization are ready then when CH approaches a donor we can try to seek funds.

Group work presentations:

MP & CG: MP no data, will see maternal health indicators, compare with previous and current status. Identify maternal deaths, services available to people or not? If not, what was the reason for that? i.e BP skills problem of measurement or altitudinal problem and simply writing 120/80.

Data reliability will be verified. They work with 93 centres, will do MDR, data collection in five blocks. Through the existing maternal health care project they will work with RHPs. For safe abortion they will take approval of government so that they can provide services in interior area. Will work with private practitioners.

Safe abortion services are available only at the district place. Need to organize workshops for the sensitization of government functionaries.

Maharashtra: In medical colleges MTP and abortion techniques/skills and attitude related study can be done. Maternal health care will be included.

Need to revisit tribal areas what is current situation? PCPNDT and MTP need to be discussed together.

Review and records of deaths of 15 to 45 years of women and need to work for the same group. Safe and institutional delivery centred advocacy efforts should be made.

Goa: To increase the awareness in interior villages. No public health facility available in such areas so women go to big hospital. Need for documentation of data. Safe abortion-church is very sensitive to abortion. Social workers of church go to hospitals and they teach natural family planning and no abortion. Goa being tourist place sexual promiscuity is there-need for safe abortion. For the safe abortion pill, need to work with doctors and pharmacist. Unmarried pregnancy is quite high but is hidden.

Gujarat: various initiatives done by government and civil society organization. Such as:

Sensitization of government functionaries of PCPNDT act, declining female sex ratio, sensitization workshop was organized with political leaders-MLAs, private bodies-IMA, FOGSI, Judiciary system, Community level sammelans, School level sensitization through various competitions.

Facility level: registration of USG machines, norms for the mobility of USG machine, display of boards i.e not doing sex selection test, on line reporting of the USG done in private sector, punitive actions were taken if doctor found violating norms.

In spite of all such efforts sex ratio in urban area is declining specially in elite community while in rural area it is improving.

Government Schemes: for promotion of girls' social status various schemes were launched. i.e free education, free bus, free cycles were given to girls to go to school, educational scholarships,10 kg grains for 2 girls to family per month., Kuvarbai nu mameru- Rs.10.000/-fix deposit put on name of girl.

There is need to address safe abortion and legal abortion.

Closing session:

We closed the meeting thanking all the participants for having attended the meeting. Those who are not CommonHealth members were encouraged to join. The discussion of this workshop and action plan should be shared with respective state members who are not able to participate in this meeting. During any other state events/workshop CH member can come and share their experiences and about CH. The publication can be taken back home and shared with other friends/people working on same issues.

Anand Pawar shared his thoughts that it is always beneficial to work collectively and asked if there was any provision to have CH state chapters and share ideological issues such as sex selection and safe abortion etc.

Suchitra thanked all participants for their active participation and making the meeting successful.

Annexure 1

List of participants

S No	Name	Organization
1	Sushil K Sharma	HARD, MP
2	Sant Kumar Mahato	Individual. Ganiyari, Chhattisgarh
3	Nilima P Rane	TNAI, Goa
4	Shrutika Kotkunde	SAMVAD, Chiplun
5	Florence Mendes	Bailancho Saad
6	Afroze Shaikh	Bailancho Saad
7	Shobha Mishra	Medical College, Baroda
8	Ramanand Singh	RAHA
9	Shakti Jamdade	CHSJ
10	Pramod Shimpi	CHSJ
11	Yogini Dolke	Srujan
12	Shobha Shah	SEWA Rural
13	Sharada More	SNEHA, Mumbai
14	Ajay Kumare Das	IHDAWC, Nabrangpur, Odisha
15	Gayatri Giri	Individual member, CH
16	Lakshman Singh	Gram Seva Samiti
17	Nilangi Sardeshpande	TISS

18	Renu Khanna	SAHAJ, CH
19	Neha Rathi	Sneha, Mumbai
20	Sumeet Pokharnikar	CEHAT, Mumbai
21	Dipa Nag Chowdhury	Mac Arthur Foundation
22	Moutushi Sengupta	Mac Arthur Foundation
23	Anand Pawar	SAMYAK, Pune
24	Preet Manjusha	SAMYAK, Pune
25	Arun Gadre	SATHI, Pune
26	Kajal Jain	MASUM
27	Hemlata Pisal	MASUM
28	Manisha Kunjim	MASUM
29	Vaijayanti Valavi	Janarth Aadivaasi Vikas Sanstha
30	Vijayalakshmi Vadhare	Amhi Amcha Aarogyasathi
31	Bhavna Jadhav	Amhi Amcha aarogyasaathi
32	Amita Pitre	Oxfam India
33	Sachin Shejao	Khoj
34	Martha D'Souza	Mamta Bahuddeshiya Society
35	Mahendra Kumar	CHSJ, Bhopal
36	Alka Barua	GHP, Ahmedabad