REGIONAL CONSULTATION ON MATERNAL-NEONATAL HEALTH AND SAFE ABORTION

September 11-12 2015

CommonHealth - a Coalition for Maternal - Neonatal Health and Safe Abortion
in collaboration with
SUTRA (Himachal Pradesh), VHAP (Punjab), ISRD (Haryana)

Background

Maternal Health is an issue of grave concern in India. India contributes roughly 20 % of all maternal deaths globally. The current status of maternal health[1] in India is a human rights challenge demanding re-examination of our current understanding of underlying causes and pathways, and reorientation of programme strategies and interventions.

While India's maternal mortality ratio has declined during the past decade from above 300 per 100,000 live births to 178 per 100,000 live births in 2010-12 (SRS 2013), it is now certain that India will fail to meet the MDG 5 on reduction of maternal mortality to 109. Updating our knowledge base on the changing epidemiology of maternal deaths and maternal ill health is essential for developing appropriate health programme strategies: a focus on skilled birth attendance and emergency obstetric care may be suitable for preventing direct obstetric deaths, but preventing indirect obstetric deaths and reducing the burden of maternal morbidity requires long-term investment in reducing malnutrition and on the burden of diseases in the community as a whole and in women in particular.

The National Rural Health Mission (NRHM) launched in 2005 is India's response to the meet the MDG challenges for health. Its Janani Suraksha Yojana (JSY) seeks to make a major impact on reducing maternal mortality through promoting institutional delivery, principally through cash incentives for institutional delivery to low-income women. The JSY has met with considerable success in promoting institutional deliveries[2] . However, the rapid increase in institutional deliveries without adequate investments in health-system strengthening has caused enormous strain on the public health system, contributing to further compromises in quality of care.

In addition, the exclusive focus on promoting institutional delivery has often been accompanied by a near-total neglect of the need to increase access to and availability of safe abortion services[3]. Between 9-18% of maternal deaths in the country are from unsafe abortions. The Abortion Assessment Project India (AAP-I) identified poverty, gender discrimination and health systems failures, as some of the major barriers preventing women from accessing safe abortion services in the early 2000s. Even as little progress has been

[1] Throughout this document, maternal health refers to pregnancy, delivery and post-partum physical and mental health. It includes health needs related to safe termination of an unwanted pregnancy

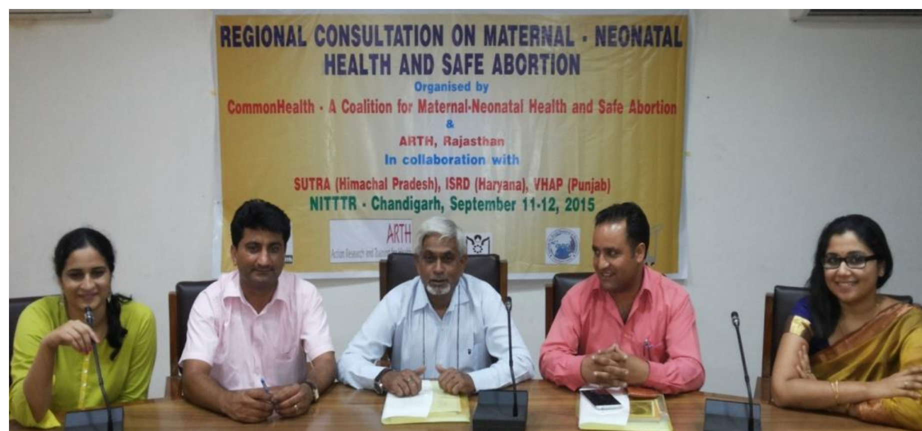
[2] (http://mohfw.nic.in/NRHM/NRHM%20%E2%80%93%20THE%20PROGRESS%20SO%20FAR.htm)

[3] (For example in Tamil Nadu, the number of MTPs in registered medical facilities actually declined between 2005 and 2008).

made in removing these, a new barrier is getting stronger. Concern over India's declining sex-ratio and the related opposition to sex-selective abortion has created an environment of reluctance to perform any abortion, especially in public sector facilities.

The female child sex ratio (0-6 yrs) in India fell throughout the last century. Sex determination and sex selection are one the many manifestations of son preference and daughter aversion. However, some of the steps taken by various state governments have contributed to denying women access to safe abortions and compels them to seek abortions from unsafe providers causing an increase in maternal mortality and morbidity. The current challenge faced by advocates for sexual and reproductive health and rights is to speak out against sex-selection in favour of the male child on the one hand yet defending the right of a woman to access a safe termination of an unwanted pregnancy. As always, it is women from vulnerable and marginalised sections of society who are being most affected and bear a disproportionate burden of morbidity and mortality related to unsafe abortion.

Similarly, India is faced with an unparalleled challenge in the area of child survival and health. Neonatal mortality is one of the important parameters of measuring the social development of nation. India contributes 27% of the global burden of neonatal deaths, which is the highest for any nation in the world. Of the three million neonatal deaths globally in 2012, 779,000 took place in India (Levels and Trends in Child Mortality 2014).



With this background forty three representatives from various civil society organizations from Punjab, Delhi, Haryana, Himanchal Pradesh, Chandigarh and Jammu and Kashmir had gathered together in a regional workshop on maternal-neonatal health and access to Safe Abortion. The consultation was organized by CommonHealth, which is a national forum working on these issues (and a project of Action Research and Training for Health (ARTH)), Institute for Social Research and Development (ISRD), SUTRA (HP) and Voluntary Health Association of Punjab. CommonHealth (CH) is positioned as a multi- state coalition of organizations and individuals that can bring voices from diverse constituencies to influence discourse at the national level.

The current status of maternal health in India is a human rights challenge demanding re-examination of our current understanding of underlying causes and pathways, and reorientation of programme strategies and interventions. In Chandigarh, figures shows that

neonatal mortality is on rise, which is linked with poor quality of health care services and increased burden on the health care providers due to rapidly growing urbanization of the city.

With this context, the consultation reviewed situation of maternal-neonatal health and access to safe abortion in various sessions. The objectives of the Regional Consultation were

- Understand the situation of Maternal-Neonatal Health and Safe Abortion in these five states – both from the policy and programme perspective as well as the ground level realities, in order to identify issues of concern.
- Examine Maternal-Neonatal Health and Safe Abortion from a gender and rights perspective
- Develop plans for collective state level action.

Some of the topics covered in the consultation were:

- Overview of the situation in the 5 states – policy and programme context
- Issues and challenges on the ground
- Emerging vulnerable groups and their SRHR issues
- Access to Safe Abortion Services – challenges and opportunities
- 'Repositioning Family Planning' – need for rights based contraceptive services
- Declining sex ratio and implementation of the PCPDNT Act
- Plan further action and advocacy on these issues.

Agenda for the Consultation attached as Annexure 1, List of Participants attached as Annexure 2. Presentations by speakers attached as Annexure 3.

Northern Region Common Health Meeting – 11th September, 2015

The consultation started with a welcome address by Mr. Pawan Sheokand followed by a round of introduction of all the participants present. Participants also shared their experience in the field of maternal and reproductive health as well as the organizations they are associated with.

Session 1 - 10.30 a.m. to 11.00 a.m. – Introduction to CommonHealth

Ms. Renu Khanna took this opportunity to familiarize participants to the CommonHealth platform. She introduced CommonHealth as a membership based coalition which is positioned as a multi- state coalition of organizations and individuals that can bring voices from diverse constituencies to influence discourse at the national level. These constituencies have been diverse in terms of different areas of expertise such as health care providers, public health researchers, non-governmental advocates, research and service delivery organizations, human rights lawyers, grassroots activists, public sector programme managers etc. She mentioned that the Coalition is steered by a Steering Committee of individuals with considerable expertise in one or more of the three thematic areas: maternal health, safe abortion and neonatal health.

She explained that the **goal** of CommonHealth is to advocate for better access to and quality of **maternal-neonatal health and safe abortion** services. It engages with issues of women's gender and reproductive health and rights through a broad-based advocacy strategy to bring together and mobilise citizens, health providers, researchers, administrators, policy makers and others to identify significant gaps that exist in maternal-neonatal health and safe abortion in terms of health outcomes and women's sexual and reproductive health and rights. She said that declining sex ratio is jeopardizing reproductive rights and reproductive health and all agencies should lay due focus on this issue. In a nutshell, she said CommonHealth is advocating the case of women having control over their own bodies.

She also pointed out to the fact that though Maternal Mortality Ratio (MMR) has declined from 254 per 100,000 live births in the period 2004-06 to 172 presently, this decline has not benefited disadvantaged communities that CommonHealth and other civil society organizations are catering to.

Ms. Khanna elucidated CommonHealth's maternal health objectives as:

- to advocate for every maternal death is reported, recorded and paid attention to, to ensure that essential medicines for maternal health are available, to advocate for safety and quality for women in delivery care and put an end to labour room abuse.
- Promote community monitoring for health care services so as to bring in transparency and accountability to the system.
- Focus on bringing the issue of neonatal health to the limelight and disseminate information on the same.
- Carry out sustained campaigns to promote access to safe and quality abortion services for all women irrespective of marital status, especially those from disadvantaged sections.

She added that periodically, CommonHealth members organize state and regional meetings to sensitise other potential members on the gender and rights aspects of Maternal-Neonatal Health and Safe Abortion and to further their state agenda for collective action around these issues. She informed the participants that last General Body meeting of CH was held at Bhopal on 17th and 18th of August 2015 and that these meetings are a platform for sharing technical updates on the thematic areas, identify members' needs for support and publications and other related resources, and plan activities for the coming year. Participants were also given a quick tour of the website and its relevance. They were urged to give suggestions and feedback to make the coalition more useful and pertinent to the issues. Ms. Khanna also invited the participants to become a part of the coalition and also explained the benefits, roles and responsibilities of the CommonHealth members.

Mr. Anand Pawar also further explained CommonHealth's objectives to the participants. He said that a holistic participation from various agencies working on reproductive health issues in CommonHealth makes it a unique platform especially for all technical and practical inputs. He also added that a consultation like this will help us to accept national challenges in the context of State Plans for maternal mortality and neonatal mortality. He said that CommonHealth is a space for accommodating all these contexts which work with the final objective of safeguarding women's reproductive rights.

11.00 a.m. to 11.30 a.m. – Discussion on the Objectives of the two day Consultation in Chandigarh

Mr. Subhash Mendhapurkar explained the objective of the meeting in detail to the participants.

He said that the prime objective is to assess the condition of maternal health, neonatal health and access to safe abortion in the five northwest states namely Jammu & Kashmir, Punjab, Haryana, Himachal Pradesh, Delhi and UT Chandigarh at two levels – policy level and implementation level. These states claim that their health programs have been running very successfully but it is imperative to discuss the effects of these programmes at the ground level. For example: Himachal Pradesh doesn't publish its MMR figures as it claims that less than 100000 deliveries take place in the state but these statistics should be looked into.

He added that another major focus of the consultation would be on safe abortion services in the region. This aspect would again be discussed at two levels:

- ✓ Firstly, about the availability, accessibility and quality of safe abortion facilities in these respective states.
- ✓ Secondly, to clarify whether these abortion services are based on a perspective of reproductive rights or provider dependent as in the MTP Act.

- ✓ Thirdly, to understand that how things are shaping up at the ground level in context of safe abortions, in terms of attitude of the paramedics and other stakeholders and accessibility of safe abortion amenities for women.
- To understand the contexts in these states within which reproductive health, neonatal health and access to safe abortion are situated.
- To carve out an integrated action plan for these five states which would help us build a knowledge sharing platform and bank on each other's strength areas.

Hence, based on the inputs from Mr. Subhash, the objectives of the consultation were set. Briefly the participants were given a run through about how the two day consultation will progress and the participants were advised to give maximum inputs and suggestions, based on their experiences so as to cull out successful policy interventions and prepare a way forward. Ms. Khanna reiterated the objectives of the two day consultation, which are as under

- It is of critical importance to compare or relate the national level policy programmes and data aggregates to the status in the respective states and individual experiences.
- North West states are undergoing a rapid transformation process, which has led to certain dynamics and imbalances leading to emergence of certain vulnerable groups and communities. The consultation should also look into how their sexual and reproductive rights are being taken care of in their states.
- Sharing CommonHealth experiences and perspectives will also help to build an integrated action plan.
- Access to Contraceptives is an emerging area that CommonHealth is just embarking upon. Any partnership and suggestions in this regard are welcome.
- Collective action and solidarity is the need of the hour. If we join hands, build on each other's energy and complement each other's strengths then there is a hope to alleviate the situation in context of maternal and neonatal health.

Session 2 - 11.45 a.m. to 2.00 p.m. – Panel Discussion on overview of the Situation of Maternal & Neo Natal Health in the region

The first session was chaired by chaired by Dr. Pyarelal Garg who has extensive experience of working in the field of maternal and neo natal health in Punjab. The session began with the introduction of the panellists - Dr Ashwin Nanda, Dr. Rainuka Dagar and Dr. Manmeet Kaur by the chair.

Summary of Dr. Aswini Kumar Nanda's Presentation on Neo Natal Mortality in five States

Dr. Aswini Kumar Nanda who is associated with Centre for Research in Rural and Industrial Development (CRRID), Chandigarh presented **Levels and Trends in Neonatal Mortality in North West India.** He informed the participants that the data has been acquired from SRS (Sample Registration System) which has data dated back to 1970s. But, according to him the data for last one decade in context of neonatal health holds more significance mainly because of the following three reasons:

- ✓ Impact of Globalization on Health Sector
- ✓ Introduction and use of ICT (Information and Communication Technology) in the health sector is growing rapidly. Example: ANM getting online feedback, computerized sub-centres
- ✓ Introduction of NRHM (National Rural Health Mission) has made a semantic shift in the delivering of health services in rural pockets of the country.

He explained that his basic objective is to build an overview amongst the participants to understand where we stand in these 5 states as far as neonatal mortality is concerned. He added that it is crucial to discuss infant mortality before neonatal mortality is discussed at length. Infant Mortality Rat (IMR) is basically the number of children dying before their first birthday. He added that IMR varies from region to region, community to community and from class to class and currently infant deaths constitute 12 - 13 percent of all deaths in India. He pointed out that Haryana has higher infant mortality but it is reducing. Similarly, states like Punjab and Himachal Pradesh are also doing well and the infant mortality in these states is also consistently declining as are the cumulative figures for the entire country. Certain states are performing exceptionally well (better than European countries) in this regard like Kerala, Mizoram, etc. But unfortunately, 58 to 60% infants die in the neo natal stage i.e. within four weeks of their birth. Hence, if the IMR needs to be reduced, it is vital to bring down the number of neonatal deaths since the number of infant deaths after neonatal stage is steeply declining.

To address the issue of infant mortality, it is mandatory to deal with the neo natal mortality. In fact, an infant is more susceptible to infections in the first 7 days of his or her life. But a very dangerous aspect is that **environmental and behavioural factors are contributing more** to these deaths than the bio medical aspects. Dr. Nanda highlighted that the issue also holds profound significance in the United Nations **Millennium Development Goals** and a nation can reduce child mortality if it reduces infant mortality which in turn is dependent on neonatal mortality. He also pointed out that according to our National Health Policy 2002, our IMR should have been less than 30 by 2010 but it is disheartening that India's IMR is still greater than 40 by 2013. So we are lagging behind the goal that we had set for our self and losing precious lives.

He shared a slide depicting the **share of neonatal deaths in total infant deaths** for all North West states and Delhi in 2013. Where national average is around 68%, in J&K and Himachal,

neonatal deaths contribute to more than 70% deaths out of total infant deaths. For Punjab, this figure is around 60%.

Dr. Nanda in his next slide presented the **trends in early Neonatal and Neonatal Mortality over the last decade** for the North West states as compared to the national average. It was observed that Delhi had the lowest numbers due to good education levels and J&K had the highest numbers in early neonatal deaths in the region. The graph displayed a very fluctuating trend but only after 2008-09 these numbers started to decline, which coincides with the launch of National Rural Health Mission. Hence it is evident that this programme has made a substantial impact on the rural health delivery mechanism.

Based on National Family Health Survey data for 1992-93 (NFHS 1), 1995-96 (NFHS 2), 1998-1999 (NFHS 3), Dr. Nanda tried to give an overview about the **Gender Composition (m/f) in Early Neonatal Mortality** highlighting the human disadvantage zone where more number of female neonatal deaths take place than male. This trend was observed only during NFHS 2 and only in Punjab and Haryana, where female disadvantage was clearly visible during this period.

Causes of neo natal mortality are listed as follows:

- Premature birth and low birth weight
- Neonatal infections (including sepsis/pneumonia, tetanus and diarrhoea etc.)
- Birth asphyxia (lack of oxygen) and birth trauma

If these causes were controlled, we can reduce around 75-80% of all neonatal deaths in the country.

Next, Dr. Nanda discussed the **role of NRHM** (flagship Programme of the GoI in partnership with the States) in improving the reproductive health across the country.

- Substantial enhancement in the share of institutional deliveries has been observed. As per the District Level Household and Facility Survey (DLHS-4) Punjab (83 %), Haryana (77 %), HP (78%) have shown a considerable increase in institutional deliveries which leads to less chances of neonatal mortality.
- There has been a shift from Private share of institutional delivery to public share. Some factors contributing to this scenario are free transport to and from health facility, referral facility round the clock, free provision of diet, consumables, blood transfusion, drugs, cash incentive like JSY and others, cashless services including tests and diagnostic services, free C-section, etc. (He pointed out that even if the medicines are not available, the doctor is supposed to provide the same to the patients from the market and get these costs reimbursed later)
- Central provision of functions, funds and functionaries is adding to this positive shift. NRHM has not only ensured access to funds but also issues a set of functions that ought to be carried out by the state governments. Under NRHM, a lot of medical and

non – medical staff has been deputed in the rural areas (additional NRHM staff) which is a boon for successful health delivery services.

- Learning from NRHM's success and failures, GoI has also launched a similar programme for urban population of the country.

He further explained that apart from NRHM, the other **determinants** also play a key role in reducing infant and mortality rates which have been listed as follows:

- Socio-economic conditions like place of residence, mothers education, fathers education, mothers work status, etc
- Demographic variable like age of mother, birth order, preceding birth interval, sex of the baby
- Maternal health that includes antenatal care, institutional delivery, 2+ tetanus injection
- Community-based services like hospital based births, clean and skilled care at the birth; newborn resuscitation; clean umbilical cord care; exclusive breastfeeding; and management of infections in the newborns, increased and smooth transport to health facility, advanced care of premature births, etc.
- Essential **elements of quality of care** (WHO Identified Dimensions) to prevent should neonatal deaths should also be given due importance. The various elements are effective, efficient, accessible (No discrimination on the basis of caste, creed, etc), safe, equitable and patient centred.
- If our health system has better Ante-Natal services (which include taking 100 iron folic tablets, proper immunization, checkups, etc) we decrease the chances of neonatal mortality. He also shared that there is a limitation in collecting data on these fronts and hence there are contradiction in data for these aspects.

He added that we have to enhance the reachability and accessibility of our programme on the following dimensions:

- While equipments are available, repair under AMC is cumbersome.
- Essential drug list is displayed but non-availability, delayed availability, quality of drugs, are still issues requiring action.
- Shortage of human resources such as specialists, MOs, paramedical staff, nurse and ANM is still an issue and even non-medical staff is deficient. Use of existing personnel (commuting, absenteeism, night duty, lack of field visit, poor supervision, peripheral areas) needs to be streamlined to improve the present situation.
- Special Newborn Care Unit (SNCU) are not available at all districts.
- Another critical aspect - Immunisation also needs to be smooth and regular. Cold chain problem for storage is another limitation that needs to be rectified.
- Absence of Nutritional Rehab Centre further adds to the problem

- A micro-plan available against all killer diseases needs to be prepared where in all migrants and mobile population are covered.
- Lack of Infrastructure like proper building, beds, other facilities, lighting, etc. maintaining cleanliness of the building, toilets along with fumigation etc will also help a great deal in solving the issue of neonatal health
- NRHM also lacks the element of supervision. Project Officer hardly visits the field and there is more emphasis on statistics, reviews, meetings, etc.
- Community process and monitoring process needs to be strengthened. Performance based incentives for ASHA workers can help a great deal in developing a better health delivery mechanism.
- Maternal Deaths are being recorded and investigated by the DC but infant deaths are not being reviewed by the DC. Practice of Infant Death Review needs to be streamlined

Summary of Dr. Rainuka Dagar's Presentation on Declining Sex Ratios and Gender Issues in Haryana and Punjab

Dr. Rainuka Dagar heading the Gender Studies Unit at Institute of Development and Communication, Chandigarh presented the issue of declining Sex Ratios and Gender Issues in Haryana and Punjab. Her presentation was in three parts – issues of female de-selection and gender justice, intervention strategies and challenges.

In a nutshell, she explained since 2001, Punjab and Haryana have been in limelight vis-à-vis other so called *bimaru* or *demaru* states because of declining sex ratios. She added that biologically, a girl child has more chances of survival and hence, there are definitely some socio-cultural elements which are playing a crucial role in determining this skewed ratio. The 2001-2011 SRS data shows continuing unfavorable sex ratios in these states. Although there is an improvement, it is only marginal and ratios are exceedingly poor and adverse as compared to other states. She supplemented this information with role of technology in this problem. Dr. Dagar said that preference for male child has never been hinging on technology and contrary to the general perception, doing away with ultrasound machines, penalising doctors, sealing clinics, etc will not solve the issue of poor sex ratios. She drew upon history to show that adverse sex ratios existed even when there was no technology. We can just say that the technology has just added to the set of present problems.

She added that despite the fact that the government has announced schemes incentivizing the birth of girl child, the challenge remains. She touched the following issues in her presentation:

- She tried to draw a link between 'female feticide' and a number of girls dying post birth due to infection, diphtheria, etc. This is clearly a result of lack of care and

gender discrimination and cultural neglect which needs immediate attention and redressal.

- She presented data highlighting the time site and population group specificities. Peasantry, economically poor Malwa have historically had worst ratios. Post militancy these ratios improved. An environment of peace and prosperity led to improvement in household level incomes further leading to better sex ratios.

  Dr. Dagar emphasized it is essential to link household survival strategies for income with a girl child's survival in the family.

- Realization of various social – cultural issues to curb this issue is also vital in this regard. Dr. Dagar added that gender rights need to be backed up by a favorable environment for the girl child to progress and flourish. Taking practical examples from daily life, she said that women's security, her accessibility to police stations or any hospital, etc is not easy and this discourages parents from favoring a girl child in the family. Social capital plays a great role in this regard. So just claiming the equality of girls and boys without addressing these basic and pragmatic issues, we won't go a long way in solving the problem.
- She also pointed out that in a survey 48% women did not find anything wrong with 'female foeticide'. Hence it is critical to understand that it is not necessary that if the women have access to reproductive rights, they would also help to boost the sex ratio in the region

Dr. Rainuka Dagar also provided a way forward, suggesting few steps that the government can take to better the situation:

- Different Strategies for different groups. Empowering the Girl Child – She highlighted the fact that it has been observed that the service class does not differentiate much between male and female child. So projecting them as role models while incentivizing the role of care giver (giving tax rebate to the care giver like in Britain) will help to inspire other communities. Groups can be offered 'gender credits' much like carbon credits, for example: for lower income more NREGA employment days, etc and peasantry can receive more Minimum Support Price for their crops as gender credit
- She pointed out the paradox in development in terms of male child preference stating that nowadays if the first child is a boy, parents don't plan a second child. Hence they, in no way, violate any guideline but in other ways contribute to the skewed sex ratio in the state. She added that unlike decades ago practice of wife sharing, there is a kind of rotation in the society with high divorce rates .
- Issue of Practice versus Norm – Dr. Dagar pointed out that on one hand religious clergy tries to boost the skewed female sex ratios and on the other hand, there are

institutionalized practices for supporting male child preference, such as gurudwaras granting a boon of a male child.

- Improving governance for gender based violence (GBV)– There is need to provide visibility to the actual extent of GBV. If we link the census and crime data, it is observed that only 8 % of crimes against women are reported and rest go unnoticed.

Gender Based Violence & VAWG: She added that gender is not a woman centric subject and it has a much larger nuance. She said that if the interventions doesn't take care of the issue systematically, it may soon backlash against women because all resources are being directed towards the women and girl child rather than a universal provision of basic needs to all.

Summary of Dr. Manmeet Kaur's Presentation on Gender, Maternal - Neonatal Health, Safe Abortion and Family Planning Status in Punjab

Ms. Manmeet Kaur commenced the session by comparing the neonatal mortality rate, infant mortality rate, maternal mortality ratio and total fertility rate, etc of Punjab with that of national rates.

	Status in Punjab	National Aggregate
Neonatal Mortality Rate	24 per 1000 live births	31 per 1000 live births
Infant Mortality Rate	28 1000 live births	42 per 1000 live births
The Maternal Mortality Ratio	155 per 1000 live births	212 per 1000 live births
Abortion Rate	0.24	0.17
Women using sonograms, ultrasounds and amniocentesis test	34% higher than national figures 17% higher access to antenatal checkups	
Total Fertility Rate	1.8 (Reached the replacement level).	

Based on her experience of working with the disadvantaged sections of Punjab in the field of sexual and reproductive health, she pointed out that a major cause of maternal deaths has been anaemia and resistance of mothers to avail institutional delivery in public sector health facilities. 64% mothers die because of anaemia and only 77% go in for institutional delivery in public hospitals.

She explained that in the age group of 6 to 9 years, 53.6% boys and 55.1% girls are anaemic but as children get older, gender differences in anemia become visible and by the time these children are between 10 to 19 years of age, 52.8 % girls remain anaemic and only 42.5% boys face this issue. This issue gets aggravated leading to maternal and neonatal mortality in the later stages. She suggested that there is an urgent need to build social capital in the field of health service delivery. This would in turn to help promote health literacy amongst the uneducated sections of the society. According to her, mother dying of an easily curable

disorder like anaemia is like a blot on our information system and health delivery systems in the country.

She brought forward a number of case studies done conducted by her and her team and also shared the lessons learnt from them:

- Nutritional Status of Children

The growth monitoring data of the Anganwadi Workers for their centers was routinely checked. In one such center, amongst a group of 8-10 children under 5 years, there was one girl of 3 years of age, whose weight was normal until the last 6 months but was constantly declining from then onwards. It was learnt later that since the birth of the child's younger brother, she has been neglected by her mother and this has resulted in the decline of weight. This clearly indicated the gender discrimination against females is still very much prevalent in the society.

- Middle Class Punjabi Families

After a survey of a number of middle class Punjabi families, it was learnt that most of them feel the couple with no son and more than two daughters is entitled for sex selection test and it was shocking to learn that more proportion of women (73%) than men (60%) are in favour of terminating female fetus. Major reasons observed for such an attitude were: a male dominated society, social stigma attached to having a daughter and difficulty to afford dowry amongst many other such reasons.

- Adolescent Health and Attitudes

Dr. Kaur talked about the issue of 'eve teasing' and its far reaching impact. She said that the initial study estimated that 30-50% of young women experienced 'eve teasing' in the past 1 year and most participants reported that eve teasing resulted in significant negative consequences, including tight restrictions on girls' mobility, inability to attend school or work, girl's being blamed and causing various other family problems. Among those who reported eve teasing victimization, psycho-social responses included feelings of fear (88%), anger (78%), and shame (68%).

She further added that nearly half of participants reported some form of child abuse or neglect in their adolescent years. Among this group, common mental disorders, like anxiety and depression, were four times higher than girls who did not report having been eve teased. These mental disarrays were directly linked to suicidal tendency amongst girls.

- 'Smart Women' Group

A very interesting attitude and belief system was brought forward by Dr. Manmeet Kaur in the form of a case study where a group of women were asked certain questions. These women gave some shocking and 'smart' responses. They said that they don't use

contraception as they know the natural method to avoid pregnancy. This natural method implied that they know their menstrual cycle dates and hence, they ‘meet’ their husbands only on safe days. They sense their husband’s frame of mind and manage the situation accordingly. But sadly this group of ‘smart’ women who did not believe in killing a child, had no qualms about sex selective abortions. These women believed that fetus has no life and used this argument to justify their actions.

In a nutshell, she advocated the case to promote health literacy amongst women. She discussed that still births also has socio cultural issues associated with them and it is important to address them along with the already known bio medical issues. She also emphasized on the profound role of internal migration in aggravating the reproductive health situation in the state. By the end of the presentation, Dr. Kaur posed certain questions to the gathering related to the general attitude of the masses towards women - their security, ‘eve teasing’, sex education in schools, rape, dowry, safe motherhood and safe childhood.

Inputs from the chair – Dr. Pyare Lal Garg

Post the presentations, Dr. Garg summarized the inputs from the three panellists as below:

- It was clear that reproductive health is not a medical issue alone. It has various such socio cultural factors associated with it. He emphasized this point with an example of the huge literacy campaign that initially improved the situation in context of declining sex ratio but since then the improvement has been marginal. Hence, while dealing with sensitive issues like MMR, IMR, NMR these social complexities should be duly taken in consideration by the policy makers as well as other stakeholders.
- Declining sex ratio is not a technological issue and we need diverse lens to view the issue in a different perspective of it being a behavioural and cultural problem.
- He reiterated the fact that thanks to NRHM, there is enough infrastructure but health delivery mechanism lacks enough specialists. He added that para medical profession is being neglected. Training, placement and proper utilization of human resources is extremely crucial in the present scenario as they already are a scarce resource.

  He disagreed with a point earlier made by Dr. Nanda as he felt that most doctors and para medics are working as statistical machines and not focussing on their role.
- He also added a new viewpoint stating that we are creating a more dangerous situation for the marginalised sections of the community if we keep pushing the idea of institutional delivery without adding sufficient number of specialists, paramedics, etc in the system.
- He agreed that community participation is the key to fight issues of reproductive health. It is critical to make the Panchayats and VHSCs aware about the various available schemes as well as other health aspects of the programme.

Questions, suggestions and inputs by audience were shifted the post lunch session.

Discussion and Round of Queries from audience

Participant 1 Dr. Rehana Kausar sought clarification from all the panellists about why are we pushing the concept of institutional deliveries so hard if the health delivery system is not that prepared to deal with the same. The lack of doctors, para medical staff, etc at the grassroot level may end up aggravating the whole issue than solving it.

Participant 2 Dr. Arvinder Singh shared his experience of working in this sector in Punjab. He pointed out at the review meetings being held by the DC where MMR is the last point in the agenda and is hardly discussed. Also, maternal morbidity has no reporting at all. This is where, according to him, community participation is of utmost importance. He also felt that some discussion of the Project Implementation Plan with the community would help us to meet our objectives in a better manner.

Participant 3 Ms. Silky Grewal (HRLN) brought her experience from field. She said that there has been a constant increase in demand for institutional delivery from expecting mothers. But she also added that there has been no reporting on the increasing number of still birth cases. She further said that one of the many reasons for the increasing number of such cases is sheer negligence or the callous attitude of the para medical staff who finally just give a small slip stating IUD (Intra Uterine Death) without proper investigation of the case. She emphasized that training and capacity building of para medics is vital as per the NRHM manual. She said that it is not fair to blame illiterate women for their poor health conditions as this was the sole reason for building up ASHA network across the country. Updation of maternal and child health care card also needs streamlining along with certain modifications in the card itself (Delhi HC has ordered a review of these NRHM cards). She felt NRHM is a very holistic programme and if we go by the book and train the medical as well as the non medical staff accordingly, we may solve the various reproductive health related problems to a great extent. She felt that certain diagnostic tests that the NRHM guidelines enlist in the desirable category should be added to the mandatory list of tests to avoid various maternal and neonatal mortalities in the later stages. Referring to one of the presentations, she added that Nutritional Rehab Centres in Punjab and Haryana will go a long way in solving maternal health and malnutrition issues. These Centers hold more significance in these states as a large chunk of migrant population avoid malnutrition resides here and needs such services.

Participant 4 – Kuldip Chand (Punjab) said that on field it is disheartening to observe that health service has given way to health industry where reproductive health has become a booming business. He added ASHA and ANM workers have become mediators for private health agencies and the worst sufferer of all these is the disadvantaged BPL community. He quoted cases from the field where government doctors have referred patients to private

clinics over phone and data collected though RTI suggests that as a result of this, over last few years number of caesarean cases have increased.

Ms. Khanna responded to Dr. Kausar's query and said that CommonHealth is laying emphasis on safe deliveries (wherever they are) rather than institution deliveries. She said that the problem is that these days institutional deliveries are equated with safe deliveries.

Dr. Kaur also gave some inputs to the participants about the issue of collecting authentic and accurate information on these aspects. She added when we are collecting data, we do not capture the socio-cultural aspects of the problem and hence, put in no efforts to address those issues. But, she said we are approaching a time we will exhaust all the bio medical possibilities pertaining to these issues and end up with all social problems with no answers. Maternal Death Reviews should provide us an opportunity to dig deep into these social-cultural causes and find answers to the same. For this it is essential that our data collection personnel are properly trained and our bureaucracy is ready to look beyond medical reasons causing maternal and neonatal deaths. She quoted that her team has collected around 65 case studies on maternal deaths where the cause was more pertinent to social problems like domestic violence, gender discrimination, etc.

Dr. Garg added that community participation is one solution to all the issues listed above. He added that the focus should be on safe deliveries rather than institutional delivery and it is unfortunate that medical industry has become a source to earn rather than serve the masses.

Session 3 - 3.30 p.m. to 4.30 p.m. Panel Discussion on overview of the Situation of Maternal & Neo Natal Health in the region

The second round of panel discussion was chaired by Dr. **Alma Ram** with Ms. Janet Chawla from Jeeva, Himachal Pradesh, Rahi Riyaz from J&K and Mr. A.K. Wani working on PCPNDT Act in J&K as panellists in this round of discussion.

Summary of Ms. Janet Chawla's Presentation

Ms. Janet Chawla commenced her session with a clarification that JEEVA is not a NGO but a research project in various sites in India including one in Himachal Pradesh. She said that around 7 people with a different backgrounds, some doctors, have initiated this project to understand and document the practices of Dais and their life situations – questioning whether they are responsible for maternal mortality or are other issues like lack of nutrition, status in the family, levels of anaemia and inadequate institutional facilities have a role to play in the entire problem. The team has tried to look into various other linkages like socio-economic factors, socio-cultural factors, presence of Jhola-Chaap doctors in the region and their contribution to the issue of maternal wellbeing. She added that since the project needed a holistic view of the problem, JEEVA team is working in various other so called

underserved areas like Bokaro district in Jharkhand, Nandurbar in Maharashtra, Bellary in Karnataka in addition to Mandi and Kangra districts in Himachal Pradesh. The objective of the research project was to collect data and document what the Dais actually do in the region and how people as well as other formal and informal service providers perceive Dais in context of reproductive health issues.

She informed that this was basically a multicentric interdisciplinary study of the interaction between the traditional and modern health care services. The study was based on data acquired from multiple tools from around 650 households chosen from random sampling in each of these areas. A survey of all the women who underwent a live birth in the last 2 years was also conducted which gave the team access to immediate qualitative interview data about the birth practices amongst the communities. Around 30 Dais in each of these areas were also interviewed around 2 to 3 times to learn about the birth practices being followed by them. Ms. Janet added that what makes this study unique is that the researchers involved did not rely merely on data collected based on 'research', but rather stayed in the area between 1.5 to 2 years. Not only did this help them build a better rapport with the community but also gave them a chance to observe and study various birth practices closely.

In Kangra and Mandi districts where the Jeeva teams as well as Dais were working, first step was village mapping through community participation. It helped the researchers to familiarize themselves with the area and learn about the community living in the region. They learnt that each Dai serves around 12 to 15 villages in a region and are extremely accessible and responsive even if the terrain is hilly and hostile. Ms. Chawla compared this scenario with that of the PHCs where there is a shortage of manpower, medicines, equipments, etc. Ms. Janet further explained that it is extremely impressive to learn that these Dais' have a thorough understanding of normal physiological functioning of the human body. She quoted an example of Placenta Simulation of seemingly lifeless or limp or not breathing newborns carried out by the Dais and applying heat to the placenta before they cut the umbilical cord where the Dais use a simple procedure of milking the cord, instead of using any surgery or costly allopathic medicines. She added that the Dais are a very respected community of the region majorly because the people here understand and appreciate their worth. She showed various pictures of village mapping and learning about birth procedures in these areas. She added that communities in this region are largely dependent on each other for agriculture, etc. Hence, there is a certain social thread which binds them together which also plays a key role in post natal care of the mother and the child.

She summed up her presentation with the following three learnings from her experiences:

- Replacing Dais in such regions is not possible. The rich traditional knowledge along with the lack of institutional facilities in the region makes it almost impossible to do away with these midwives who have different names in different regions.

- Women are usually reluctant to the idea of delivering their child in a foreign place. Also these formal institutional channels are difficult to access for these communities due to lack of infrastructure, the terrain and long distances in the region.
- It is critical that these traditional midwives are recognized and collaborated with the formal health delivery channel. It would be beneficial to build on their capacities instead of building a new health delivery cadre all together.

Summary of Mr. Rahi Riyaz's Presentation

Next session was taken up Mr. Rahi Riyaz who brought in his field experiences of Jammu and Kashmir through his NGO – National Society for Human Welfare. He agreed with the other experts that the problem of maternal and neonatal mortality has greatly reduced in the state but the poor communities or communities residing in the far flung areas are still the most vulnerable to reproductive health issues and a lot is still to be done to address these issues. He listed the following issues in J & K pertaining to maternal and neonatal mortality:

- Lack of awareness amongst the rural communities is an issue in the region as this disables the disadvantaged communities to avail the benefits of government schemes. The print as well as local media doesn't give enough coverage to these schemes which adds on to the problem
- He discussed that early adolescent marriages in the region are also an obstacle to reduce mortality deaths in the region. Though he suggested that the number of such marriages taking place has gone down but the problem still persists.
- He explained that in many cases it has been observed that district hospitals shift the expecting mother to state level hospitals in Jammu or Srinagar at the eleventh hour without proper transportation arrangements. Even if the transport arrangement is done, the attendants are not skilled enough to take care of emergency situations leading to a number of deliveries in transit and due to lack of proper care this adds to the list of maternal mortalities.
- Shortage of experienced gynaecologists and other para medical staff at PHCs. It has been observed that the attendants take care of the patients there.
- He said that condition of district hospitals as well as non availability of new born units adds to the woes of the expecting mothers. There is usually a shortfall of essential drugs and the families are asked to purchase the same from open market.

Mr. RIyaz suggested few immediate steps that need to be taken so as to curb the problem in J & K:

- One important subject was that of the ASHA worker. He urged that it is essential to incentivise the work done by them. He further added that ASHA workers are involved in various other government programmes like Census, etc which defeats the main purpose of their deputation. So this practice needs to be discouraged.

- He explained that role of NGOs in this regard to create awareness and work at the grassroot level would be crucial.
- It is essential to sensitize the para medical and non medical staff that deal with the mother in the labour room to be respectful and sensitive towards her. Lack of an empathetic attitude towards the woman urges them to move towards private health delivery services.
- Provision of essential drugs is of vital importance to save lives. Lack of infrastructure and manpower at the grassroot level is making the problem more grave.

Mr. Riyaz also suggested that a team should be formed that assesses the status of reproductive health in all states at the grassroot level and learn from each other's experiences so as to support each other with their strength areas.

Summary of Mr. A.K. Wani's Presentation

Mr. A.K. Wani, Sr. Programmer Manager from Jammu Kashmir Voluntary Health Association, Srinagar shared his experiences of running an NGO in these areas. He added that there was a time when role of Mother NGOs was crucial at the district level and it helped the state to reach out to the underserved regions. But due to elimination of the Mother NGO scheme from the 12th Five Year Plan, NGOs have to carry out all the work from their own resources which makes the task even more difficult. He touched three following issues during his presentation:

- **Overview of the situation in J&K**

He began his presentation with statistics from across the state pertaining to demographic details and other health related indicators for Jammu & Kashmir. He pointed out that females per 1000 Males number stands at 883 and is alarming. He also highlighted that J&K's doctor to population ration in the state is 1:2142 vis-a-vis WHO standards of 1:1000.

- **Declining Sex Ratio and implementation of the PC& PNDT Act**

Mr. Wani briefly explained the PC & PNDT Act that came into operation in 2006 and it prohibits Sex Selection before or after conception and misuse of pre-natal diagnostic tests in clinics for the determination of the sex of the foetus.

He informed that the State Govt. has constituted State Supervisory Board (Monitoring Committees) under the chairmanship of Hon'ble Minister for Health & Medication Deptt. in the year 2002. Appropriate authority for registration of ultra sound clinics has been allotted to Director Health Services Jammu/Kashmir. The State Govt. has also constituted the divisional advisory committees in the year 2008 for Jammu and Kashmir Divisions to conduct surprise visits or periodic visits to centres, laboratories and clinics with the provisions of the Act and Rules. The State Govt. has also constituted the District Advisory committees with

DDC/DC also Chairman with similar powers and creation of public awareness on the issue of sex selection among common masses and the directions are that the intervening period between any two meetings should not exceed to 60 days.

Major Interventions under National Health Mission

- ✓ **Child Health**

  To improve the Infant Mortality Rate, State Govt. has established Sick New Born care units (SNCUS) in 15 District Hospitals, New Born stabilization units (NBSUS) in 76 First Referral units (FRUS) and New Born Baby corners (NBBCS) in 279 PHCS. Efforts have also been made to strengthen the Neonatal Intensive care units (NICUS) in LalDed Hospital, GB Panth Hospital Srinagar & SMGS Hospital Jammu. Home Based neonatal care (HBNC) scheme has also been launched to tackle the issue of infant mortality.

- ✓ **Maternal Health**

  There has been a considerable improvement in the field of maternal health mortality and Institutional Deliveries have improved from 55% in 2007-08 to 85.11% in 2013-14. But he added that shortage of manpower and drugs still pose threat to maternal health issues.

- ✓ **J&K Health Referral Transport service No 102**

  The scheme caters to the transportation needs of the pregnant women and sick neonates under JSSK. About 400 Ambulances have been engaged for this purpose and two call centres have been set up which regulate / manage the Ambulances centrally and make the entire system extremely effective. But this service has still not been able to cater to the far flung areas in J&K.

- ✓ **Immunization Programme**

  The programme aims to protect the children against seven killer diseases and is being implemented successfully across the states.

Issues & challenges.

- ✓ Sanitation in Rural Areas offers formidable challenges to the health and well being of rural population, especially expecting mothers. Most challenging factor in the rural sanitation comes from the habit of open area defecation which results in gastroenteritis related diseases and is a major cause of Infant Mortality. Lack of proper disposal of domestic refuse also adds to the health challenges. Implementation of the Niramal Bharat Abhiyan (NBA) needs to be streamlined in this regard where the families should get the amount well in advance for toilet construction.

- ✓ Lack of motivation for adoption of Family Planning methods was also pointed out as a major issue for poor female health for which it is essential that male participation in use of Family Planning methods is promoted.
- ✓ Through Education and Child Development Projects, life skill education needs to be promoted among adolescent girls and boys in and outside schools so that they are better aware about their rights as well as health issues.

Discussion and Round of Queries from audience

The following points came forward from the round of discussion that followed the panel discussion:

- Awareness amongst the rural population about various reproductive health issues is required and to achieve this objective and community participation is definitely the means to achieve the same.
- There was a remark from amongst the medical fraternity in the participants about the other side of the coin i.e. Dais not always proving to be a boon and the need for skilled birth attendants who are trained to handle emergencies and can also visit homes to carry out safe deliveries, to which following inputs were given:
  - ✓ Ms. Janet pointed out that this is a critical juncture of practicing traditional health ideas versus adopting modern biomedical practices. She further explained that there are five medical best practices in Europe and U.S. that have scientifically proven to be extremely beneficial during child birth which the Dais have already been practicing since ages but the medical practitioners didn't accept them.
  - ✓ We need a mutual exchange of ideas between these schools of thought. She also pointed out that the Dais JEEVA has worked with are willing to learn and supplement their knowledge with modern practices. Dais are highly respected in the village communities and it is important to collaborate them in the formal institutional delivery system.
  - ✓ She added that it has been a matter of caste and class and since mostly these Dais belong to lower castes, they are being sidelined. Based on her experiences, she felt that there are embedded policies and the government finds it a more convenient to develop a new cadre rather than to incorporate dais. She pointed out that there is no community participation in choosing the health workers which can help in solving this issue.
  - ✓ Mr. Mendhapurkar supplemented this information by adding that 'modern uneducated literates' have ruined the traditional practices without realizing their significance. He added that Government has systematically ruined the Dai tradition in nexus with the big pharmaceutical companies. The need of the hour is to recognize their skill, give them their due respect and bring

them back to the limelight. He urged the participants to collect and share any case study based on this Dai tradition.

- ✓ It is essential that Dai tradition is followed specially in the rural areas where the formal facilities have not reached yet. So, handholding and capacity building of these Dais as an available resource would have been a solution in areas facing severe crunch of medical staff and para medics. It was realized that Dai would have been a better ASHA than creating a new cadre altogether.
- ✓ Ms. Renu Khanna gave a view point from CommonHealth at this point and added that strengthening the 'good' in the traditional knowledge base (like in Shodhini - herbal remedies for gynac problems) can help a great deal in solving the issues. She added that this power struggle has become a global phenomenon whereas it should have been an opportunity to learn and share knowledge. With this background, CommonHealth is planning a position paper on the emerging role of the dais. She explained that we cannot rule out dais as they are playing different roles in different contexts and it is essential that we understand the context specific issues of safe deliveries.

Session 4 - 4.30 p.m. to 5.00 p.m. – Presentation on experiences of working with Migrant Pregnant Women and children in Chandigarh

Dr Madhu Gupta, Associate Professor (Department of Community Medicine & School of Public Health), PGIMER, Chandigarh presented her study based on her 10 year experience of working with communities in slums of Chandigarh with focus on maternal and child health

- She explained that alienation, low or no education, less contacts with health workers, rude behaviour of health care providers, etc are some of the **factors affecting utilization of health services among migrants.** She pointed out that migrants utilize the services and finally opt for home deliveries in their comfort zone by dais**.**
- Dr. Gupta shared that all health facilities have counsellors now and counselling of husbands plays a vital role in maternal health requirements. She quoted that institutional deliveries have increased from 55 to 96% and IMR has dropped from 25 to 7 per 100 live births amongst migrants.
- She quoted some figures highlighting the **Inequity in access to health services between migrants and natives.**
- She discussed the issue of maternal anaemia prevalent amongst the lower sections of the society and shared her findings based on the Focus Group Discussions conducted amongst migrant pregnant women. Interplay of a multitude of factors led to anemia persistence in Chandigarh. Few were direct

factors like lack of iron and other nutrients in the diet, irregular supply of IFA, lack of awareness about the reason of taking IFA tablets and other were Indirect or Societal factors like low status of women in the study setting, poor communication between health care providers and pregnant women, poverty and illiteracy combine to make pregnant women more likely to not get the health care and education they require to not become anaemic

- A monitoring cell has been established in PGI since 2007 and all neonatal and maternal deaths have been recorded since then. Data was collected from various reporting points like tertiary and secondary hospitals, cremation grounds, and ANM data for home births. Neonatal mortality, maternal mortality and live births trends were discussed by her where MMR showed very slow improvement (a lot of referral cases and migrants in Chandigarh) but neonatal mortality has shown a rise because though the number of institutional deliveries has increased, the hospitals are not equipped enough to deal with such numbers and that's an alarming fact.
- JSY expenditure has gone up in the region but the families have reported a huge chunk of personal expenditure on transportation, drugs, consumables, diet, etc, which discourages them to opt for institutional deliveries.
- Ms. Gupta suggested the following measures to be adopted to improve the present situation:
  - ✓ Strengthening of infrastructure in all secondary and tertiary care hospitals e.g., increase number of beds, equipments as per the load. This will prevent level three delays in care provision and unnecessary referral.
  - ✓ Capacity building of health personnel should be done to improve maternal health. Special one day sensitization of health personnel should be done on 'how to behave with patients/mothers in labour room or wards and their attendants' should be carried out to make the health delivery attitude friendly and prompt.
  - ✓ Complications should be identified at the earliest and prompt referral to the appropriate hospital should be done.
  - ✓ There should be increased awareness and accessibility of maternal and child health facilities among slum and migratory population which can be done by sensitizing them regarding RCH services on regular basis.
  - ✓ Regular monitoring and evaluation of RCH health services in all health facilities.

Session 5 - 5.00 p.m. to 6.00 p.m. – Group Discussions and Plenary Session

In the last leg of the consultation for the first day, the participants were divided in three groups and were given three broad themes to discuss and report back.

- Safe Abortion Services and MTP Act
- Declining sex ratio and PCPNDT Act
- Maternal and Neonatal Health

The groups had to discuss about the issue, the implementation challenges and suggestions for way forward.

Group 1 Safe Abortion Services and MTP Act

The group briefed about the Medical Termination of Pregnancy (MTP) Act and spoke about the various issue pertaining to Safe Abortion services:

- Lack of awareness amongst people and health workers about the MTP Act. ASHA and Aanganwadi workers lack awareness and training about the MTP Act and its implementation guidelines.
- It has been noticed that there immense social stigma associated with abortions. There have been instances wherein any and every abortion has been categorized as sex selective abortion.
- Misconceptions about the MTP Act, its legal obligations and its implementation are prevalent in the society and hence many women still opt for unsafe abortions.

The group also presented various challenges in the implementation of the MTP Act:

- Amongst the underprivileged sections of the society, confusion still persists about the access to these services since they do not know where to go and whom to approach.
- Lack of training to ASHA workers is another pertinent issue. They need to be trained on the content of the Act as well be sensitized about the issue.
- Easy availability of MTP kits (Medical Abortion pills) also poses a threat especially for the adolescents who are the most vulnerable group in this regard.
- Lack of awareness about contraceptives, reluctance to accept them and their failure rate are further challenges that need to be taken care of.

Group 2 Declining sex ratio and PCPNDT Act

The group discussed the history and need of PCPNDT Act in the country. The declining sex ratio and a preference for male child amongst parents was an alarming signal to introduce some legal framework which was in form of this PCPNDT Act.

- The group discussed that not only easy access to technology but various other societal reasons have been responsible for female de-selection which include tradition of dowry, status of women in the society, social stigma (less respect if daughter in the family) are also some of the reasons leading to decline in sex ratio.

The group proposed the following solution to curb the issue:

- Stringent implementation of policies related to girl child and women rights is imperative. Also, the Act should be implemented in all earnestness across the country.
- Social shaming of the family that practices or encourages female de-selection taking cue from the Navasheher act.
- Most importantly, it is essential to nurture a women friendly environment which is safe and progressive.

Post presentation, participants made few comments on the presentation which were as follows:

Technology can't be blamed for declining sex ratio. If we do so it will be like killing the messenger rather than focussing on the real issue. Female infanticide was prevalent before the inception of ultrasound technology which implies that there has always been an unfavourable attitude towards female child and technology just completed this model of demand and supply.

It was pointed out that countries like Bangladesh, Pakistan and some states in USA where it is legal to determine the sex of the baby before birth, female sex ratios are much better than in our country.

Women and men are both agents of patriarchy and it is vital to do away with this attitude of aurat hi aurat ki dushman.

The negative effects of Navasheher example were also discussed where one of the family members committed suicide on being wrongly accused of 'female foeticide'.

There is an essential need to create sensitization amongst people about sex selection. Otherwise, we may end up discouraging the practice of safe abortions resulting in their categorization as murders/taboos.

Group 3 Maternal and Neonatal Health Issues

Some of the issues listed by the group in context of maternal and neonatal health were as follows:

- Bad or rude behaviour at health facilities discourages women from opting for institutional deliveries.
- Less funds for health services leads to shortage in drug supply, equipment maintenance, etc.
- Reluctance of pregnant women in taking Iron folic tablets due to certain side effects like nausea, headache needs to be addressed.

- Extreme discrimination against TB/HIV+ mothers takes place at the health facilities where they are asked to bring in their own needles, medicines, etc,
- Nutritional needs of pregnant and lactating mothers are not taken care of which increases the complexities and eventually leads to high number of maternal mortalities.
- Every pregnancy and child birth is not considered special and child birth is not considered as a risk to both mother and child which gives rise to a callous attitude amongst the medical attendants in the labour room.
- Health facilities are not equipped to deal with complications related to neo-natals increasing the neonatal mortality rate.

Some of the solutions proposed by the group were as follows:

- Imparting soft skills to all the medical and non medical staff is essential to comfort the woman in labour. It is already a part of the NRHM training manual but it needs to be further put into action.
- Health Counselling for pregnant women needs to be taken care of. They need to be told about how they can start with small doses of iron folio acids and eventually increase the dose to do away with the side effects of the same.
- Sensitization about HIV+ patients also needs to be undertaken
- Community kitchens/Aanganwadis should be well stocked to take care of the nutritional needs of the mother and child.
- Proper implementation of JSSK is also important to reduce the number of maternal and neonatal deaths.
- Information dissemination at all levels of implementation is essential to create awareness amongst all the stakeholders about maternal and neonatal mortality.
- Fully equipped NICUs and their monitoring for atleast two months will also help a great deal in solving the issue of maternal and neonatal mortality.

Day 2 – September 12, 2015

The second day began a brief review of the highlights of Day 1 by the participants. There was renewed discussion on the role of Dais – dais should be used as a resource, their capacities should be built, they should be upgraded. Two participants' shared experiences of training Dais – Jan Swasthya Sahayog in Ganiyari gives delivery kits to each woman who attends the ANC Clinic at the hospital just in case she is unable to reach the institution for her delivery, she should be able to get the dai to use the delivery kit. Another perspective was provided by a doctor in the group – he said his experience was that sometimes some dais refer a complicated delivery to the hospital too late and he has seen many maternal deaths in his hospital, even while their team has also saved many maternal lives. He emphasised the need for training of dais as well as providing delivery kits. Another discussion was around Madhu Gupta's presentation which highlighted migrant women

being pushed into institutions which are not ready to give them quality intranatal care. Participants working on Urban Health said that the presentation raised a shocking mirror to their own practice. Another point that was discussed was around Rainuka Dagar's presentation on the issue of service class having better sex ratios – many participants disagreed with this finding from Dr. Dagar's research. Dr. Jyothi Sethi associated with Jagori said that Chandigarh figures belie this claim. Another point mentioned in the review was new concepts and terminologies mentioned the previous day like Gender Credits and Designer Families.

Session 1 – Access to safe Abortion Services: Gender and Rights' Perspective

Chaired by Anand Pawar

Anand opened the session by giving the legal context – the fact that under Indian Penal Code abortion is a criminal act, and at the same time under the MTP Act 1971 it is legal under certain conditions. He discussed the amendments to the MTP Act and stated that while the current proposed amendments would increase access for women, expanding the provider base would have to be implemented with care, ensuring proper training and certification of the skilled providers. He stated that access to safe abortion was a problem because of social cultural reasons (paap and punya discourse), providers' attitudes, and the fact that abortion is not a 'right' in India.

Dr. Arvinder Singh Nagpal – Abortion a Gender and Rights Issue

He said that among the reasons for the need for abortion are women's lack of control over her own body, men's abdication of responsibility for use of contraceptives and the resultant burden on women. Women don't know about the legality of MTP services. There is also stigma attached to obtaining abortions – he quoted the recent statement by the Pope who said that women who have had abortions need to be forgiven! There are several health system barriers like – cost of services and inbuilt exploitation – charges increase as weeks of pregnancy increase. Women's lack of access to financial resources makes it difficult for them to meet these costs. Another health system factor is that public health facilities are not woman friendly – they are ridden with ridicule and insults for women/girls wanting to avail of MTP services. Also there are caste and class biases.

Dr. Nagpal mentioned that Policy and Programme level factors also affect women's access to safe abortion services. Hardly any planning document mentions Safe Abortion or MTP services. Training for MTPs does not feature in any document. Regulatory processes for certification and approval of health facilities are problematic. Since there are no reporting requirements for number of safe abortions provided, or incentives given, there is low priority given to this issue. Post abortion care is very important – this is not emphasised. Medical Abortion – should this be an Over the Counter service or should it be under supervision of medical provider? Do women know when the process is over? Providers' knowledge and skills as well as their willingness are issues. The consent process is coercive because of the conditionality of acceptance of a contraceptive method. Confidentiality which is so important for women is often ignored by service providers.

Safe abortion becomes a woman's right to life issue – because of many of the above factors she is pushed to go for unsafe abortion. Dr. Nagpal made an important point as he concluded his presentation – if there is such an emphasis and a push towards institutional deliveries why not also use the same facilities and same trained providers to provide safe abortions?

He stated that women's right to control over their bodies and right to consensual sex are fundamental in this discussion around access to safe abortion.

Study on Knowledge and Attitudes around Abortion in 3 villages – School of Public Health Students and VHAP

Sukhman Preet Kaur, Garima Bhatt had interned with VHAP over the summer. They were guided by the alumni of the CH CREA institute. Their study included three villages in Punjab, Haryana and Chandigarh where they interviewed 25 women in each village and some frontline health providers. They found a high awareness about contraceptives, but low use. The prevailing perception among men is that women should use contraceptives. There is a belief that Copper T 'ooper chadh jati hai'. Unsafe abortions are because of low contraceptive use. They cited the story of a 20 year old girl who had four abortions and all at home, because her husband did not let her use contraceptives. Their study found that women generally had 'home abortions' (43%) because an Aadhaar card was required if they went to a health facility. Also 'doctor daanti hai'. The women from UP and Bihar had a lower knowledge of contraceptives, but said that back home access to MTP services was easier. They found that 47% of the frontline workers did not know about the MTP Act and legality of abortion under certain conditions. An ANM said that Oral Contraceptive Pills result in cancer. Most said that they get no continuing education.

Some findings of the study that surprised the three researchers were:

- Unwanted pregnancies and not the sex selection , was the reason for most abortions that women underwent
- Only around 15% women were aware of the MTP Act while 65 out of the 75 women interviewed knew about PCPNDT Act.
- Belief that hospital abortion is both a crime and a sin, and that 'home abortion' is neither a crime nor a sin.
- Women prefer medical abortion (home abortion??) because of bad providers' attitude and behaviour.
- Women use Oral Contraceptive Pills surreptitiously and also get Copper T inserted without husbands' knowledge.

There was animated discussion after this presentation. One participant shared his own experience of his wife seeking an abortion from a government health facility, where the doctor 'samjhaane baith gayein'. The conclusion was that widespread discussion is required around the MTP Act both in the community and among providers – the PCPNDT Act has overshadowed the MTP Act even though the MTP Act is much older. It was clarified to the participants that MTP Act in India came without struggle as a part of family planning programme.

Session 2 – Maternal Deaths and Maternal Mortality

Dead Women Talking – Sanjeeta Gawri (CommonHealth)

Sanjeeta Gawri presented CommonHealth's Dead women Talking initiative. (See PPT in Annexure – summary is not being presented here). The purpose was to inform participants of this meeting about

the second round of Social Autopsies that the members wanted to do and if any of the participants here wanted to join the second round, they had the opportunity to do so. The Nov. 20-21 dates for the Mumbai meeting were shared with the group. Dr Arvinder expressed that he was a member of the District MDR Committee and this presentation as well as being part of the DWT initiative would inform his participation in the committee. Silky Grewal later wrote in that the DWT Report would be very helpful for litigation for the state chapters of HRLN.

Other comments were as follows:

- Mr Wani (J and K) said that state governments should deploy adequate resources for doing effective MDRs. The analysis should inform strategies to bring down state MMRs.
- Subhash Medhapurkar warned us that highlighting the health system gaps so much, might boomerang on health activists in India because this would feed into the government argument of non-performing public health system and therefore privatisation of health services.
- Janet Chawla said what about nutrition and food? Her point was that we need to emphasise social determinants of health and go beyond the biomedical causes of maternal deaths.
- Dr. Nagpal reflecting on his experience in the District MDR Committee, said what about maternal deaths in the private hospitals? These are hardly reviewed because a 'compromise' is reached with the management in these hospitals. He also remarked that well done 'social autopsies' would also tell us reasons for late referrals.
- Post natal care has to be strengthened – majority of deaths happen in post natal period and women are sent home within 24 hours of an institutional delivery.
- During referrals trained para medics should be there in the emergency transport to stabilise the woman.

Maternal Mortality – Dr. Rehana Kausar (J and K)

As an introduction to her presentation Dr. Rehana said that while we discuss so much on Maternal Mortality, we need to remember that for every maternal death between 20 and 30 women suffer from maternal morbidities and unfortunately there is no way of capturing this suffering of women. And while we celebrate reduction in the country's MMR, we must remember the inequities – the regions of India where most women die, the fact that it is the most vulnerable women who are the ones dying. She stated that J and K has no SRS figures for MMR, but state level estimates are an MMR of 70 per 100,000 live births, an estimate that she has serious doubts about. Another estimate is 150 deaths per 100,000 live births. Dr. Rehana stated that distance and terrain are major determinants of maternal deaths in J and K. And Gujjar and Bakhral communities especially vulnerable. She pointed out that the new RHIME method should be used in the SRS[4]. (please see PPT in annexure for further details).

[4] From Dr. Mala Ramanathan AMCHSS - The RHIME is the method adopted by a very well known group of researchers lead by Prof.Jha from University of Toronto who have utilised the deaths that happened during the periods 2001-2003 in the SRS sample and reclassified them to determine the underlying cause of death using a form of verbal autopsy called the routine, reliable, representative, resampled household investigation of mortality with medical evaluation. (RHIME). This is popularly called the one million death survey and the data has been released by the Registrar General's office to a group that has access to the data. They organised the certification of documented deaths by retabulating them by causes based on ICD10 classification and adjuricating carefully for mis - classification. That is a special data set that is not accessible to the public as this reclassification was funded by someone and undertaken by Prof.Jha and others. It is indeed

The discussion was initiated by Janet Chawla asking round what the house thought about professional midwives? Dr. Rehana said that since the Skilled Birth Attendants – mainly nurses – were conducting most deliveries within facilities, the potential for a professional cadre of midwives was high. Then there was a discussion on Simulation Labs for training SBAs. While they are a good way to teach birthing skills, there is the aspect of 'each woman is unique – with her needs for emotional support, comfort, touch…' Soft skills was the emphasis of this respondent.

The discussion once again reiterated the need for state and district level data in J and K.

Session 3 – Building Common Ground - Chaired by Dr. Monica Munjal Singh

Declining Sex Ratio and Effects on Women's Access to Safe Abortion - CommonHealth Perspective - Anand Pawar

Anand's presentation began with highlighting what was happening to access to safe abortion services in the context of the increasing emphasis on 'save the girl child' campaigns and other work around declining sex ratios. The presentation then went on to explain how the women's movement was concerned about both the declining sex ratio and its significance and access to safe abortion issues. Gender inequality was at the root of both these problems. He then explained about the PCPNDT Act and that this Act nowhere mentions 'abortion'. This is a regulatory Act - it regulates use of prenatal diagnostic techniques (PDT) in different ways. However he said that while regulatory frameworks are necessary, they are not sufficient. There is a critique of the PCPNDT Act. It can be questioned on the following grounds

- Is there any way to ascertain that sex detection is not carried out in facilities which follow all legal requirements?
- Can the Act ever keep up advancement of technology where tests will leave no evidence? Currently IVFs are hubs of sex selection.

Further, even though the law mandates reporting of cases, conditions under which PDTs were conducted, patient details (Form-F) etc, both clients and service providers record reasons that fit within the legal framework. Sex of the fetus is disclosed through non verbal gestures and verbal

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an excellent method and we need to request/ask the govt of India to take the maternal deaths in the SRS over the recent periods, to use a modified verbal autopsy tool (that is mutually agreed upon by the SRS/Medical Professionals) and reclassify the cause of maternal deaths to do a tabulation of the direct and indirect causes of death in the SRS sample.

This is a huge task and needs financial resources as well as and assured skills.

Govt of India owns the SRS so without its cooperation it cannot be done. Second, it needs concentrated skills and managerial strengths to manage the records - take all the death records, copy them, send them to designated medical professionals - two for each case record - with a criteria for classifying cause of deaths. Then tabulating the causes carefully so as to identify a third party adjudication in case of dispute in the cause of death classification.

What the J & K doctor is suggesting is that you do a similar effort for maternal deaths - and that has already been done - Maternal Mortality in India: Causes and Healthcare Service Use Based on a Nationally Representative Survey

codes …it is hard to establish that sex of the fetus was disclosed. Often ultrasound test and abortion are done at two different places, making it difficult to establish a link between the two. Proving that a particular abortion is sex selective is as difficult as proving that USG test was conducted for sex detection. In practice, it is impossible to identify sex detection test. So the focus shifts to preventing abortion following that.

Anand then went onto explain that the MTP Act, on the other hand is an enabling act which addresses a public health priority. It aims to improve the maternal heath scenario by preventing large number of unsafe abortions and consequent high incidence of maternal mortality and morbidity. It legalizes abortion services and promotes access to safe abortion services to women and de-criminalizes the abortion seeker while offering protection to medical practitioners.

The effects of the PCPNDT Act are adverse for safe abortion services. While PCPNDT Act makes the act of sex-selection illegal, it is silent on the issue of abortion. But, through the anti sex selection campaign, right wing anti-abortion groups' promotion of the girl child is conveying the message that abortion itself is unethical and immoral. The anti sex selection campaign has been derailed by media sensationalism – language of 'female foeticide', visuals conferring 'personhood' on foetus. The result is reduced access to safe abortion services – providers are scared of providing abortion services to any woman. They are scared that they will be harassed by PCPNDT Act regulatory authorities.

The perspective within CommonHealth is that gender issues are important and gender discrimination exists. Our work is against gender discrimination, for gender equality and a rights based approach is non negotiable. CommonHealth members do not believe in denying an abortion to a woman who needs it and is eligible as per the law of the country. Neither do they accept sex selection as a valid indication for an abortion by itself. They do however understand that denying a woman for fear of consequences, may lead to a denial of safe abortion services. Members feel that denying safe abortion just by suspecting a woman of having done a sex determination test, can also lead to unsafe abortions. Members feel that they cannot close our eyes to sex selection and must make efforts to stop misuse of technology. Also changes in the community mindset are crucial since it is patriarchy and traditional practices such as dowry etc which are responsible for unwanted-ness of girls.

Anand concluded by asserting that CommonHealth strives to create common ground between the discourse on women's right to safe abortion and the discourse on prevention of sex selection.

Understanding Sex Ratios – Pawan Kumar Sheokand

Pawan began by asking certain questions – have there ever been 1000 girls for every 1000 boys? If sex ratio were to improve, will we say that everything is fine for women and girls in our society? He explained what sex ratio is and how it is presented in India vis a vis other countries, sex ratio at birth and child sex ratio. He said that sex ratio at birth is not constant, it is affected by the sample, birth registration (unwanted births, delivery at home). The estimation of sex ratios is a complex demographic exercise that requires following a large population over a significant period of time and requires 5000 births or more are required to estimate the sex ratio. Births have to be followed for more than 3 years to assess changes - because of large sampling errors due to moving average. He spoke about some patterns that can be seen. There are variations by:

- **Age**

- At birth favours males (known since 17th century)
- Lower at very young ages- Gender gap in CMR
- Gap narrows with increasing age – Increasingly favours females
- Sex ratio - 1000 after 64 years

- **Population** – small population – possibility of errors
- **Order of birth-** 1st and last birth favours male
- **Birth interval** – Shorter favours males
- **Parity** – Increase favours males
- **SE determinants**- Higher castes, APL, Literacy favour males
- **Race / Ethnicity**– Black population – More males
- **Location- Urban/rural** – Urban favours males (China)
- **Conflicts/ wars**: Favours males

Pawan told some fascinating stories about gender discrimination through the ages.

> *Raj Kaur* was the mother of one of the most famous kings Maharaja *Ranjit Singh* who ruled Punjab in the 18th century. It is widely believed that she was put into a pitcher after her birth and buried. Around the same time a soothsayer visited the royal court and prophesized, "*The girl you have just buried is destined to bear a son who will become a king and illuminate the name of the dynasty*". The pitcher was dug out and she survived. Ironically, she survived because of the role she was expected to play! Nevertheless, not everyone so fortunate to survive
>
> In 2010, *Pritam singh*, a truck driver from the same state is a subject of envy amongst all his bachelor friends. *Pritam singh* has managed to get married in his late-thirties. His wife *Soni* is less than half his age. *Soni* was born in a poor family in an Eastern state in India. *Pritam singh* paid handsome amount to *Soni's* father to "buy" her. Soni's parents were happy to give her away. He "married" her and brought her to his village in Haryana. *Soni* does not speak his language, is unaware of customs in his state and family. But the marriage suits both of them. *Pritam singh* has a wife and *Soni* has roof over her head and two square meals a day. *Soni* too survived because of the role expected of her. Is she fortunate?

Several factors affect sex ratios. These are: Ratio at birth (historical decline, registration, CSR completeness), Mortality amongst women (upto 34 years age), Discrimination against women in the form of female infanticide in some pockets, nutrition, health care in illness, Care during difficult childbirth, Decline in pregnancy wastage because of better care, Family planning programme (small families), Migration (women do not migrate alone), Genetics (viability of sperms), Age misreporting (age at marriage), Fear of women being enumerated (seclusion), Sex selection, Timing of conception. Thus the decline in sex ratios cannot be explained by technology alone - discrimination against girls was practiced for long time in the country.

The declining sex ratio has given rise to several phenomena in Haryana, like:

***Avivahit Purush Sangthan* (Bahu dilao, vote pao)** – Rough estimates are that in Haryana's approximate 7,000 villages 3,50,000 males are without life partners. Bachelors asked for brides in exchange for votes

Paro - Yamuna ke us paar se - Eight years ago motherless Samira from the North East was picked up by four women and a man who said that they would take her to her uncle's house. They brought her to Rajasthan to a district where men found it difficult to get married as there were no girls. She was sold for Rs. 5000 and was married of to her present husband. She became a mother at the age of 14 years and even 17 years after marriage has no money or freedom.

Bahupati vivah (Aja beti le le phere, yo marega to aur bahutee) – Sushila from a district in western UP was married legally to her husband but was later on forced into multiple relationships with her husband's brothers.

Pawan spoke about long term solutions to empower women and increase their autonomy, as well as to change community mindsets and reduce excessive son preference with a focus on religious rites and ancestral worship customs, daughters value to her parents, fundamentals of the family system and investments in daughters, bilateral kinship systems maintained through both male and female line, and recognition of women's economic contribution as well as old age insecurity for women who outlive their husbands.

Reflections by Subhash Mendhapurkar

He spoke on their 16 years of work along with Shri Manmohan Sharma of VHAP on the issue of declining sex ratio. He reminded the participants that the MTP Act came in because of the population control mindset of the then government – MTP was actually seen as a contraceptive method. He pointed to the conditional nature of the MTP Act and pointed out that the IPC clause criminalises illegal abortions. He stressed the need for safe abortion as a right of women.

Subhash said that engagement with the Beti Bachao Beti Padhao campaign provided opportunities for learning which can be surmised as government initiative and there seems to be no space for civil societies in the campaign. According to Dr Bedi the sex determination and sex selective abortion is s a Rs. 20 billion industry and that there exists a deep nexus between the machine manufacturers, radiologists and the Civil Surgeons. Drawing upon similarities between the PCPNDT Act and the Dowry Prohibition Act he says that both are ineffective – prevention of dowry has not happened because of the Act, will prevention of sex selection happen because of the PCPNDT Act? He too asked the question raised by Pawan and others earlier – will the situation of women actually improve, if we manage to improve the sex ratios?

Speaking of the context of small family norm, he said that in one analysis that they did, they found that 25% families complete their families with one / two male children. Increasing globalisation and increasing privatisation of education and health sectors, is making it difficult for families to raise more than one child. Subhash stated that during UNFPA Asia meet he learned that better sex ratios will result when Capitalist patriarchy will replace Feudo Patriarchy as capitalist patriarchy demands optimal output with minimum inputs – whoever gives it – sex doesn't matter.

In the discussion that followed, Subhash was asked to explain his last point about Capitalist Patriarchy, which he could not because it was a topic of a detailed discussion. Garima Shrivastav mentioned that we need to move the discussion away from the sex ratio numbers to structural issues – women need to be given a chance to create enabling environments to raise their children, whether boys or girls. And in our discourse on migration of women and treating them as victims, can we see how better conditions can be created to increase their agency? What can be done to create social cohesion? Anand said that we should conclude this session by committing, that at the very least we will stop using words like – foeticide, sex selective abortions, mother/sister/bahu while referring to girls/women. And we will not use illustrations/pictures/visuals like – knife, splattered blood, cute girl with ribbons and bows in the uterus, and such like.

Session 4 - Advocates' Guide for Rights Based Contraceptive Services and Information Chaired by Subhash Mendhapurkar

Renu Khanna shared with the group CommonHealth's latest publication. She gave the context for the importance of rights based advocacy on this issue. At the international level there is renewed interest in Family Planning following the FP 2020 Summit in London in 2012 where many government heads, Ministries of Health officers, INGOs, corporate sector heads (including Bill and Melinda Gates Foundation) came together to commit to increased emphasis on access to contraceptives for women. And also at the global level, the WHO finalised recommendations on rights based contraceptive services to be followed by governments. In India, we know what the context is – continued, although misplaced (because many states have already achieved there Net Replacement Rates), emphasis on population control in the form of 'ELAs' or 'Estimated Levels of Achievement' (a euphemism for 'targets'), as well as dangerous levels of quality of care for female sterilisations as evidenced by the Bilaspur deaths in November 2014. Also the government's push for PP IUCDs is working out adversely at the ground level, with consent and information being short circuited.

Speaking about a rights' based approach, Renu questioned the name of the programme – Family Planning Programme – which excludes contraceptive needs of all those not in the purview of the 'family' or those not in the 'Eligible Couple Register'.

The CommonHealth Advocates' Guide has been published in English and Hindi. It is based on the WHO Principles - Non discrimination, Availability, Accessibility, Acceptability, Quality, Informed decision making, Privacy and confidentiality, Participation, Accountability. The 24 Recommendations made by WHO have been adapted to the Indian context. The Guide provides explanations of the importance of each Recommendation as well as some standards laid out in government guidelines and protocols against which monitoring of both Policies and Programmes at the state level as well as Service Delivery at the ground level, can be assessed.

CommonHealth will organize a meeting in January 2016 and members are encouraged to attend it. The meeting is to create a concrete plan on monitoring of contraceptives' delivery in different parts of the country. Renu mentioned that in the Annual General Body Meeting (August 17-18, Bhopal) CH decided to monitor PP IUCD programme. This and other such ideas would be concretised in the January meeting.

In the discussion, participants raised the point of why no research on new male methods? Why does use of contraceptives continue to be a women's responsibility?

Final Session – Way Forward Chaired by Anubha Singh

In this session, Pawan Sheokand and Dr. Nagpal initiated the discussion by sharing what they had done after the April CREA CH Institute. Pawan shared about how his perspective towards gender issues had changed and how he had realised how important it is to talk about Safe Abortion issues. When he spoke about this with colleagues, initially they rejected his opinions because they were still so steeped in the declining sex ratio arguments. But gradually they began to listen to his reasoning. He guided the study done by the three interns from School of public Health Panjab University on Safe Abortion, MTP Act that was reported earlier. He also reported about his discussions with the Rural Development Minister about the need to orient newly elected panchayat members about social issues like declining sex ratio, gender issues, female literacy, and so on - the Minister agreed to a meeting after the elections.

Dr. Nagpal also reported on a major shift in perspective – 'I was working on these issues earlier also, but after the 5 days' inputs, could infuse all my work with the gender and rights' perspective'. He spoke about how he shared the folder of all the reading material with the District FP Officer who then used the contents with all his officers. Dr. Nagpal's interventions in the district committees' meetings are more informed post the training. He is trying to initiate and plan a two day training with District Family Planning Officers and PCPNDT Nodal officers of Punjab state. And also safe Abortion training with 40 female medical officers of the state.

The report from the VHAP representative was they organised the MTP Act study for the 3 students and also did 5 one day workshops in two districts which were attended by 700 people – in these meetings they discussed the role of the VHNSC in stemming declining sex ratio and gender issues.

About future actions, Himachal Pradesh representatives reported that with panchayat elections coming, they would be campaigning in 300 panchayats on Reproductive Rights friendly panchayats and the ICPD promises. They would distribute booklets on panchayats' role related to the PWDVA, PCPNDT Act, MTP Act, CEDAW etc.

The Panjab University students spoke about organising educational and awareness sessions on the MTP Act in the hostels – '4000 of the 6000 students in the University are girls and they would benefit from such sessions'. The ASAP representative, Garima said that in their institutes they discuss how to talk on these sensitive issues – their Facebook page is also a good resource for University students.

Kuldip Chand said that maternal deaths from unsafe abortions need to be documented – his organisation would like to work on this. Silky from HRLN followed this up by saying that HRLN had 100 Reproductive Rights cases in 10 states and they were getting good orders from the judges who are taking cognisance of maternal deaths. HRLN would like us all to become petitioners in such cases.

Dr. Manmeet Kaur from PGIMER said we should all take up common issues and use mass media and learning messaging from advertising professionals. We need to both spread awareness as well as influence politicians around issues related to Adolescent Health, Abortion, Maternal Deaths. We

need to magnify our ideas, highlight the right things and not get into sloganeering or political rhetoric.

Vandana Shukla from the Tribune was of the opinion that we need to advocate to editors to create columns for these issues.

The Consultation ended high on energy, with new questions being opened (for example, on consent for adolescents' abortions and POCSO, and so on) even as we tried to close the discussions. Around 15 participants became members of CommonHealth and wanted to keep in touch and wanted collaborative activities in their states. With heartfelt thanks all around the consultation finally ended by 4.30 pm on the second day.

(Endnote: A press note was sent out on Sept 11 evening and Amar Ujala covered the meeting subsequently.)

Report prepared by Nandita Mathur and Renu Khanna

Report reviewed by the day 1 speakers and ……

Annexure

Annexure I – Schedule for the CommonHealth Meeting, Chandigarh

September 11-12, 2015, NITTTR, Sector26, Chandigarh

September 11

TIME	DETAILS	
10.00-10.30	Registration	
10.30 – 11.45	Welcome and Introductions Introduction to CommonHealth Objectives of the Consultation	Pawan Sheokand Renu Khanna Subhash Mendhapurkar
11.45 – 12.00	Tea	
12.00- 1.30 pm	Overview of Situation of Maternal – Neonatal Health and Safe Abortion in the 5 states (1) (12 minutes presentation by each state speaker)	Chair: Dr. Pyare Lal Garg Dr. Aswini Kumar Nanda – (Neonatal Mortality in 5 states) Dr. Rainuka Dagar (Declining sex ratios and Gender Issues IN Haryana and Punjab) Dr. Ashish Gupta (Haryana) (DID NOT COME) Dr. Manmeet Kaur (Punjab)
1.30-2.15 pm	Lunch	
2.15 – 3.30 pm	Overview of Situation of Maternal – Neonatal Health and Safe Abortion in the 5 states (2)	Chair: Alma Ram Janet Chawla (Jeeva, HP) Rahi Riyaz (J and K) AK Wani (PCPNDT in J and K)
3.30 – 4.15 pm	Emerging Vulnerable Groups and their SRHR issues	Chair: Dr Madhu Gupta – Urbanisation, Migration and Maternal Health Film (COULD NOT SHOW DUE TO LACK OF TIME)
4.15 – 4.30 pm	Tea	
4.30 -6.00 pm	Voices from the Ground – Group discussions and Plenary Presentations	Moderator: Sanjeeta Gawri

September 12

9.00 -10.30 am	Access to Safe Abortion Services – Problems and Challenges	Chair: Anand Pawar Dr. Arvinder Singh Nagpal Garima Bhatt, Alampreet Kaur, Sukhmant Preet Kaur – Panjab University
10.30-11 am	Tea	
11.00 – 12.00	Maternal Health – Maternal Mortality	Chair: Dr. Rehana Kausar Sanjeeta Gawri - Dead Women Talking
12.00 – 1.30 pm	Building Common Ground between Safe Abortion Advocates and Declining Sex Ratio Advocates	Chair: Monica Munjal Pawan Sheokand - Understanding Sex Ratios Anand Pawar- CommonHealth's position Subhash Mendhapurkar - GOI Guidelines
1.30 - 2.15 pm	Lunch	
2.15 - 3.00 pm	Access to Contraceptives : Situational Analysis and Challenges	Chair: Subhash Mendhapurkar Renu Khanna
3.00 - 4.00 4.00 – 4.15 pm	What can we do together? Developing action plans for each state Vote of thanks and Closure	Chair: Anubha Singh Arvinder Nagpal, Pawan Sheokand

Annexure II – List of Participants

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