DEAD WOMEN TALKING- IV Learning from Women's Experiences

Report of a Workshop, January 5th and 6th , 2015

CommonHealth with Oxfam India, SAHAJ AND RUSSEC

DEAD WOMEN TALKING IV

Learning from Women's Experiences

Report of a Workshop, January 5th and 6th, 2015
INTEGRATED SOCIAL INITIATIVES,

Indian Social Institute, 10, Institutional Area Lodi Road, New Delhi-110003.

BACKGROUND

Maternal Mortality continues to be an unjustifiably significant problem in India. In spite of the attention received by the issue in policy and programme by the Government of India and International bodies, the solutions proposed often fail to capture or be relevant to the lived realities of people.

Many organizations and networks across India working in the area of maternal and neonatal health came together as a group to develop a framework wherein they could advocate for the cause and influence policy changes. The group came together as ***Dead Women Talking*** in a Workshop in Chennai in June 2012. What emerged was an understanding of the gaps in the GOI MDR Guidelines and tool, wherein *social determinants were missing*. A small group of individuals attending the DWT meeting came together to develop a Social Autopsy tool for Maternal Deaths. Post the DWT Meeting, CommonHealth, with the help of several individuals and organizations, engaged in training several grassroots organizations across the country in use of the tool and documentation of maternal deaths.

In the second round of Dead Women Talking, the members from various organizations across the country who had been actively involved in documenting these deaths came together in February 2014 in Mumbai, to share their experiences of conducting social autopsies, to explore what is emerging from these varied contexts in terms of determinants of maternal death as well as to share their recommendations for modifications required in the tool. Besides this, discussion took place about coming out with what could possibly be a civil society shadow report on maternal.

In the third round of Dead Women Talking, held on 25th and 26th of June, 2014 at Mumbai, participants shared updates from their respective states about the process as well as advocacy initiatives post February 2014. Besides that, participants provided feedback and recommendations on Dead Women Talking report which was a compilation of deaths across various States of India.

In the fourth round of Dead Women Talking, held on the 5th and 6th of January 2015, participants had gathered for the following reasons:

- To take stock of the issues that emerge from this initiative and the maternal health scenario in the country
- Develop consensus on certain urgent issues, e.g. blood availability, role of midwives, etc.
- 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.***

DAY 1, 5th January 2015

10.00 a.m-10.15 a.m. - Introduction and objectives of the meeting- chaired by Priya John

The introductory session for the day was chaired by Priya John. She commenced the session by reiterating the objectives of the two day consultation, which are as under:

- What is the work that has been done collectively so far?
- How do we go ahead in future and form a policy consensus since we are all from different organizations, different places?
- What will be the shape of our policy dialogue?

She tried driving home the point that building a policy consensus was very important. That would help us to become a regular watchdog. For that purpose, it was imperative that our political engagement was consistent.

It was well known that the government had used divisive tactics, made hate speeches, propagated anger among masses and now it had become an everyday reality, and was gaining newer ground. Everyone working in the rural areas knew that these were important matters- "Jan, Jungle, Zameen" (People, Forests and Land). Maternal Health as an issue couldn't be understood in isolation, but had to be converged within the larger framework of "Jan, Jungle aur zameen".

The previous government as well as this one has been gambling with the poor. Their land rights have been severely compromised. This is very critical to women's health, and we need to actively engage with this. On one hand we see rights entitlements being provided, and on the other hand we see rights being violated. Local livelihoods have been threatened, and coverage of policies like NREGA has been very limited. In such a scenario engaging with the State is very critical.

10.15 am- 10.30 am- Introduction of participants- chaired by Alka Barua

The introduction to the consultation was followed by an introduction of all the participants present there, moderated by Ms.Alka Barua.

10.30 a.m. -10.45 a.m. - Dead Women Talking- A review process, findings and recommendations- chaired by Subha Sri

During this session, Subha Sri ran through the agenda for the day in detail. The power point presentation on the National Dead Women Talking report was displayed, however, Subha Sri only focussed on the key processes and findings from the report.

She mentioned how the entire process of compiling the Dead Women Talking report had been a collaborative one with involvement of many people. Knowledge collection had been democratised and data collection was done by people very close to the ground.

The initial objective of the report was to focus on the social determinants of maternal deaths, however during the process, the health system flaws emerged so prominently from every case, that they couldn't be overlooked. It has been very overpowering. So a big chunk of the report is the Health System issues. It is important to look at the larger Health policy, and only then can we locate maternal health within a larger context.

10.45 a.m. - 11.45 am- Working with the MDRs and DWT report at State and District Level- a sharing by participants- chaired by Sanjeeta Gawri

Sanjeeta Gawari from OXFAM India facilitated the session. Initiating the session, she tried to recap the processes during the previous DWT workshops. She mentioned about the last meeting that was held with participants in June, 2014 when findings about maternal death reviews from different States were shared and the participants discussed what policy changes could be done from the recommendations of the DWT 2 report.

After the workshop in June, the participants conducted activities and initiated efforts for advocacy at their respective district, state or national levels. So Sanjeeta emphasized how this workshop was an opportunity for all participants to share their initiatives amongst participants from all across the country. She opened the floor for the participants to share what they had done.

Participant 1 from Azamgarh, Uttar Pradesh, Rajdev Chaturvedi: State government had given the order to carry out maternal death reviews (MDRs) in all districts, but this has not happened in his district. He shared about an RTI that was lodged by Health Watch Forum UP

following which a committee was formed at district and block level. He also mentioned that he had discussed the need for reporting of maternal deaths in the last District Health Society meeting. He shared that his organization is conducting FGDs with ASHAs on maternal health and he urged the need for orienting ASHAs, *Anganwadi* workers and other related staff on maternal health, which is also the state's order. But, the orientations have not been done and he could also not take this forward due to limitations of staff, resources, etc.

Participant 2 from Gadchiroli, Maharashtra, Dr Satish Gogulwar shared that they have been carrying out MDR and have also provided a report of the last 6 months to the government with recommendations (e.g. blood, equipment, etc.) for which now they are following up. Discussion took place over a case when even though ambulance was able to bring a woman to a hospital; her child could not survive due to unavailability of a doctor that time. So, he pointed out the challenge of follow-up on such cases even when documentations are done. Related to this process of follow-up, a State level consultation was organized on December 6, 2014 in collaboration with Oxfam India and CommonHealth, where many participants from NGOs and GOs were present, including the NRHM mission director, wherein they tried to review strategies and also discussed how they could systematically follow up and do advocacy.

He also shared about other challenges of tribal areas, like people abstaining from going to hospitals even after taking appointments, transfer of doctors, and also budgetary constraints- especially of late release of funds. Some issues like that of recruitment of human resource had to be sorted out at the state level. He explained how late release of funds affects all aspects of service delivery that need cash payment such JSY, transportation and so on. In this situation, the local authority becomes disabled. He further mentioned that this issue of PIP was not just a local issue, but a National Issue.

Participant 3 from Mirzapur, Uttar Pradesh, Sandhya Mishra shared that there is provision for MDR at district and below level, and the health system claims that MDRs are being carried out, but in actual practice they were not carried out. When the family members of the deceased women were asked if any person had come to ask about the death, they said no one had come. She also mentioned that her organization had lodged an RTI on how many deaths were there and how many reviews were done, to which the answer was that reviews for all the deaths were carried out. But, when they (her organization) tried to match the number of deaths reported and recorded to actual ones, they discovered that many deaths were not reported at all.

She also mentioned that ASHA, who has a very crucial role to reduce maternal deaths, is not properly oriented or trained on this and her role in MDR. Further, she shared some ASHAS encouraged women to go private hospitals due to payment of extra commission for the same.

She shared during the three orientations that she had done for ASHA, the ASHAs expressed that they were never oriented about their roles, but were just given the forms which they did not know how to fill, and did not have much understanding about maternal deaths. She also mentioned that in an orientation program with the government people, she had shared about ASHAs taking women to private hospitals for commission, to which they responded saying that they would release such ASHAs. However, she emphasized the need for systemic change and that releasing/ terminating anyone was not a solution. She urged the need for proper training, monitoring and orientation of ASHAs in this regard. She also shared about sloppiness in VHND, and ANC, which is crucial to reduce maternal deaths. She exclaimed how "the person responsible for the ANC in VHND considers *tikakaran* as ANC".

She also highlighted the situation of inappropriate referrals. She mentioned that when she questioned about the reason behind referrals to health personnel, the response she got was- "women come late to the health facility, when the complication is too severe to manage, so nothing can be done at the block level where there is a dearth of equipment. So they have to be referred". She mentioned that the nurse is usually ill-equipped, so women are transported to district, which is a great distance away and then, a lot of them die in transit.

Participant 4 from Gujarat (ANANDI), Neeta Hardikar shared that most deaths reported at Dahod and Panchmahal (their work area), have shaped into advocacy efforts. They have also tried to address the issue of maternal mortality at district level meetings.

She highlighted details of a case from Dahod, wherein the MO claimed that the death of a woman was not a maternal death; however the evidence collected by field staff validated it as a maternal death. That family was called to the Collector's office, and asked questions. ANANDI was not called, but they got to know from the ASHA worker of the village. She shared that usually family members are not called when a maternal death occurs. She also said that there is hesitation at district level among the government staff to call civil societies/NGOs to be part of MDR committees and she questioned if this was intentional, and so seemed the attitude of not wanting to share the findings. She mentioned that a good system exists but a proper process is not followed. The medical causes are being identified but there is no progress in system to address them efficiently. Yet another huge problem was that of blood, and families faced a lot of difficulty in travelling all the way to the districts in critical situations to arrange for blood.

She shared about the social autopsies that *ANANDI* had been conducting for maternal deaths and that reports were being shared at block level as well as district level (in meetings with THO/CDHO). The ANANDI team felt that the advocacy efforts have helped to some extent as they have been able to address some recommendations.

Participant 5, another participant from SEWA Rural, Gujarat, Dr Shobha Shah shared about the need for advocacy for referral of emergency cases to the nearest facility available, with appropriate EmOC service/facilities. Besides, she shared how intra facility transfer through 108 was made workable through advocacy efforts in Jhagadia, their intervention area. She also spoke about the problem of documentation of deaths that happened in transit, how no health facility took the responsibility for such deaths, there was lack of clarity over the cause of death, and this was important issue to systematically advocate for. She emphasized how this also called for basic orientation on maternal deaths to the 108 staff.

Ms. Renu Khanna provided updates on advocacy in Gujarat through SAHAJ and Jan Swasthya Abhiyan, in the year 2014. A Gujarat State Report on Maternal Deaths had been compiled by a few NGOs working on this issue in Gujarat. She mentioned about a State level consultation held in Ahmedabad on 9th and 10th of April, 2014 titled "Maternal Health-Realities and Challenges in Gujarat", wherein NGOs from various districts of Gujarat participated on sharing about the situation of maternal health in their district and discussion also took place over equity issues. Following this consultation, a group of individuals representing different NGOs met the State health officials at Gandhinagar in October 2014. They were not allowed to meet the Health Commissioner, but met the Additional Director and the State NGO coordinator. When a memorandum of issues was presented and discussed with them, they claimed they had been doing everything that was put up. Ms.Renu Khanna has requested them to give this to them in writing. She expressed how the State was completely impervious to any civil society activity. She also shared that another follow up meeting of the JSA members was planned in March 2015, where the government officials will be invited, sharing among NGOs will take place and the Gujarati State report on maternal deaths would be released.

Participant 6 from Orissa, Jiban Behera shared that MDRs are conducted for the sake of it. The MDR committee is very dormant. MDRs are usually done on the same day when there is a health department meeting. He also shared the contradiction that existed between 102 and 108. 102 which was the equivalent of the Janani Express elsewhere would not reach remote areas.

Participant 7 from Bilaspur (Chattisgarh), Sharayu Shinde added further to this and shared that when the Janani Express (102), was launched it was only meant to go to government facilities without taking into cognizance the local reality of a defunct PHC or CHC. However, with advocacy efforts, a woman can request, pay money and go the health facility of her choice.

Participant 8 from Bundelkhand (Uttar Pradesh) mentioned about the MDR process and training of ASHAs on maternal death reporting. However she shared how the ASHA/ANM was reluctant to report any deaths owing to a fear of losing their job. So when the issue of

maternal deaths was put forth at the District level, they refused to accept that any such deaths were taking place. She expressed how their organization had recorded 11 deaths, while in the government system only 3 deaths were reported. She also highlighted the callous attitude of the health system by quoting examples wherein for any maternal death that occurred, the staff would ask for signatures of the husband on a document stating that the death did not occur due to any fault of the health facility, but they themselves sought the service very late, and that's why the woman died. She also shared about how early discharge from hospiatl was contributing to death.

Participant 9 from Chhattisgarh, Yogesh Jain shared how the MDR is conducted at the Block Level as well as District Level. However, the state perceives this activity as a fault finding process. He expressed how even in the DWT report, the maximum focus was on the health system issues. Even the health system has its own issues, which is usually not noticed by the NGOs. Community based monitoring alone, cannot help to overcome the health system issues/ structural problems. To change the structure, higher level advocacy is required.

He also mentioned that rather than having general/ diffused recommendations if we have specific concrete points there might be some possibilities for change. E.g. if its related to transportation, we need to be specific or if its related to referral then we could be more specific like how the referral should be, who should do it and when, etc.

Subha Sri also shared about the policy advocacy process carried out in Delhi after the DWT report was released in September. She mentioned that like Gujarat's experience, the team tried to meet many people, like Health Secretary, Deputy Commissioner, WCD Secretary, etc. but they we were not able to meet them. There are many issues like abortion, maternal deaths that are divided between various officers due to which they were not ready to give appointment. However, she expressed how they managed to hold two very good meetings, one of which was with the member of National Commission for Women, who was interested in taking forward the issue of maternal mortality. She mentioned it was a very impressive meeting not only because the member showed interest to take the forward the issue to Health Secretaries of various states (for which she had asked for a formal letter), but she also shared some criteria on how the process could be taken forward. She also had suggestions on how to involve the State Commissions for women.

Second meeting was with the Advisor of Health Ministry who asked for three to four concrete issues that CH and JSA as a body wanted to address. She mentioned three issues related to MDR (professional midwifery, blood, and referral). They realized that that we need to have more nuanced understanding of some of these issues. It was also important to have a better understanding of the different positions that people had, in order to reach a consensus/ common understanding with regards to the policy dialogue which was scheduled for the next day.

Participant 10 from Jharkhand, Lindsay Barnesshared about *Mamta Vaahan* in her district and that women could call the vehicle and go to the nearest health centre with the ASHA during delivery. But, she highlighted the fact that there were no effective Emergency Obstetric Care Centre in the district hospital and how women wished to therefore visit a private hospital. So, she highlighted the need to advocate for the *Mamta Vahan* to take to the nearest effective referral centre rather than just nearest referral centre, be it public or private and not just emphasize over visiting private hospitals.

11.45 a.m. – 2.00 pm- Dialogue for Policy Consensus I- Role of TBAs- chaired by Sundari Ravindran. Speakers: Mira Sadgopal, Lindsay Barnes

Sundari Ravindran facilitated the session. The session started with a presentation By Mira Sadgopal of a large study, the Jeeva project, conducted with Dais in four states, largely surrounding the role and traditional wisdom of Dais, followed by Lindsay Barnes' presentation on the Role of Traditional Birth Attendants- experiences from Jharkhand.

Summary of Mira's presentation

Mira presented the findings of a national level study on *dais* that was carried out in four states of India- Jharkhand, Karnataka, Maharashtra and Himachal Pradesh over a two-and-half year period.

She commenced the presentation highlighting the role of Dai in helping innumerable women meet the needs and challenges of child birthing despite contexts of severe limitations. It's unfortunate that "the Dai" has been made a scapegoat for the issue of 'maternal mortality', while her skills and wisdom is neither explored nor understood. Dai has also been excluded from NRHM or JSY, in spite of exemplifying a very supportive and crucial role even in institutional deliveries.

The study attempted to understand child birth care from ***a dual perspective*** from the lens of community women, Dais and other providers of maternal health care (ANMs, ASHAs, etc):

- Of health services governance of maternal care
- Of local community health knowledge around birthing

The Dai interviews elicited the knowledge and skills of Dais during the pregnancy period, onset of labour, labour and birth, getting the placenta out, cord cutting, disposal of placenta, and postpartum care. Some key observations that emerged from the data were:

- *The issue of caste*- The *dai* from lower caste, when called for the delivery of a woman of higher caste, is only allowed to cut the cord and clean her, while in her own caste

she handles the entire delivery process. On the other hand, a *dai* from upper castes can handle the delivery process, but she hesitates to cut the cord. She mentioned that caste discrimination permeates the entire system and the role of *Dai Sangathans* is crucial to address this issue. At the same time caste discrimination also permeates the whole Health Services system and it is equally essential to address caste in the system among providers and administrators.

- *Community Cultural Rootedness*- Clear evidence shows that dais share common knowledge of body and birth process with the women they serve. Due to the warmth and caring support they provide, the women have greater degrees of trust and comfort on the dai as opposed to the alien environment of the hospital.

- *Cash payment and quality of care* – the data from the study elicits that women go to hospital largely for cash, but not for care they received there.
- *Power structure* – Caste, class and bio-medical orientation are stacked against the dais. While dais know their own care limitations and are willing to refer, they are treated badly when they do.
- *Changes over time* – By and large, the Dais reported that the younger generations are not learning from them and their knowledge and skills are not passed on.

- *Validity of indigenous knowledge* – Dais practice skills developed to be non-invasive, synchronised with and taking advantage of natural body processes in childbirth. Common areas of such body knowledge are the importance of 'heating' during birth to enhance the downward-outward flow, the practice of 'opening' windows, removing bangles, untying knots mirroring the body's opening, and giving support and pressure by body, hands and feet.

- *Dai learning & Formal Training* – Dais learn much from apprenticeship with older dais – skills, knowledge and an ethic of service. Formal trainings have been quite helpful with few practices such as cleaning, giving babies for breastfeeding soon after the birth; etc, however what was not looked into or explored was what they already knew or how they could be linked with formal health services.

She mentioned that there was no mention of the word Dai in the "Delhi Statement", which was shocking. She also mentioned that even in the CHSJ report of the dais consultation of 2008, caste was mentioned only twice and nowhere was it considered as an issue. Lastly she concluded by saying that in the Indian context, wherein women in rural areas consider home as the best place for normal birth, the role and wisdom of a dai was indispensable, despite trained doctors or midwives. If policy opened a window to include the Dais, the Jeeva collective was willing to work share their experience on how this could be done in an organic and inclusive manner.

Summary of Lindsay's presentation

Lindsay commenced the presentation by highlighting the role of the Dai, specifically traditional roles such as using various techniques to help the mother be at ease such as helping her to be mobile, eat, drink, squat for delivery, cutting the cord, cleaning the mother, baby, burying the placenta, and providing post partum care.

She then highlighted the sad state of affairs in today's scenario, where the dais are dying out; there is a reduction in their number as the younger generations are not taking up their roles. With impetus given to institutional deliveries, there is drastic de recognition of the dais because she is not looked at as a skilled worker, but as a sweeper, cleaner or someone meant to do the so called menial jobs.

Lindsay posed 3 questions to the audience:

- Is there a role or need for dais in the future?
- Is there a role for the knowledge and practices of Dais?
- Is there a need for another cadre of health workers? (apart from TBAs/ASHAs/ ANMs)

With the help of examples, she explained how the woman is exposed to a series of caregivers during pregnancy, delivery and post partum and usually none of them collaborate with each other, rendering different services and roles, and thereby there is no one providing a continuum of care to the woman, on whom she can lean on comfortably/ reach out to for her needs.

She shared findings from an international review, wherein with continuous support provided by Doulas, women experienced several benefits such as decrease in use of oxytocin, decrease in the risk of C section, increase in the likelihood of spontaneous vaginal birth, and so on. She also shared data from another review which showed significant reduction in perinatal and neonatal deaths due to interventions incorporating training and support of traditional birth attendants.

The existing caregivers are not expected to play the role of continuous care and support for the woman and new born, while the TBAs already possess the knowledge, experience and willingness to care for women in child birth. In this manner Lindsay tried to establish how the community women would benefit from additional training of TBAs and stronger links between TBAs and the formal health care system.

After the presentation, ***Sundari opened the floor for questions and discussion*****.**

- ***The concept of heating***- Ms.Alka Barua requested Mira to elaborate on the concept of 'heating' mentioned during her presentation. Mira responded explaining that heating was a very important aspect of labour as well as child birth in the dais' worldview. Locally, the body was understood to be heated during the process of birth, and the dai understood different ways of speeding up her metabolism. So in traditional knowledge, there was an indigenous understanding of the body to handle whatever was happening, without necessarily having to rely on the modern idea of medicine.

- Dr. Yogesh inquired if there was any mapping done of the Dais in the areas where Jeeva was functional. He also asked if anywhere in the country official training of Dais was still continuing. Mira Sadgopal responded saying that there has been no mapping of the Dais. They had been approached for conducting a nationwide survey; however it was not carried out. She also mentioned about local Sangathans in some States and some efforts at training them such as the Dai Sangathan of Gujarat, Sangathans in Maharshtra or in south, however they all need to come together.

  Need to come up with standards for evaluation of Dais- Ms.Renu Khanna added saying that the evidence had been laid out quite clearly. However it was important to discuss how to counter the so called allegations on the Dais regarding harmful practices, and how also to arrive at a policy consensus with regard to Dais. Health system emphasized on monitoring and evaluation for everyone, so she expressed if we all felt that Dais were very important and we were going to make recommendations for the Dais, then how do we monitor them? It was needed to come up with some standards for evaluation.

- ***Doulas-*** A participant inquired about who the Doulas were, as mentioned during Lindsay's presentation. Dr. Evita Fernandes responded saying that Doulas were women who provided emotional and physical support to pregnant women before, during and after child birth and served as birth companions. However, unlike Dais they lacked the technical skills of conducting a delivery or offering medical advice. She emphasized that the dai was a technically skilled person who could be much more than a doula.
- ***Argument against institutionalizing Dai training***- A participant from Amhi Amchya Arogyasathi expressed concern over need for advocating on a policy level with regard to Dai training. He mentioned the example of the ASHA training model, which got generalized and the crux of the matter was lost coupled with very poor quality of training. That quality of training was poor was generally true of all training within the health system. So while advocating for Dai training he expressed that in an absence of a system for the same, we will need to discuss what the module would look like, how intensive it would be and so on. Institutionalizing it in the government was also not the best option, as then the quality would suffer.
- ***Active discouragement of the Dais***- Ms.Leila Varkey from the Jeeva collective shared that the government officials talk about validity of studies. Despite the fact that some studies like the Jeeva project are funded from the government, some senior level bureaucrats are unwilling to be supportive and accept the findings of the study questioning the representation and so on. So she expressed that there is active discouragement of the Dais from the government's side.

Ms.Sundari tried to drive home the point that there has been clear representation from two people about the same issue, and we have findings from two different presentations, so now we need to arrive at some fundamental agreement. The following issues, previously mentioned by Lindsay need to be considered bearing in mind four different scenarios.

Issues:

- Is there a role or need for *dais* as human resources in the future?
- Is there a role for knowledge and practice of *dais?*
- Is there a need for a separate cadre if Dais are dying out?

Four scenarios:

1. *Dais* are actively providing childbirth and delivery care, but there are reasonably functional places of public institutions for delivery (~Gujarat situation)
2. *Dais* are providing childbirth and delivery care in a setting where public health is dysfunctional and women have few other alternatives (but few might only be able to access them) (~Jharkhand situation)
3. Institutional delivery is the norm, and public health system is functional; there are *dais* providing supporting role even though they are disrespected (E.g. Tamil Nadu)
4. No tradition of *dais* and also the public health system is dysfunctional (e.g. Some north eastern states)

Given these four scenarios, Ms.Sundari proposed that we can look at the role of Dais in each of these scenarios/ contexts, so that we have some fundamental points contextually which we want the policy makers to take into cognizance.

- ***Dai as a watchdog/ coordinator***- Dr. Prakasamma expressed that she felt we were still looking at dais within a bio medical context. She felt the Dai had a very crucial role to play irrespective of whatever the scenario was. The Dais role was everywhere, not only within a home delivery. Neither the ASHA nor the ANM were present in all situations, so the Dai became indispensible. She accompanies at the PHC and is present even with a skilled ANM. Even at the CHC or sub district hospitals, she becomes an important partner, the family could play a supportive role like a doula while the Dai could be there as a watchdog and could play the role of a coordinator. We need to decide whether we need the Dai for her unique qualities or whether we need her as an alternative medical provider.
- ***Birth as a human event and woman's agency to decide***- Janet Chawla questioned the pre-supposition that urban areas had all the facilities for women- they mainly served the middle class and the upper middle class. Private practitioners have been on the rise, and the C sections have increased. Birth is a human event and not a medical event. This thought borders on the rights approach, where the woman should be in a position to decide and choose where she wants to deliver, but the family is the primary decision maker, especially in the Indian society. However, this has been a struggle world over. In terms of policy recommendation, identification of the strengths of the Dai is very important, and also becomes a basis for dealing with issues of caste, class, etc. Elevating the status of knowledge of Dais is very important, as it would serve as a method of educating the medically trained people.
- ***Incompetence of bio medical professionals in conducting home deliveries***- Leila pointed out that there were two sides of the debate. One side was the impetus given to the institutional deliveries for the past 15 years, due to which bio medically trained professionals are now not competent to conduct home deliveries. The Dai continues to be the only one who is trained and competent to provide care at home. Secondly, we need to talk from the perspective of who are the people providing the care, do they fit in full-time or

are they fulfilling specific roles, who are they more specifically in terms of age, education, caste, representation from a particular Panchayat and so on. Dai is the only who has a good ecological understanding of women's work and is adapted to the needs of the local community. We need to broaden our understanding to also talk about women's occupation; nobody is talking about the marginalization of these women, or addressing what happened to the livelihoods of these women.

- ***Dais to be acknowledged in policy***- Dr Evita Fernandes drew everyone's attention to policy flaws explaining how policy does not allow anyone in a labor room of a public hospital along with the woman, and that is a basic rights violation- to allow a woman to deliver all alone or deny her the choice of a birth companion. So the Dai definitely has a role in today's scenario, where there is less or no access to care. It is a unique calling, as the Dais have a lot to offer. If such women need to be trained, then they should be trained. If the government brings in this, a lot of women can also look at this as a supportive profession.
- ***Need for sync between Dai and ASHA***- Dr.Shobha Shah from Gujarat expressed her concern over the phasing out of Dais in spite of the presence of Dai Sangathans. Wherever institutional deliveries were good, Dais should work as a birth companion. She also mentioned the situation where an ASHA receives incentives for assisting in delivery so there is a conflict of interest between the Dai and the ASHA, wherein she is unwilling to allow the Dais to accompany the women. She added that in a good public health system three things need to be taken care of for Dais: Good Training, Kits, supportive equipments & accessible and supportive care.

- ***Neglect in building capacities and financial support to Dai Sangathans-*** Ms.Neeta Hardikar expressed how the Dai Sangathan had been recognized in Gujarat, yet there was a major neglect in building their capacities. There was a push to bring in ASHAs into the Sangathan. Post formation of the Sangathan no financial investment was made by the State- neither has it helped in acknowledging the identity of the Dais. She wished to emphasize on two points.
  - How dais provide post natal care, no ASHA or ANM does the home visits which a Dai keeps track of. This needs to be pushed at policy level. The so called untouchable chores are done by the Dais, and they are also more accessible with regard to knowledge.
  - The capacity building of Dais is of utmost importance and this is what is hampering the profession. The younger generations of Dais are not willing to go into the profession and absence of training hampers the future of Dais, there is no transfer of knowledge and skills.

Mira suggested that regulation of the dais be seen as the issue of *dais* themselves to solve, not individually but in their Sangathans. Most Sangathans function within the framework of the government, which doesn't understand them as skilled people. So one should work with Dais in Sangathans to have their identities acknowledged, and their knowledge and skills accepted. There needs to be an amalgamation of the best of both the traditions.

- ***Dai as future trainers***- Mira Sadgopal expressed how the Dai played a very vast role and with her traditional knowledge, she did many things which are beyond the imagination of doctors and nurses. There is a seamless continuum in the way they perceive things, which helps to avoid methods of c section, avoid referrals and other kinds of damage that happens. They use their hands for checking what's wrong. When there is need for the birth passage to be big enough for the baby – they use hands, feet, weight on the woman. We need to have a better understanding of the range of skills that the Dai encompasses, which could be further taught to mid wives of tomorrow.

- ***Dai as a village health worker***- Evita Fernandes expressed how the Dai could play a very important role in post natal care and management and could become an active village health worker. She proposed if we could envisage the Dai as commanding the village health.

  Lindsay expressed that two roles emerged very clearly, Dai as a provider and as a supporter. The attitude so far has been to place the Dai wherever required because she is available and accessible, which is disrespectful. The Dais have been flexible to fill the gaps and change themselves. It's not just the Dai who needs to change and adjust; even the system needs to make similar adjustments, it's a two way process.

- Renu Khanna exclaimed how she was uncomfortable with the term 'Capacity Building' being used for the Dais. She reiterated how most of the work had been done in a largely bio medical framework, so the challenge was to understand how to translate the role of Dais. It was important to list down 10 most important things which the Dais do, which the bio medical system needs to uphold and understand. Since we are referring to policy recommendations, many aspects also need to be pointed out which are not acceptable. We should not be afraid to address these as well.

- ***Pressure to adhere to international standards***- Sandhya Gautam highlighted that most of the policies are made by the bureaucrats and they usually tend to listen to WHO kind of recommendations. She brought into light that WHO has thrown *dais* out of the window and in this situation she emphasized the need to articulate the points in a manner that they are accepted.

  Ipsita shared that we need to exercise caution for policy making, as the government always asks questions inquiring if we have adhered to international standards. This could be a step backwards if we intend to advocate with the government, so in this context it was important to be backed by evidences.

- ***Need for documenting Dais' skills***- Satish pointed out how the new generation of Dais was not as supportive as the older ones. The incentive initially given by the

community has been discontinued. We need to systematically document *dais'* traditional skills and knowledge so that it can be replicated or transferred into new generations.

Prakasamma asked the audience if there was still a way in which we could play on the rich cultural heritage of the country. She highlighted the need to develop courses so that dais' knowledge and best practices integrated with evidence based practices are transferred to other cadres- to the new age Dais and ANMS, which could then be showcased to the government. All the Dai training done so far has been from our point of to teach them, not to learn and spread what they already knew- this really undermines them as human beings.

Subha Sri added few questions that she mentioned that we are not yet clear and we need to have answers to:

- Who are we looking at as care providers for women during pregnancy and childbirth?
- What is the mix of skills and set of knowledge that various groups of providers have?
- Are they mutually exclusive? Are we looking at a provider who can do this mix of skills?
- Are there any meeting points where international best practices meet/converge with the local practices?
- Who is the best person that is suited in the various contexts with regards to care for women?

Sundari mentioned additional questions:

- Is there a minimum set of skills that we expect *dais* should have? How do we ensure that?
- What are the harmful practices that *dais* have and how do we ensure that these don't not happen?
- Where *dais* do not exist, how do we make sure that beneficial knowledge and practices reach women?

- ***Need for caution against arriving at a National Level Policy-*** Ms. Ramapadma expressed concern over the issue for arriving at a National Level policy with varying scenarios in different states with regards to presence of Dais. She also mentioned that with all good intentions and knowledge policy comes in place but it gets diluted at the grassroots implementation. She also highlighted that some incentives in maternal health have become detrimental in extending services at grass-root level. E.g. ANMs are supposed to extend services to grass-root and ASHAs to act as

advocacy for the services. But, now due to government incentives the role of ASHAs is changing.

2.30 pm- 4.00 pm- Dialogue for policy consensus 2– Blood availability- chaired by Dr.Sridhar. Speakers: Yogesh Jain, Latha Jagannathan

Dr. Sridhar commenced the session by providing a background about the situation of blood, and how international climate affected indigenous policies on blood.

- Regulations brought in the wake of the AIDS epidemic have tightened blood bank regulation and restricted blood availability and access in India.
- As per NACO norms, if blood donation is done without adequate testing, a huge section of the population could be infected with HIV. So blood banking not only became very difficult, but the use of blood also became very scarce in this scenario. The requirements/ criteria laid down by NACO for blood banks (such as specifications for dedicated area, use of refrigerator, qualified staff, etc); made it difficult to have functional blood banks as most of them could not fulfill such criteria.
- Act amendment: Blood storage units were therefore allowed as part of an amendment to the act. Blood banks maybe elsewhere but you can provide blood to CHCs/FRUs etc. if use at these centers is less than 2000 pints in a year. But again there are restrictions about trained manpower, testing abilities, blood storage guidelines which hamper availability at these centers.
- Clear data on blood availability is not available. The amendment to the act was made to increase access to blood, but it has not been implemented adequately on the ground. However, the question to address is, with this system in place can we try and arrange for blood? As a group can we recommend something to the government?

Dr. Latha Jagannathan took over from Dr. Sridhar to elaborate on access to blood as well as safe blood.

- Safe blood is one which is obtained through voluntary or replacement methods. Voluntary donors are safer as they usually provide accurate information about risk behavior.
- Rapid test on blood for safety is possible and this could widen the number and kind of places which could offer blood transfusion but the problem is that often there is no documentation to prove that all the required tests were done.
- She emphasized on the need for tube testing for blood group and cross matching, and that mere slide testing is not enough.
- She also highlighted problem of access to blood in rural and peripheral areas and spoke of the need for blood components.
- She also spoke about how access to blood could be improved by centralized collection, component separation and testing along with blood storage centers at district hospital and FRUs.

- Blood storage centers: Dr Latha highlighted some challenges in the current functioning of blood storage centers.
    - The concept of a blood storage centre today is that it can function as a storage centre if using only less than 2000 pints a year and that the blood can be used only for that centre, in a particular hospital, not even for a nursing home next door.
    - Only government and pre-identified blood banks are allowed to provide blood to blood storage centers. This needs to change. Storage centers in private hospitals should be allowed to give blood to other hospitals as well.
    - She emphasized that centralized blood banking with functional blood storage centers was a viable option and quoted the example of Rakhtvahini- a service started in 2010 in Karnataka wherein 8 district hospitals participated in the programme and packed red cells and blood components from BMST (Bangalore Medical Services Trust), Bangalore were sent to all hospitals in the districts as per their requirement.

- Reducing IMR and MMR
    - Dr.Latha also spoke of preventive measures for reducing IMR and MMR and highlighted how it was inappropriate to see treatment of anaemia as possible with blood transfusion alone. She mentioned how the policy document on anaemia control was indeed a wonderful document; however there were huge implementation flaws.
    - Iron supplementation in pregnant women, adolescent girls and infants should be ensured.
    - Safety, availability and equitable access were all important dimensions of the blood issue. Safe blood should be made available at peripheral hospitals. Provision for storing fresh frozen plasma and cryoprecipitate should be made at peripheral hospitals.
    - There are implementable best practices such as those followed in Surat blood banks, Maharashtra – 104, Rakht Vahini- Karnataka

- According to her, Unbanked Direct blood transfusion has many issues which are mentioned below:
    - Safe donor availability is a challenge today.
    - Quality of testing is of utmost importance and several tests need to be conducted.
    - There are concerns of post-transfusion deaths because of complications
    - Amount of blood required is an important concern. There have been several examples of irrational use of blood and blood wastage. There needs to be research and documentation on need and use of blood and also on what the transfusion triggers are.
    - Only whole blood can be used in UDBT not its components
    - A decision to do transfusion when it is not required can lead to circulatory overload and / or DIC

- Regulation of who does unbanked, direct blood transfusion (UDBT) is necessary. There is potential for misuse in the name of emergency.

Dr. Yogesh Jain took over from Dr. Latha to share his experience as well as knowledge on safe and secure blood.

- He shared that the estimate for need for safe blood in India was around 1% of all pregnancies. The need was for all blood groups, all components and was immediate or at the site. This blood also needed to be safe i.e. No transfusion transmissible infections and no serious transfusion reactions while also being affordable or free.
- As against this need, he highlighted the shortfall in supply
  - According to a WHO study, while 10 million units were required for a 1 billion population, only 4 million were recorded in the country, a shortfall of 6 million units.
  - 6 million blood bags though were sold, thus showing a reporting gap of 2 million.
  - A study in 2009, in Maharashtra and Gujarat showed that Government blood banks are able to provide only 31% of total blood (Maharashtra) and 13% of total blood (Gujarat)
  - India stats (2012) providing Government statistics on blood shows huge deficit in Actual requirement Vs. Use – at the national level 31% (116 lac units Vs. 80 lac units); and for Chhattisgarh: 80.9% (236 thousand Vs 45 thousand available annually)
  - He highlighted that this is still disregarding the time and effort to get blood to a rural hospital and the cost involved, both direct and indirect.
- Regarding blood storage centres, he pointed out several issues – they offer only storage of blood, replenishing stocks from mother blood banks. Lack of continuous power supply in rural areas is an issue. As of now, blood storage centres are far too few and most are dysfunctional even at model FRUs. Dr Jain showed data of how a very meagre proportion of blood collected in a blood bank was actually sent to the blood storage centres to be used at the periphery.
- He highlighted that the following were issues regarding blood.
  - Regulators worry about safety but not supplies
  - Very few banks offer components
  - The amount of blood actually needed is 1% of all pregnancies.
  - At present the banker has no responsibility to ensure access to blood except controlling the supply.
- He then made several suggestions as ways forward.
  - **Ease area and equipment norms for blood banks**
  - **Minimum number of camps** and a minimum number of units collected and issued each month should be mandated according to class of blood bank
  - **Replacement of blood** by a relative should **not be mandatory,** to get blood from a blood bank or BSC.
  - **Blood storage centers must be approved and made functional** for every 1,00,000 population in next 3 years

- Dr Jain then called for legalizing **UDBT in emergency situation** after proper testing by licensed blood storage centers or physician/ lab tech/nurse trio who have had the appropriate short training. He also explained in detail what the implications were and suggested checks and balances to prevent misuse. Dr. Jain emphasized that any regulation has to be equity based and should be responsible.

Discussion points

- Dr. Sridhar expressed that we as an audience need to understand what more information we need in order to make some concrete recommendations on blood.
- Dr Leila Varkey from Jeeva collective mentioned that the intention of the regulators should be to approve/ facilitate rather than hesitate/ disapprove as it seems to be presently.
- Subha Sri raised concern about the need to question on whatever is supposed to be functioning, why is that not functioning, e.g. dormant blood storage centers/ banks.
- Lindsay pointed out that advocacy was needed at the community level about irrational use of blood, as it was putting a lot of people at risk.
- Priya John pointed out that as blood storage centers are not functional, at least in rural remote areas, direct donation and transfusion, i.e. UDBT, which does not need blood banks or storage units, should be allowed"
- Ramapadma also highlighted that the UDBT was permitted for the armed forces and expressed whether army hospitals could be used for blood transfusion in interior areas. Others however pointed out that army hospitals were not present everywhere and therefore this was not a viable solution universally.

- Experiences that take us back a few steps:
    - JSA and CCHI (Christian Coalition Hospitals of India) had advocated for UDBT in emergency situations.
    - Dr Lalitha Regi from Tamil Nadu shared that the Association of Rural Surgeons of India prepared a draft proposal for legalizing UDBT, and was handed over to the Blood control authorities, however no progress on this took place.
- Dr Latha Jagannathan pointed out that according to one study, irrational use of blood is as high as 70% in cities and is mostly indulged in by obstetricians. There is an urgent need to do more research on need and use at every level, particularly in view of the data on irrational use. She also mentioned that some statistics was required on how many deaths have occurred because of unavailability of blood.
- Dr. Evita Fernandes expressed how there was a gradual shift even amongst obstetricians towards blood components, so this could be presented to the government.
- Study should be conducted on transfusion practices. This will give estimates based on haemoglobin and history of bleeding etc. and set standards for comparison elsewhere.
- Dr.Sundari stressed on the below mentioned points:
  a) She emphasized that there was need for more research and more information on what is the actual need and use V/s the unmet need.
  b) Policy should not only restrict itself to safety but also look at equitable availability

c) Malpractices in urban areas should not dictate the policies rather efforts should be towards regulating them.
d) Efforts are needed at public level to educate about transfusion, the need, conditions, circumstances and perhaps even the dangers.

- All serious adverse events need to be listed and registered.
- Efforts are also needed to ensure management of Anaemia by focusing on causes (at the source) rather than using blood transfusion for treatment
- Dr. Latha highlighted how practices such as AMTSL are known to reduce PPH by two thirds. There is no longer a need for blood transfusion. This needs to be widely publicized.
- Blood at FRUs is meant only for mothers and children. It is not used for management of other conditions that need blood like Anaemia, Thalassemia.
- Women who need blood at any time should get it. The issue of non availability of blood for single mothers is a serious issue.
- Dr Yogesh Jain said that no more research is actually required about non-availability. CommonHealth needs to take active stand and if necessary opt for litigation rather than advocacy
- Ms.Renu Khanna highlighted how there was a place for blood bank, blood storage unit and UDBT at different levels in the policy. All three need to be advocated for. Districts which need UDBT need to be identified till blood banks and blood storage units are set up in these districts. There should be parameters to identify areas deprived of blood.
- Dr.Latha mentioned that in Armed forces license is renewed every three years. UBDT can be implemented in outreach areas. This is however, one way of interpreting the regulation.
- Dr.Sridhar and Subha Sri also emphasized the role and responsibilities of the community in contributing to availability of blood.

Based on this discussion, a few recommendations on Blood were finalized the next day, which have been elaborated in the proceedings of Day 2, under the session on "Finalizing Policy Demands"

4.15 pm to 5.30 pm- Dialogue for Policy Consensus 3- Strengthening a cadre of midwives, chaired by Renu Khanna. Speakers: Leila Varkey, Prakasamma

Prakasamma commenced the session elaborating a meeting with Mr.Ranjit Roy Chowdhary, who had asked them to bring 3-4 important issues. So they discussed about Midwives. Prakasamma mentioned how there were quite a few unresolved issues since morning, but some discussions had been very rich.

Summary of Prakasamma's presentation

Prakasamma elaborated on the definition of midwives. She also distinguished between midwifery and nursing as separate professions. Professional midwives integrated technical knowledge and skills along with ensuring rights of normal pregnant woman, supporting low risk childbirth, as well as post natal care of women and children. While nurses worked with patients, woman/children with illnesses.

Midwives were also trained to be sensitive to women's needs- personal, socio cultural as well as spiritual. There has been ample evidence to show that countries with the longest tradition of midwifery as a profession are also countries with the lowest MMR and NNMR, E.g. Sweden, Brazil, etc.

Gaps in Midwifery in India

- Today, there is no professional midwifery cadre in India. Today midwifery is one of the subjects taught in basic nursing courses, though the course still retains the word midwifery (ANM, GNM), and graduates. Staff nurses and ANMs have only been able to partially fill the vacuum created in maternal and new born health due to non availability of midwifery cadre.

- Indian government recognizes obstetricians, staff nurses and general doctors. However, obstetricians are not available everywhere and the MBBS doctor does not have adequate training in midwifery. So models of cost efficiency, safety and client friendly services need to be demonstrated to the obstetricians.

- What women really want is to be safe, sensitive and culture specific services, and also easily accessible services (preferably close to their homes).

- In the interior/peripheral areas, the government discontinued the Dai and chose to rely on ASHAs and ANMS. The ANM is a multipurpose health worker, while the ASHA is not a trained technical provider. Expecting the ASHAs and ANMs to do a lot at very low wages leads to sub professional development and exploitation.

What blocks introduction of the midwifery cadre in the country?

There is a zone of discomfort among obstetricians and doctors about introduction of midwives due to misplaced sense of professional scope of practice.

Women have not been exposed to models of care during normal birth, except the dai. Education and information about normal birthing processes have not been adequate. There is no continuum of care, any guidance and birth preparedness. Dais, midwives and obstetricians have to be seen as links in a continuous chain

Prakasamma proposed Midwifery cadre would include three layers: Professional midwife, specialist midwife, and ANMs designated as Public Health Midwives.

Prakasamma also explained how the ANM was a public health worker and not a clinical care provider. The ANM is trained to be a midwife; however, several gaps exist before she can be called a professional midwife.

Summary of Leila Varkey's presentation

Leila Varkey elaborated examples of midwifery professions in West Bengal and Gujarat through her presentation.

She also mentioned how the debate on the need for a separate cadre of midwives was limited to the public sector, and how very few private hospitals recognized it.

At West Bengal a separate PHC was set up by the government which was meant to be only run by professionally trained midwives, in absence of medical officers. It was fully equipped with facilities, infrastructure, etc however lack of access to water made in dysfunctional with time. There were also issues due to staff's unwillingness to work at night. 5 deliveries happened there; however, problems were operational even during the pilot phase.

School of Nursing, at Rajkot, Gujarat recognized midwifery, however, lack of clarity on posting and responsibilities was a challenge. She highlighted the need for clarity on roles and responsibilities of midwives, career pathways, and legality of independent practice as some of the issues that need to be addressed.

Discussion post presentations:

- Renu Khanna expressed how there were different types of nurse practitioners, specialists, ANMs, midwives at various levels and so on. However, the terminology gets confusing and clarity was required over this.
- Praksamma questioned whether we demand a basic cadre or a post basic cadre of midwives?
- Renu Khanna reiterated how the rationale for wanting a midwife was that obstetricians do not reach everywhere. But it was important to consider that trained midwives do not want to remain in remote, inaccessible areas. One way to deal with this problem would be to train the local girls in midwifery skills.
- Mira Sadgopal suggested that even the daughters of Dais could be trained to become midwives.
- Ms.Ipsita Basu mentioned that mid wife is trained in such a manner she can deal with normal pregnancy, child birth and only look at low risk pregnancies – so there are restrictions like a twin pregnancy, which cannot ideally be handled by a midwife.

- Dr. Evita Fernandes drove home the point that midwives were professionals. If the government did not recognize them, or remunerate them adequately, it would be difficult to sustain them. Midwives had demonstrated a lot of potential. There are many centres in the country (e.g. Jharkhand) which do not have doctors and are managed by a combination of Dais and midwives.

- Prakasamma also expressed that we did not need midwives merely in absence of obstetricians, but we needed midwives in any case.

- Dr.Sundari emphasized that there needed to be consensus about what had to be recommended to the government- whether we need a midwifery cadre of different layers?

- Dr.Alka Barua expressed that the rational and evidence of very positive role of midwives had been documented and we cannot question it. If we proposed that all sub centres could function as delivery points, then we needed to think of the enormous resources that need to be pumped at the Sub Centre level. We need to find out if there are Sub Centres functioning where there are dais and midwives. And if these midwives are posted at SCs and PHCs, the role of Dais needed to be clearly defined.

- Prakasamma expressed how ideally there was a strong link between the Dai and the ANM which has been eroded with time. ANM could be the first point of contact since she is trained.

- Renu Khanna stressed that the Quality of training was very important so there must be clear standards set for training. Suggestion was to have 6 months training and apprenticeship.

- Dr.Sundari expressed how the training would depend on the duration/ curriculum/ competence. Competence will be based on ICM framework and that should be our recommendation. Dr.Evita Fernandes added mentioning that recommendations would also be based on the area of operation.

- Dr. Sundari also added saying that Power dynamics would exist between OBGYN/ midwives and staff nurse/ dais. However, Dr. Evita Fernandes highlighted how our recommendations should be to support the teamwork, and not highlight power or hierarchy.

- Clarifying confusions about role reversal between Dais and midwives, raised some participants, Ms. Prakasamma explained how creating a totally new cadre of midwives was difficult. So we need to start from what we already have. In this situation the ANM is best provider. ANM cannot move on to become a GNM.

Therefore, a person having completed standard 12th and a 3.5 year nursing course can become a professional midwife.

DAY 2, 6th January 2015

9.30 am- 11.00 am- Finalizing Policy Demands- chaired by Subha Sri

The second day commenced at 9.30 am with Dr.Subha Sri recapping the learning of the previous day. Besides this, Subha Sri briefed the outline of the presentation to be done for policy dialogue. She said that the presentation would be done in two parts: first, laying out the contexts by sharing the DWT process and its findings and secondly, sharing the recommendations that emerged out of the DWT process, which was documented by a small working group the previous evening. The recommendations were broadly divided under four headings: i) maternal death review (MDR), ii) referral and emergency transport, iii) blood, and iv) human resources - *dais* and midwives.

It was collectively decided that Priya John would present the recommendations to the policy makers, while Renu Khanna would chair the session. It was also decided that a printed copy of the recommendations would be submitted to the policy makers and other members. A summary of the recommendations prepared on the previous day along with discussion that took place over it is as under:

The following changes were discussed with regards to recommendations on Maternal Death Reviews

- To fine tune the recommendations making them short, pointed and focused.
- Enquiry should be confidential so that health workers or obstetricians are not made scape goats. However, other participants expressed that MDR was carried out in a community setting and not an institutional setting, so a confidential enquiry was not possible.
- To treat it as a fact finding exercise, rather than a fault finding one, so that people are not penalized.
- To stress on the existing recommendation- to make the MDR process transparent and accountable.

The following changes were discussed with regards to recommendations on Referrals and Transport

- Issues with Inter- state and inter facility referral and how toaddress them to be added in the existing points.
- Staff in emergency transport should be trained to manage complications.

- Generally recommendations are made keeping in mind the situation before death, however, after the woman dies, there is no facility which takes her back to her home. This can be added in the transport section of the recommendations.

- The entire availability of emergency transport is based on mobile network, and many places don't have a network at all. So it would be advisable in such areas to have a vehicle for say every 10 villages, rather than calling it from outside.

- There should be a separate recommendation for what protocol to follow for delivery in a van/ in transit, as there are no records of such deliveries. The team suggested making changes as 'protocol to stabilize women and protocol to communicate what was done'.

- As a response to a suggestion from a participant on safety and security of health workers, *Renu Khanna* suggested that there should be overarching policy recommendation for safety, rights and security of health care workers.

The following changes were discussed with regards to recommendations on Blood

- The stated policy of blood bank and blood storage should be immediately implemented.

- The recommendations on blood should have the aspect of accountability included as well.

- Dr.Yogesh had several issues with the way recommendations on blood were framed or understood. He also felt that certain needs were being trivialized. *Renu Khanna, Subha Sri* and the team, acknowledging the confusions that exist out of the technical presentations made on blood the day before, blood being one of the urgent and critical issues and given the time constraints, suggested a small group to work separately simultaneously and come up with specific recommendations. A small group of participants attempted to work out the set of recommendations on blood while the rest continued with the discussion ahead. This is presented in the recommendations section.

- Doctors practising UDBT in emergency situations should not be penalized. Some doctors who engaged in UDBT are facing court trials, this reality needs to be discussed and methods need to be suggested to deal with this.

The following changes were discussed with regards to recommendations on Human Resources

- Prakasamma made suggestions on the proposed midwifery cadre, mentioning that the first level ANMs would make public health professionals. The ones who have

acquired one year training + have completed their study course, the mid career GNMs may not want to reside in rural areas, or would spend maximum 2-3 years in such areas before moving into the cities. Therefore it was important to invest in the first level ANMs.

- About *dais, Dr. Fernandez* and *Prakasamma*, emphasized that investment should be done to define *dais,* the concept of *dais* had to be clear as one who has psycho social and cultural skills, is practicing and socially accepted during childbirth. There are different kinds of Dais with different sets of skills. By creating SBAs, and attempting to bring in a separate cadre by the government, we have lost out on Dais.

- *Lindsay* also highlighted the point of mapping *dais* contribution on maternal health in different countries.

- *Prakasamma* also emphasized that a system of accreditation and standardization needs to be worked out for the Dais.

Most of the suggestions made above were incorporated and finalized tentatively for the policy dialogue scheduled on the same day.

(PPT on Recommendations is attached within Annexure 3)

11.00 am-1.30 pm- Policy Dialogue- chaired by Renu Khanna

The session on policy dialogue commenced with a round of introductions of all the members, some of whom were policy makers, members from various National and International NGOs, representatives from the media and so on. Ms.Renu Khanna reiterated the purpose for which everyone had gathered at ISI, and how the afternoon session would culminate in planning for future.

Subha Sri made a brief presentation about the process as well as findings of the Dead Women Talking Report. Priya John presented the recommendations finalized in the morning session. Ms.Renu Khanna then threw open the ground for questions and discussion based on what had been presented.

Some of the questions are mentioned below with responses from participants in the consultation:

- *Question: Are only public sector institutions included while collecting the data or even one from the private sector?*

Response: Data was collected only from public sector medical institutions- PHC/CHC/Civil hospitals, etc.

- *Question: What has been the criterion for selection of the 31 districts?*

Response by Dr.Subha Sri: It was a convenient sample selection, districts selection was determined by presence of partners.

- *Question: Was there any particular order in the way referrals happened?*

Response by Dr.Subha Sri: There was no particular order, referrals were quite complex. Sometimes families went from a lower facility to a higher one, while there were cases where the families were denied services in a public hospital so visited two or three private hospitals, or went back home to arrange for money before visiting the next facility so there was a lot of back and forth that happened, families ended up visiting multiple facilities.

- *Question: Dysfunctional health system was found in a particular state or everywhere?*

Response by Dr.Subha Sri: The contexts have been very different and the mal-functionality of the health system has also played out differently. The context in Jharkhand is very different from that in Gujarat, where the situation of the health system also varies from district to district. The private sector had a more prominent presence in the urban areas; there was the issue of over medicalization at certain places. Issues in health system also included care by informal health practitioners.

- *Question: How do we ensure that staff is equipped to handle complications?*

Response: Ensuring that the staff has adequate knowledge and skills to handle complications is a question of ensuring quality training. Mapping the interventions is a simple exercise; the monitoring has to be strict. These can be included in the protocol.

- *Question: What have been the community's responses/ family's responses? How has the Panchayat been involved in the process?*

Response by Ms.Neeta Hardikar: In case of maternal deaths, there is an uncomfortable relationship between the natal family and the marital family. In terms of responsibility, they usually tend to pass the buck. The relationship of the woman with her in laws, husband, neighbours, etc made it difficult to document and establish the exact cause of death. Each person would have their own perspective/ version and the Sangathans would have another angle to the story. Other social factors such as access to drinking water, access to fuel, availability of food etc have also been cited as reasons for complications and thereby death.

Role of Panchayat: Maternal deaths are shared with the Panchayat in the village meetings, although this is treated as any other death in the village. Wherever there is presence of local Sangathans, members also share it in their meetings. One of the important agendas should

be to discuss the maternal deaths in the Gram Sabhas, although this has materialized in very few areas.

Mr.Satish from Ami Amchya Arogya Saathi, Gadchiroli, added that many a times, the husband or the extended family takes the decision on behalf of the woman about ANC, where to deliver, etc so it is difficult to approach the Panchayat in such cases. There have been instances of local Samitis like VHSCs using their funds towards bettering maternal health. In such places, there is some form of local empowerment.

- *Question: Many a times, the government remarks that delay was caused due to the family. Are there any such cases in these 124 deaths too?*

Response by Dr.Subha Sri: There is no particular number of cases to this question. The first delays were less than a quarter of all the cases, many of them were compounded by the second and third delay. In many areas, no ante natal check-ups were taking place so very often the families were unable to recognize the complications. This also needs to be taken into cognizance by the Health system to improve their efforts at Birth Preparedness.

Dr.Shobha added expressing that empowering local community with medical knowledge was very necessary, and to spread awareness on complications during pregnancy or post delivery was the health system's responsibility.

Dr.Apoorva Ratnu from UNICEF added saying that they had been doing MDRs for the last two years in Gujarat. In the 800 cases they had conducted an MDR for; the first delay was noticed in 4% -5% of cases, 4%-5% of the cases were women who hadn't started from home at all, while 90% of the women reached at least some health facility, so there was scope for improvement.

Discussion by Participants:

- Dr. Somesh from JHPIEGO mentioned that there was a section on "Inappropriate Care" in the Findings. He highlighted how this was a low hanging fruit, and very relevant to the ground work. ***Quality of care needed a lot of strengthening*** and efforts were required by the government as well as by those outside the government. This should be given more emphasis in the recommendations.

Besides highlighting public sector issues, he also highlighted how 40% of the deliveries were still happening in the private sector, in spite of prevalence of various malpractices. ***More regulations and efforts were needed to be focussed on the private sector*** as well.

Another important point highlighted by him was how ***ANC care was not provided to a number of dalits.*** Generating awareness about this in the community was very important,

and the local communities could shoulder this responsibility too. This aspect on caste could be added in the recommendations.

- Dr. Rashmi from JHPIEGO also expressed that some key interventions required during labour/ post-partum were neglected. Although there were nurses, they did not have the freedom to proceed without doctor's approval in certain situations, e.g. giving magnesium sulphate injections without the doctor's permission. So ***empowering the nurses should also be included in the recommendation***. She also expressed that she was pleased to hear Dais coming back into discussion, and specified that they would need training and a lot of supportive supervision along with very clear protocols.

- Ms.Sona Sharma from PFI had three suggestions

  a) ***The policy level recommendations could be separated from those for programmes.***

  b) Similarly, ***there was a need to separate State Level and National level recommendations.***

  c) The ***aspect/ mention of the word morbidity was completely missed out in the study***, this needs to be added as this was also an outcome of poor quality of care.

- Isha from Save the Children pointed out that ***guidelines need to be implemented and audited.*** For social audits to be implemented community level awareness must increase and VHSNCs could be revitalized to perform social audits.

- Paddhati pointed out that staff nurses get trained, but after training do not get posted back in maternity wards, thus rendering the training useless.

- Dr.Rajni Ved expressed that the report was rich and highlighted some issues she had with the recommendations based on human resources- Dais and Midwives. Firstly, she spelt that the ***aspect of accreditation was very significant, be it Dais or midwives***. Secondly, it was ***important to devise a broader role for the midwives-*** beyond providing maternity care to broader SRH services, for e.g. screening of cervical cancer, etc.

- Prashant from NHSRC mentioned the following suggestions:

- As per WHO guidelines, there are no clear guidelines for reporting, anybody can report maternal deaths. However, incentive is provided only to ASHA for reporting. This needs to be looked into.

- With regards to midwifery cadre, when we recommend a new cadre, it needs to be linked with the existing cadre. There is already a task force report on the public health cadre. Also, the Indian Nursing Council Act is undergoing revision. Our recommendations need to be linked to this.

- There are guidelines developed for anaemia, however some of them, for e.g. on iron sucrose use having pending approvals. So one of the recommendations could be to expedite the approval of these guidelines so that money can be released from the central government for treatment of anaemia.

- The study lacks interviews from some authorities and their responses on some of the issues. For e.g. reporting of maternal deaths is low in spite of having incentives for ASHAs, so the problem needs to be explored deeper.

- There are recommendations for making inter-state referral and transport available; however this could be complicated as funds from a particular state are utilized for utilizing free transport services.

- A positive development is that new guidelines are being discussed by Ministry of Health for conducting a maternal death review. They cannot be shared in the current form; however, maternal health is surely a focus for the State.

- Dr.Apporva Ratnu from UNICEF made the following suggestions:

- With regards to anaemia, from the point of view of implementation, ***what were some of the actionable points that we had to propose***

- We were talking about the strengthening blood storage units, we need to advocate for expanding blood storage system

- Out of all the recommendations mentioned, a dialogue could be held with the policy makers of respective States mentioned in the report, to decide on some actionable points.

- Ms.Renu Khanna responded to Dr.Apoorva Ratna mentioning that majority recommendations mentioned were indeed actionable points. However, she requested Dr.Ratnu to help them in understanding what the government's perspective was.

- Ms. Medha expressed how health care providers receive training, but there are issues with practice once they go back, in spite of consistent supervision. The monitoring has been very casual. Ensuring quality and supportive supervision must

be a priority. Ms. Renu added saying that the training package could also include what the participants would do after they go back.

- Dr.Evita Fernandes reinforced the point on how a lot of effectiveness boils down to the ***quality of training***. Expecting to churn out competitive professionals in three weeks of training was unrealistic. She requested to prioritize in the recommendation for adhering to high standards for quality training.

- Ms. Jaya highlighted aspects about ANC and ANMs.

  ANC: Quality of ANC matters a lot and it should also happen in a particular sequence, however most ANMs do not follow any sequence. Most ANMs are not competent to take BP with newer instruments, or are not familiar with use of newer equipments. Their training and supervision is also very poor.

  ANMs: ANM is in a position of power, with regards to providing care to women. The ANMs should not abuse this power, and they should be oriented about this. It is unfortunate that ANMs are usually the first ones to abuse the community women.

- Ms.Leila Varkey expressed how she felt ***women should have the liberty to deliver where they wanted to deliver,*** and that it was a very basic right. There may be a woman who wants to deliver at home, however we do not have legal safeguards which allow this. And this is where policies become coercive. Given the sheer poverty of the masses, coupled with the reality of their households in accessible areas, the best choice of every such pregnant woman is the home. So there should be some space in policies which enables Dais to assist a woman deliver at home.

- Dr.Subha Sri reinforced the following points:

- ***The definition of maternal death in itself is a problem with regards to reporting***.

- In most states, a sensitization exercise has not taken place at all. The ASHAs/ ANMs are not even made to understand the objective of this exercise, so they do not understand it beyond a fault finding. It has become more of a blame game within the system, as well as between the system and the community.

- She shared with the policy makers as well as other members that they would be very happy to share the tool and engage further on the matter.

- Mautushi Sengupta from Mac Arthur foundation mentioned that it would be good to ***separate out the recommendations to elaborate on whose responsibility it would be to bring about the changes,*** by including critical stakeholders as well such as the Panchayat, the family, and so on so that there is more ownership for the issues, and it does not become the responsibility of the government alone.

2.30 pm -4.30 pm- Planning for future steps- chaired by Neeta Hardikar

This was the concluding session for the day and was chaired by Ms.Neeta Hardikar who commenced it by highlighting the aspects/issues which we as a group needed to look into and devise a concrete plan of action, as well as recommendations which need to be further submitted to the Health Department

Emphasis on preparation of periodic reports, with focus subjects

- Ms.Sundari expressed how it took almost two years to compile and produce the National Dead Women Talking Report and how people from distant corners of the country had actively participated in data collection and analysis of the same. She emphasized that such reports should be produced periodically, so that the civil society could play a watchdog role. She also mentioned that with every report, there could be one particular theme/ focus subject, e.g. Referrals and then major part of the report could be a detailed version on referrals.

Need for funding

Sundari specified that most of the work done by CommonHealth so far had been voluntary. She inquired if organizations or individuals could be instrumental in arranging some basic funding so that this effort could be taken forward.

Need for refining the tool

Ms.Neeta Hardikar inquired whether the tool needed to be refined further or whether this one could be treated as the final one. Ms.Renu Khanna and Sanjeeta said the final version of the tool would be sent by them, along with finalized guidelines on the use of the tool.

Suggestions for improvisation in the report

- Sanjeeta Gawri mentioned how the social determinants as well as technical issues emerged from the report. Various stakeholders were fixed such as family, PRI members however; she suggested that as a step forward we could take into account learning from the past experience. *The health system immediately questions the responsibility of other actors. So they need to be clearly spelt out and incorporated in the report.*

- Sundari expressed that detailed social determinants analysis was required, gender needed to explored, and all these aspects are missing in a verbal autopsy. Alka Barua mentioned that *systematic audit was one way of going about it*, but while conducting a verbal autopsy, along with the health system flaws, cognizance of technical issues was equally important.

- Ms.Leila suggested that a *detailed commentary on the methodology of the study could prove to be valuable.* The recommendations could also include how the civil society organizations would contribute to such an exercise. She also emphasized on *the use of language*, e.g. if it was not a referral it should not be called a referral, especially if it only amounts to passing the buck.

  Ms.Leila also added that if any information is available on the baby/ child, it should be added to the report. If there is any way to find out whether the woman had an MDR from the government, it should be mentioned.

- Ms. Shobha emphasized on the need for specific recommendations on the social determinants, in order to ensure inter department coordination. Majority of the death certificates had cardio respiratory arrest as cause of death mentioned. It was important to add in the recommendations that the medical professional should write the primary cause of death in the records.

- Ms.Sandhya expressed about the need to take responsibility for deaths which happen en route, and how even if a death happens right outside the premises of an institute, they were unwilling to take the woman in.

- A participant also suggested involving CDPOs from ICDS department, and holding these personnel accountable in the MDR process rather than merely questioning the doctors.

- Prakasamma emphasized on the need to frame each recommendation bearing in mind the woman out there in a remote interior area.

Regarding shared responsibilities and networking

Ms. Renu Khanna inquired from everyone present, if there was anyone willing to go beyond what was already done. To engage on other important issues, or explore if some other patterns emerged from a different analysis, apart from case studies. She also reported back regarding some conversations that took place during the lunch break

- The recommendations needed to be circulated among the other members as well.

- PFI had offered to participate in the advocacy on some of the National level issues.

Need to look at the Health System's perspective

Sanjeeta expressed how she felt that the report was a one sided story of the community, since the health system perspective was totally missing. We should have access to their information. The information on the last medical records from hospital should also be provided and this could be a point of advocacy for us.

Ms.Renu Khanna highlighted that in the beginning of the process an attempt was made to do the autopsies together so that the process could be complementary. However the manner in which the health system was doing it, it was not satisfactory. She agreed on the need to have access to medical records.

Ms.Ipsita Basu expressed how this could also be counter -productive/ dangerous, as sometimes the government would expect us to provide a solution, if we have access to all the information. Very often numbers make little sense.

On taking the process forward

Subhasri shared that when the report was released in Delhi, there was discussion over wanting to take the process further. There was consensus that we should do autopsies for one more round of deaths, by bringing in more states and partners. It was also recommended that at least one more southern state should be added so that there is some kind of comparison with the data. In Gujarat, CommonHealth was involved in monitoring the quality of maternal health care through ANANDI, SAHAJ and KSSS. So these were examples of ways in which the scope of collaborative work could be expanded.

Everyone from the audience also agreed that it was important to continue the process as it helped in creating pressure and advocating for the cause.

Need for documenting

Ms.Leila suggested that if we could consolidate 4-5 points which could be worked out in each state, system commitments which we would all agree upon, e.g. need for blood, then a common outcome could be observed in each state. Sundari suggested if someone could write a paper on this, then it could be circulated.

On engaging with other minority platforms

Sanjeeta suggested that that the way we tried engaging with NCW, we could also engage with other tribal or minority platforms since the data elicited that we 54% deaths were of tribal women/SC women. There were many commissions which are working on these groups. However, Sundari opposed the efficacy of this idea by explaining how there was no common denominator. So it was dangerous to assume that majority women were tribal or belonged to the scheduled caste.

Need to be more action oriented

- Prakasamma expressed deep concern over how she perceived that the focus had not moved beyond maternal health. She had compiled a maternal deaths study in 1994, and she felt that findings were more or less the same. She experienced fatigue and expressed the need to focus more on recommendations which emphasize on action.

- Ms.Renu Khanna reiterated the need to focus on specifics, in terms of deciding who would take up responsibility for what. She expressed need to deliberate over the following points:

- A small group could be formed to work on the recommendations.

- A group of people then need to come together to decide what was to be done with the recommendations, within a given time frame.

- There were some unresolved issues, which needed to be discussed.

- In the next steering committee meeting of CommonHealth, there could be an entire session on deepening understanding about “Blood”, so that we spoke about it in a more informed manner.

Need for urgent litigation

Dr.Yogesh expressed that the case of need for blood in rural areas was not only for mothers, but also for other patients. “While we educate ourselves about blood, or rural accessibility, it was also important to keep in mind that this was an issue that required urgent litigation.” He expressed that expected more support from CommonHealth, rather than merely adding it in their broad set of recommendations.

Segregating State and National level recommendations

Satish emphasized that while there were national level recommendations, there should also be recommendations state wise, so that more specific action can be devised.

Ipsita Basu further suggested that besides segregating state and national level recommendations, we could also identify who the stakeholders were so recommendations could be classified in terms of whose responsibility it would be to do what.

A small group to work on recommendations

Renu Khanna proposed to form a small group to fine tune the recommendations based on three sets of documents mentioned below. Sanjeeta Gawri, Ipsita Basu, Sharayu and Anu volunteered to work over this. January end was set as the tentative deadline for following up on this task. A panel was also needed for Hindi translation.

- The Delhi statement

- What emerges from the two day Delhi consultation report? (Dead women talking 4)

- What emerges from the National Dead Women Talking Report?

On tying up with Social Science Institutes

Subha Sri spoke of the possibility of tying up with Tata Institute of Social Sciences to take this issue forward.

Need for position papers

- Sundari expressed that if there could a fact sheet or a *position paper based on evidence which worked in India,* then it would be a very valuable document. Dr. Evita Fernandes, Prakasamma and Leela Varkey volunteered to work on the paper, and collectively decided end of March as the deadline for completing the first draft.

- Besides this three people- Sundari, Ram Padma and Priya John agreed to browse through the data to look at what *referral patterns emerged.*

- Leila Varkey inquired if there was any information about Dais, Jeeva collective would be willing to look at it. Pallavi Saha, on behalf of SAHAJ proposed to share a *study on "Exploring reasons behind Home Deliveries"* with Ms.Leila, which was ongoing in rural areas of Gujarat.

- Sanjeeta Gawri pointed out to the role of informal medical practitioners and how they were prevalent everywhere. While other participants agreed on this too, Renu Khanna suggested we need to find out the situation in each area and then discuss it during the next meeting.

****

Some Glimpses of the Workshop

Annexure 1

Agenda for National Consultation on maternal health

Date	Time	Session	Speakers/ facilitators	Remarks
Jan 5th	10 am	Introduction and objectives of the meeting	Priya John	
	10.15 am	Introduction of participants	Alka Barua	
	10.30 – 10.45 am	Dead Women Talking – a review of process, findings and recommendations	Subha Sri	
	10.45 am	Working with the MDRs and DWT report at state and district level – sharing by participants	Facilitator – Sanjeeta Gawri	
	11 – 11.15 am	Tea break		
	11.15 am	Session contd.		
	11.45 am	Dialogue for policy consensus 1 – Role of TBAs	Chair: Sundari Ravindran Speakers: Lindsay Barnes, Mira Sadgopal	
	1.15 pm	Lunch		
	2.00 pm	Dialogue for policy consensus 2 – Blood availability	Chair: Sridhar Speakers: Yogesh Jain, Latha Jagannathan	
	3.30 pm	Tea		
	3.45 pm	Dialogue for policy consensus 3 – Strengthening a cadre of midwives	Chair: Renu Khanna Speakers: Leila Varkey, Prakasamma	
	5.15 pm	Summarizing the day	Sundari Ravindran	
Jan 6th	9.30 am	Finalizing policy demands	Subha Sri	
	11 am	Policy dialogue	Facilitator: Renu Khanna	
	1.00 pm	Lunch		
	2.00 pm – 4.30 pm	Planning future steps	Neeta Hardikar	

Annexure 2

PARTICIPANT LIST

Sr.No.	Name of the Person	Organization	Contact number	E-mail Id
1	Dr. Shobha Shah	SEWA Rural, Jhagadiya	9428584746	shahshobha30@gmail.com
2	Dr. Satish Gogulwar	Amhi Amachya Arogyasathi	9422123016	arogyasathi@gmail.com
3	Sundari Ravindran	Common Health	9447757974	ravindrans@usa.net
4	B. Subha Sri	Common Health	9840260715	subhasri@gmail.com
5	Renu Khanna	Common Health	9427054006	sahajbrc@yahoo.com
6	Y Rama Padma	Common Health	9440834082	yrpadma9@gmail.com
7	Lalitha Regi	Trible Health Initiative	9444847247	thisittilingi@gmail.com
8	Sanjeeta Gawri	Oxfam India	9589092467	sanjeeta@oxfamindia.org
9	Dhirendra Arya	SOCHARA-CPHE MHRC	9424093268	dhinendra@sochara.org , MP.Mhrc@gmail.com
10	Neeta Hardikar	ANANDI	9825412387	hneeta192@gmail.com
11	Mukesh Hamal	PHD Scholar, Athena Institute, Amsterdam	9717780489	mhamal@vu.nl
12	Jiban Krishna Behera	SODA	9937121813	sodabpd@gmail.com
13	Rajdev Chaturvedi	Gramin Punarnirman Sansthan	9451113651	gps.qzm@gmail.com
14	Proshik Das	The Ant	9678494812	pdas.chb@gmail.com
15	Alka Barua	Common Health	9998066659	alki75@hotmail.com
16	Pallavi Saha	SAHAJ	7567908402	pallavisaha2@gmai.com
17	Bhanu Khristi	KSSS	9725432061	
18	Veena Baria	ANANDI	9428512757	
19	Nahju Rathva	ANANDI		
20	Priya John	Common Health	981999407	pria-john@hotmail.com
21	Anaswara k	NAMHHR	9643380779	anaswara@sahayogindia.org

22	Archana	Sahayog	7838942911	archana@sahayogindia.org
23	Bharati Songare	Amhi Amachya Arogyasathi	7588764045	bharati.arogyasathi@gmail.com
24	Y.K. Sandhya	NAMHHR	9868839789	sandhya@sahayogindia.org
25	Sandhya	Shikhar Praghikghar Sansthan	9450162867	sps.chanar@gmail.com
26	Uma Kushwaha	Tarun Vikas Sansthan	9450226932	tvsbanda@gmai.com
27	Yogesh Jain	Jan Swasthya Sahayog, chattisgarh	9425530357	yogeshjain.jssbilaspm.com
28	Evita Frenandez	Fernandez Hospital	9805040398	evita@fernandezhospital.com
29	Renuka Jane	Indian Social Institute	9810205895	renuka.javejyori@gmail.com
30	Prakasamma	Answers	9440065707	answers.mjtri@gmail.com
31	Janet Chawla	Jeeva	9810240416	jaichawala@gmail.com
32	Sandhya Gautam	Jeeva	8800607304	jeevaproject@gmail.com
33	Mira Sadgopal	Jeeva	9890144106	
34	Ipsita Basu	TISS, Hyderabad	9849080685	ipasita_basu@yahoo.com
35	Lindsay Barnes	JCMB	9431128882	
36	R. Kanantha Krishnan	ITDA	8500158413	rkananthakrishnan@gmail.com
37	Sharayu Shinde	JSS, Chattisgarh	8349883206	sharayashinde123@gmail.com
38	Preeti Bohidar	Oxfam India	9589092465	preeti@oxfamindia.org
39	Shilpa Shroff	ASAP	8879977993	shilpan_desai@yahoo.com
40	Leila C Varkey	Independent Researcher	9899500063	
41	Suchitra Wagle	CEHAT	9920444822	suchitra@cehat.org
42	Dr.Archana Sinha		9818197302	sinha3may@gmail.com
43	Malini Asola	Oxfam India	7838381185	mihini@oxfamindia.org
44	S.Sridhar	MPL	9811516335	sridhars.mails@gmail.com
45	Dr. Rajani Ved	NHSRC	9810333771	rajani.ved@gmail.com
46	Anu Verma	Oxfam India	78791122179	anu@oxfamindia.org
47	Dr. Latha Jagannthan	TTK blood bank	9980513052	latha@bmstindia.org
48		Save The Children		
49	Sunanyana Walia	Consultant	9810445833	sunayana.walia@gmail.com
50	Paridhi Jha	Faculty, Answers	8349192280	answers.mgtri@gmail.com

51	Pallavi Gupta	Oxfam India	9560080907	pallavi@oxfameindia.org
52	Bandana Das	Society of Midwives India	9433403247	
53	Medha Gandhi	Ipas	9313625544	gandhim@ipas.org
54	Dr. Aporva Ratnu	UNICEF		
55	Sona Sharma	PFI	9818315599	sona@populationfoundation.in
56	Jaya Velankar	Haryana State Health Resource Centre	9999119454	jayavelankar@gmail.com
57	Usha Rai	Journalist		
58	Prasanth KS	NHSRC	9360353647	prasanth.mph@gmail.com
59	Rajlaxmi	PJH	9718963288	rajlaxmi306@gmail.com
60	Rashmi Asif	JHPIEGO	9810095449	Rashami.Asif@jhpigo.org
	Somesh	JHPIEGO		
61	Smriti	The Hindu	9818374533	
62	Jyotsna	Down to Earth	9999332811	jyotsna.jno@gmail.com
63	B.C.S Ramayya	Freelance rappoteur	8977150785	CACSBONDADA@gmail.com