National Seminar on
Maternal-Neonatal Health and Safe Abortion:

Opportunities and Challenges

Hyderabad, India, 24-25 April 2014

CommonHealth- Coalition for Maternal-Neonatal Health and Safe Abortion

In partnership with

Tata Institute of Social Sciences, Hyderabad

Contents

Day 1 5
About CommonHealth 5
Objectives of the seminar 6
Key note address by Dr Prakasamma 7
Theme 1: Maternal-neonatal deaths and ill-health - dimensions, time trends and determinants 9
PLENARY 9
1. Dimensions and determinants of maternal health: Inequities in maternal health 9
B Subhasri 9
2. Residual MMR and NMR: What are we dealing with? What might work? (Bihar +) 10
S. Sridhar 10
Papers and case study presentations (Theme 1) 13
Parallel session 1 13
1. Maternal health in AP: In the context of MDG Goals 13
Dr. Y. Ramapadma 13
2. Geographies of maternal complications referrals: Providers' responses in four rural communities 13
Sandhya Gautam 13
3. Availability of emergency referral transportation for maternal and neonatal complications: A case study from Bihar 14
Gayatri Giri 14
Parallel session 2 15
4. Neonatal care practices in a tribal community of Odisha, India: A cultural perspective 15
Madhusmita Panda 15
5. Community conduits in continuum of care for maternal and neonatal health: Role of ASHA and Yashoda 16
Susrita Roy 16
6. Domestic violence during pregnancy: A case for routine screening in ANC 17
Padma Deosthali 17
7. Surrogate mothers and their health care 17
Dipannita Chand 17
Theme 2: Safe abortion services in India: Where do women stand? 19
PLENARY 19
1. Safe abortion in India: Where do women stand? 19

Suchitra Dalvie 19
2. Learning from campaign against sex-determination 20
Manisha Gupte 20
Papers and case study presentations (Theme 2) 21
Parallel Session 1 21
1. The abortion debate in the Indian context: Future possibilities to broaden the existing framework 21
Bhuvaneswari Sunil 21
2. Deconstructing providers' preferences towards offering MTP and EC services to women 22
Mala Ramanathan and Sunita Chowdhury 22
3. Availability and distribution of safe abortion services in Madhya Pradesh 22
Ali Sayyed 22
Parallel Session 2 24
1. Video presentation: Safe abortion as a women's rights issue 24
Shweta Krishnan 24
2. Facing the challenges of a negative impact of sex selection issue on women's access to safe abortion: A qualitative study with private medical practitioners in Western Maharashtra 24
Preet Manjusha 24
3. Barriers to safe abortion in Mumbai and Jalgaon in Maharashtra 24
Neha Rathi and Sushma Shende 24
Day 2 26
Theme 3: Accountability of sexual and reproductive health in India 26
PLENARY 3 26
1. Social accountability for SRHR : What does it involve? 26
Renu Khanna 26
2. Accountability for reproductive health – using human rights approaches 27
Jashodhara Dasgupta 27
Papers and case study presentations (Theme 3) 28
1. Accountability and maternal health care: Human Right Watch's work in India 28
Aruna Kashyap 28
2. Dead women talking initiative 29
Sanjeeta Gawri 29
3. Case study PAHEL: enforcing state accountability for sexual and reproductive health services through women leaders 30
Manju Katoch 30

4. Social accountability for maternal health: Experiences from Dahod and Panchmahal districts 30
Sunanda Ganju 30
5. Changing paradigms of women's access to health care – role of private health sector 30
Nilangi Sardeshpande 30
Advocating for change: Moderated Plenary Discussion 33
Feedback from new members 33
Challenges experienced by participants where they would like CommonHealth members to help 33
Commitment by participants 34
Suggestions for collective agenda for moving forward 34
What are the immediate requirements towards moving ahead the agenda? 36
Conclusion 36
Summary of the session by Renu Khanna 36
Summary of the seminar by Sundari 37
Annexure 1: Schedule of the seminar 39
Annexure 2: details of speakers and papers in parallel sessions 41
Annexure 3: List of participants 43

A national seminar on Maternal-Neonatal Health And Safe Abortion: Opportunities And Challenges was organised by CommonHealth in partnership with the Tata Institute of Social Sciences (TISS), Hyderabad on April 24 – 25, 2014. This is a brief report of the proceedings of the seminar. For each session, a summary of presentation is presented along with discussion / responses that followed the presentation. Schedule for the seminar and details of speakers and papers presented in parallel sessions are included as Annexure 1 and Annexure 2 respectively.

Presentations made at the seminar are available separately on the CommonHealth website.

List of participants is included in Annexure 3.

Day 1

The first day of the National Seminar started with a welcome address by Dr Lakshmi Lingam, Deputy Director, TISS, Hyderabad. In her welcome address she introduced the new TISS campus in Hyderabad and welcomed the opportunity to host this seminar on subjects very close to their hearts. She said that the seminar would help bring to fore the knowledge regarding maternal-neonatal health and safe abortions generated in various parts of the country. She also urged the participants to not limit the discussions to challenges but to also talk about opportunities. She remarked that even in challenges and resistance there are opportunities for women's empowerment. She expressed the hope that the large number of students participating in the seminar would result in an opportunity for strengthening of young researchers. She hoped that in their work they would amplify voices on the ground.

Dr Sundari Ravindran, Founder Member of CommonHealth thanked TISS for extending their partnership to host this seminar. She noted that 2014 has been a watershed year for the sexual reproductive health rights (SRHR) movement. Twenty years after ICPD, the review of progress has proved to be disappointing. There has been a modest progress on a small part of the ICPD agenda and a regression in many sexual and reproductive rights. The current global discussions seem to indicate that in the post MDGs development agenda, universal access to sexual and reproductive health may continue to be a challenge. After setting this context for this seminar, she gave a brief introduction to CommonHealth and its journey till date and presented the objectives of the seminar.

About CommonHealth

CommonHealth (CH) is a multi- state coalition of organizations and individuals in India committed to drawing attention to the unacceptably high levels of maternal and neonatal mortality, poor access to safe abortion services and less than optimal quality and lack of affordability of maternal-neonatal health and safe abortion services. CommonHealth seeks to bring voices from diverse constituencies to influence discourse at the national level. These constituencies are diverse not only geographically but also in terms of different areas of expertise and focus such as health care providers, public health researchers, non-governmental organisations, research and service delivery organizations, human rights lawyers, grassroots activists, public sector programme managers etc. Formed in 2006, the Coalition is steered by a Steering Committee of individuals with considerable expertise in one or more of the three thematic areas: maternal health, safe abortion and neonatal health.

CommonHealth envisions a society that ensures maternal-neonatal health care and safe abortion for all women, especially those from marginalised communities.

To achieve this vision, CommonHealth undertakes activities that bring together individuals and organisations who share the vision, identify priority areas and pool together ideas, knowledge and skills to develop and implement key advocacy interventions, attempt to influence perspectives and provide thought leadership for effecting policy and programme changes, organise capacity-building and discourse-influencing workshops for different groups of stakeholders, disseminate relevant evidence and information among members, provide a forum for sharing experiences through meetings, website and listserv, support, facilitate and mentor advocacy projects at the grassroots. 'Dead Women Talking' was an initiative of CommonHealth to advocate for accountability towards maternal health where social autopsies of maternal deaths from across the country were carried out. Another recent initiative of CommonHealth is Common Ground Workshop aimed at finding a common ground between prevention of sex-selective abortion and access to safe abortion.

The seminar is being held at a time when the country is going through elections. Whatever limited rights / freedom Indian women have regarding safe abortion needs to be preserved. Failure of policy makers to keep promises regarding reproductive maternal health adds to the challenges faced by women and makes it very important for forums to work towards ensuring that the government honours the prior commitments. There are challenges and this seminar is an opportunity to discuss what we – the community of non-governmental organisations, feminists, advocates for maternal-neonatal health, safe abortions - should be doing in the face of these challenges.

Objectives of the seminar

1. Examine, from a gender and rights perspective, the implications of the changing epidemiology of maternal-neonatal deaths and ill-health in India with a focus on the intersection of maternal-neonatal health and communicable and non-communicable diseases and mental health
2. Understand the policy, programme and health system context of safe abortion services in India; the multi-dimensional challenges women face in accessing safe abortion services; and the variations in these across the country
3. Examine mechanisms and processes for accountability for reproductive and sexual health/ maternal health and safe abortion in the public and private health sectors

The seminar was organized around three main themes:

Theme 1: Maternal-neonatal deaths and ill-health: dimensions, time trends and determinants

Theme 2: Safe abortion: where do women stand?

Theme 3: Accountability for sexual and reproductive health

Each theme had a panel presentation by experts in the field and this was followed by paper or case-study presentations.

Key note address by Dr Prakasamma

Dr Prakasamma has over 25 years of experience in the field of public health practice, teaching and research. She is the founder of Academy for Nursing Studies which is a professional non-profit making organization involved in research, training and information dissemination in nursing, midwifery, public health and women's empowerment. In addition to holding various academic positions at national and international institutes and organisations, Dr Prakasamma is actively engaged in designing and trying out alternative models of health care delivery and community mobilisation for reducing maternal mortality and promoting safe motherhood.

Dr. Prakasamma started her address by congratulating CommonHealth for using the term maternal-neonatal health, and acknowledging that the health of the neonate cannot be separated from the health and health rights of the woman. She said that midwives call the mother-baby, a dyad. She also said that women's health cannot be separated from comprehensive health. Health services need to be planned accordingly to meet the demands for maternal-neonatal health. She then discussed the maternal health situation in Andhra Pradesh. Andhra Pradesh presents a contradictory picture in terms of various social development and health indicators for women. For example, the state has high IMR despite much lower TFR; relatively higher MMR despite better CPR, proportion of anaemia among women is higher than the national average despite higher income levels and better sex ratio; lower female literacy despite women's movements and lower age at marriage compared to other states. Lack of political will for implementing measures to address health indicators is to some extent responsible for this contradiction.

The MAARPU programme introduced by the state government too does not have a different approach. Though it has a lifecycle approach, there are no strategies for implementing it. Less than 25% of PHCs are functional. Poor utilisation of PHCs is a waste of resources. Abortion services are an

important components of health services for women. Yet, not a single MTP has been provided in district hospitals although on paper, 17 hospitals are supposed to provide the service. She highlighted that maternal deaths are a result of the failure of the referral system where often referrals are to the wrong level of facility where required services are not available, from the initial place of referral the woman is then referred to another and at times a number of health care facilities with availability of required life- saving services, which causes delay in woman receiving the treatment and thus results into maternal death. At the level of government there is reluctance to acknowledge maternal death – therefore no redress and steps to prevent recurrence, hence violation of core principles of accountability. Dr Prakasamma narrated a case of a staff nurse from a government hospital who died of maternal complications and whose death was not entered as a maternal death in the government's records.

She suggested the VIPASS framework for advocacy which focuses on creating awareness among the **v**ictims of the system, **i**dentifying specific issue, identifying **p**ower groups that can make a decision to change the situation, identifying **a**dvocates with specific strengths, providing adoptable **s**trategies, and creating **s**upport systems through networks. She stressed on advocacy with intelligence not only with emotion. She also suggested a framework (IMPACT) for assessing individual's and organisation's efforts at advocacy. It looks at – I: issue clarity, internalisation of issue; M: how strong is the movement built around this issue and one's contribution to it; P: programmes or projects aimed at bringing about the change; A: actions generated by the government in response to the advocacy; C: commitment of the government towards the issue; T: difference the advocacy has made to the target group. She said that at present ANSWERS is developing a website to document as many as possible maternal deaths across the country and asked the participants to register maternal deaths from their area. The purpose of the website (www.maternaldeaths.org) is to –

- Acknowledge maternal deaths
- Analyse who dies, where, when and of what causes
- Activism based on the analysis to press for Action by the government

Ms Gayatri Giri gave vote of thanks.

Theme 1: Maternal-neonatal deaths and ill-health - dimensions, time trends and determinants

PLENARY

Chairperson: Dr. Pankaj Shah

1. Dimensions and determinants of maternal health: Inequities in maternal health

B Subhasri

Dr Subhasri is an Obstetrician Gynaecologist based in Chennai and working with Rural Women's Social Education Centre, Tamil Nadu. She is currently the chairperson of CommonHealth.

Subhasri highlighted the social determinants of maternal health and maternal deaths through data for various states and various sections of the community. Maternal health indicators such as maternal mortality ratio (MMR) vary widely between states, and between districts within states. While disaggregated data on maternal deaths is not available, small studies show various social groups such as caste and religious groups from the same state and district have different MMR, for example, MMR is higher for rural areas compared to urban; for SC/ST population compared to others; there is no data on maternal mortality in Muslims as compared to Hindus. Similar pattern is seen in the context of access to and utilisation of maternal health care services and nutritional status. Biases and attitudes of health care providers result in women from some sections of the community receiving poorer quality of treatment. For example, studies show Muslim women face derogatory language, insults from health care providers; tribal women are treated insensitively by the health care providers. Women's experiences with health care services are a result of complex interaction between multiple vulnerabilities. Most of the government schemes such as Janani Shishu Surakhsa Karyakram (JSSK) and Janani Suraksha Yojana (JSY) have only marginally benefitted the poor. However, with political will to strengthen public sector services; as is the case in Tamil Nadu, poor women can have better access to health care services. Yet, at present, the GOI has a narrow focus with respect to maternal health. For example, despite revision in MDG 5 targets to include access to contraception, adolescent pregnancies, and access to antenatal care, the GOI continues to monitor only the earlier targets of reduction in MMR and births attended by skilled birth attendants. There is a need for universal access to reproductive and sexual health care and efforts to ensure gender equity. In terms of research, policies and programmes Subhashri highlighted the need for disaggregated data and reducing inequity. This should to be made core part of all policies and

programmes and equity indicators to be included in evaluations of programmes, and context specific planning.

Discussion

- In this context it is important to define the term 'equity'.
- At present quantitative data on vulnerabilities, maternal health indicators for socially vulnerable groups are not available. Qualitative data is available through smaller research studies. This is a gap which needs to be addressed through research.
- It may be useful to look at how multiple vulnerabilities in the states that were mentioned in the presentation interact and influence maternal health
- Other vulnerable groups such as fishing communities, tribals from deep forest or communities at the periphery of larger cities should also be considered. Data should be documented for these.

2. Residual MMR and NMR: What are we dealing with? What might work? (Bihar +)

S. Sridhar

Dr S. Sridhar is Technical director of CARE in Bihar and an expert on neonatal health. He could not make it to the seminar, but fortunately, made a presentation (over skype).

Dr Sridhar began with drawing attention to the large gap between measured and expected mortality considering the near-absence of Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) and the pathetic quality of care and poor indicators of preparedness for maternal-neonatal emergencies. One is intrigued into asking who/what is saving these lives? And to speculate whether maternal and neonatal mortality is being grossly underestimated, and whether services are at all capable of sustaining low MMR, NMR.

The largest contributors to direct maternal deaths are post-partum haemorrhage (PPH), pregnancy induced hypertension (PIH) and malpresentations. One of the major reasons for avoidable deaths from PPH and PIH is the lack of skilled emergency response in the public as well as private facilities. Lower levels of care tend to refer cases without stabilization, reducing chances of saving lives. Blood unavailability has remained a major barrier for many years and there does not seem to be any perceptible change in this. Active Management of Third Stage Labour (AMTSL) is grossly underutilized, although their efficacy in preventing PPH is well established. There is clearly an unmet

need for Ceasarean Section, the C-section rate being less than 2%, instead of the expected 5-15% of all deliveries.

There are only one hundredth of the required Comprehensive Emergency Obstetric Care (CEmONC) facilities available. While the prescribed number is 1 facility /100,000-200000, what we have available is 10-12 facilities / 110 m or 1 CEmONC centre for one crore population. It is not the infrastructure or the transportation that is the main problem in most areas, but the limited number of nurses and doctors available.

Dr Sridhar recommended that under these circumstances it would be prudent to focus on block PHCs (for BEmONC) and DH (for CEmONC) until major change in availability of skilled staff, and to improve skills and emergency response, blood and ambulance services within second and third level care. Starting up new level 1 facilities without any place to refer complications to would not be the best route to prevent maternal deaths.

As far as neonatal mortality (NMR)is concerned, the major causes of death are asphyxia, sepsis and prematurity. Asphyxia remains largely unattended and gets classified as stillbirth. Prematurity remains largely unrecognised because gestational period is not always recorded. Providers rarely monitor foetal heartbeat and c-sections for foetal indications are relatively rare.

There are several difficult programmatic challenges for the further reduction of neonatal mortality. One is the large proportion of neonatal sepsis that now gets treated in the informal private sector. The second challenge is that there are few public institutions with neonatal ICUs capable of providing care for pre-term babies. The third challenge is asphyxia management. It is as yet not clear as to what proportion can be saved without advanced care.

There are some promising lines of treatment available. For example the antenatal administration of certain corticosteroids to women at risk of preterm birth is know to cause a considerable reduction in the risks of complications of prematurity such as respiratory distress syndrome, intraventricular haemorrhage and perinatal death. Government of India now permits ANMs to provide this. What we need to figure out is how effective the treatment is and more importantly, who will take care of the salvaged babies. Chlorhexidine for cord care and Gentamicin for sepsis management are other promising therapeutic developments. The question to be asked is why we have we not tried these lines of management seriously.

Dr Sridhar ended his talk challenging us to ask ourselves whether we are mere observers or actors, and if the latter, then we would need to constantly monitor the situation and evolve strategies to prevent avoidable maternal and neonatal deaths.

Discussion

There was a discussion on SRS as a method of getting MMR estimates. Dr Mala Ramanathan pointed out that SRS was originally developed to measure fertility rates and IMR. As live births decreased over time, the estimates of MMR were based on increasingly smaller samples with large 'confidence intervals', i.e. the estimate was less and less precise.. There was a call for 'Count Every Maternal Death', so that maternal mortality ratio estimates could be more accurate.

This presentation highlighted the role of modern technology in including persons who are away from the meeting place, even in remote areas into the proceedings and discussions. The success of this long distance presentation opened up the possibility of bringing in those who are unable to travel to participate in the meeting.

Comments from the chairperson

Commenting on the presentations Dr Pankaj Shah reiterated the importance of disaggregated data on maternal deaths. He also stated that since most maternal deaths take place in ante natal and intra-natal period, it is essential to ensure early identification of complications during pregnancy and effective referral.

Papers and case study presentations (Theme 1)

Parallel session 1

Chairperson: Dr Lindsay Barnes

1. Maternal health in AP: In the context of MDG Goals

Dr. Y. Ramapadma

Dr Ramapadma presented an analysis of data from DLHS3 and NFHS 3 for Andhra Pradesh looking at the state's progress towards MDG 5. Overall, it seemed that AP will reach very close to the MDG target for MMR by 2015. However, when looked at disaggregated data from the state, several disparities emerge between districts with some districts being much ahead of others in terms of health indicators. In addition, she also brought out that 11% of births in AP occur to women in the 15-19 age group and the age at marriage in the state has increased by only 3 years over a 60 year period.

In the discussion, it was again brought out that fertility indicators of AP were good, for eg. the Couple Protection Rate was high and the TFR was 1.7. However, the mean age at female sterilization, the most commonly used method, was 22 years. While ANC coverage was very high, quality of care was deficient. One of the participants highlighted that in districts like Mahboob Nagar, their field experience pointed to 12 year olds being married and having babies – these were not even picked up in the 15-49 years definition of reproductive age group in most data sources.

The chairperson, Lindsay Barnes, also highlighted the need to question the way DLHS defines safe delivery as institutional delivery or delivery by a skilled birth attendant only.

2. Geographies of maternal complications referrals: Providers' responses in four rural communities

Sandhya Gautam

Ms Sandhya Gautam presented findings from the preliminary review of data for the Jeeva project that explored child birth practices from the perspective of dais and women who lived in four geographically and socially marginalized rural communities in four Indian states. The paper presents health care providers' perceptions of dais' role in ANC, delivery and PNC. Anganwadi workers and private doctors acknowledged the role of the dais in home births more frequently than did

Anganwadi Workers and ANMs, while medical officers did not mention dais as having any role in birthing. Based on the data the authors point out the urgent need for acknowledging the role played by dais in remote areas and for including them in the network of providers, in order to prevent maternal deaths and improve maternal health.

3. Availability of emergency referral transportation for maternal and neonatal complications: A case study from Bihar

Gayatri Giri

Ms Gayatri Giri presented findings from a qualitative study that explored the existing referral systems for maternal and neonatal cases and barriers to referral in Khagaria and Samastipur districts of Bihar. Through a series of graphic photographs, she presented the abysmal state of transport for women in medical emergencies. The pictures were of the modes of transport that were available for transporting women in case of obstetric emergencies, and included cycle rickshaws and horse carts. There were images of the slushy terrain where every step would be a major effort, and getting a woman to a health centre an extraordinary feat. One graphic image that made a deep impact was a picture of a woman experiencing an obstetric emergency being carried to a health centre on a cot by her husband, all alone, the reason being that they belonged to the *mahadalit* caste and no other caste member would give him a hand. The photo was a poignant summary of how social exclusion and poverty and residence in an economically backward region came together to erect a formidable barrier to access to emergency obstetric care.

Discussion

There was a discussion on awareness of people regarding the referral chain and availability of services at facilities at different levels of the three tier public health system. In general people know that the persons in need of emergency care die if taken to PHC or CHC and hence they try to reach the nearest medical college hospital. However, the most vulnerable sections are compelled to follow the chain of referral if they are to be eligible for availing the benefits from various government schemes. This adds to their already numerous disadvantages.

There was a suggestion that referral audits need to be done to understand the outcome following a referral. One example was to analyse logs maintained by the ambulance drivers to understand gaps and delays in transportation related to referrals.

Parallel session 2

Chairperson: Anagha Pradhan

4. Neonatal care practices in a tribal community of Odisha, India: A cultural perspective

Madhusmita Panda

Ms Madhusmita Panda presented various neonatal care practices among a tribal community from Nabarangpur district of Odisha and commented on their possible role in neonatal mortality and morbidity. Neonatal deaths are disproportionately high among the tribal districts of Odisha, the state which has among the highest neonatal mortality rates among Indian states. The presentation was based on a study carried out to understand the intra-partum, postnatal and neonatal care practices among a selected tribal community and cultural beliefs that are at the roots of the neonatal care practices. The learnings from the qualitative research aimed at helping researchers develop effective communication strategies for reduction in neonatal morbidity and mortality in Odisha.

The study documented a number of post-partum, post-natal and neo-natal practices among the tribal community. Distress in newborn (if the baby does not cry after birth) is not considered a reason for seeking medical help but efforts to induce breathing include exposing the new born to loud noises, blowing in his/her ears, splashing cold water on the baby's face etc. The practice of bathing the newborn within one hour of birth with soap and water to remove vernix and at times multiple times (Budu practice) as well as the practices of leaving the newborn uncovered till delivery of placenta, use of pre-lacteals such as ghee, honey, black tea and wrapping the new born in thin cloth (sometimes synthetic fabric) were noted to be particularly harmful for newborn health. Dietary taboos such as exclusion of green leafy vegetables from the new mother's diet could be a contributing factor to maternal morbidity.

Discussion:

Participants strongly suggested reinforcement of positive / beneficial care practices among tribal communities, such as cutting the cord after delivery of placenta but while ensuring that the new born was laid on clean surface and wrapped adequately to maintain body temperature. Another child care practice that needs to be encouraged is exclusive breastfeeding till six months of age. It

was suggested that researchers could examine the care practices against some criteria to ensure demonstrable benefits before encouraging these.

5. Community conduits in continuum of care for maternal and neonatal health: Role of ASHA and Yashoda

Susrita Roy

Ms Susrita Roy presented the ASHA – Yashoda model implemented in Rajasthan as an example of continuum of care for maternal-neonatal health. She began by the concept of continuum of care. There are two dimensions –

1. Time – from pregnancy to delivery to post-delivery and
2. Place – from home and community to facility and back.

She said that the continuum of care breaks because the person providing the care is not the same. In pregnancy it is the ANM and the ASHA. And in institutional deliveries, it is the health care provider. This was the basis of her study. In addition to the ASHA (Accredited social health activist – introduced as community based health workers in NRHM), in Rajasthan a cadre of Yashoda – non-clinical volunteer worker from the community, based at health care facilities – was introduced through the Norway – India Partnership Initiative (NIPI) in 2006. An evaluation of the Yashoda scheme found the cadre to be a positive contribution towards improvement in post natal care practices. Ms Roy presented findings from a small study that explored the links / relations between ASHA and Yashoda in the context of continuum of care. The study explored two reasons for gap in the continuum of care – one, the physical distance between the community and care facilities/providers (contact) and second, the rapport and responsiveness between community and the health care facility / provider and interrelationship between the two cadres of care providers (connect). The study found that continuum of care could be maintained to a large extent when delivery took place at home or at sub-centre and to a lesser extent when it took place at block level CHC or district hospital.

In terms of coordination between the two types of health care providers, the study noted that better contact and connect between the two resulted in better continuum of care. When ASHA and Yashoda were aware about their individual roles and roles of the other, when they had clear understanding of the concept of continuum of care there was coordination and the model succeeded in ensuring continuum of care for maternal-neonatal health. Additional human resource in the form of supervisors placed by the NIPI was one of the factors that contributed to coordination

between the two cadres. The study highlighted the potential for effective implementation of such model of continuum of care.

Discussion:

Participants suggested further analysis of available data to explore association between neonatal morbidity and mortality and effective implementation of ASHA – Yashoda model.

6. Domestic violence during pregnancy: A case for routine screening in ANC

Padma Deosthali

On behalf of the researchers, Mr. Sumit presented the findings from analysis of records for 178 pregnant women who approached a public hospital based crisis centre in Mumbai. These women reported emotional, physical, financial and sexual violence. The data showed that a high proportion of women who experienced violence during pregnancy experienced negative pregnancy outcomes such as induced or spontaneous abortions and still briths. The paper argues that since most of these women were in the first two years of their marriage and more likely to frequently visit the health care facility, it is important that health care providers are trained to recognize the signs of violence and ask relevant questions to screen women for abuse.

There could not be any discussion due to shortage of time.

7. Surrogate mothers and their health care

Dipannita Chand

Ms Dipannita Chand presented a review of literature on health care for surrogate mothers. She briefly presented types of surrogacy and theoretical frameworks to look at the phenomenon of surrogacy. In India where commercial surrogacy has become fairly common, assisted reproductive technology often used by those who can afford the costs, the ICMR guidelines express concerns about the health of the foetus/child carried by the surrogate mother but do not lay down any guidelines for safeguarding the health of the surrogate mother. The whole process of pregnancy is medicalised in case of surrogacy and aimed at 'producing a healthy baby' with little attention to psychological, social needs of the surrogate mothers. The women – often from marginalized communities, are not aware about medicines prescribed and adverse effects these might have on their bodies. The women stop being of any importance to the physicians as they relinquish the baby.

The surrogate mothers suffer psychological stress at various stages through the process of surrogacy, from screening, implantation, and the period of pregnancy which might include selective termination of additional embryos, isolation from her biological children and family, unconscious attachment to the baby they carry, and post-partum issues including separation from the baby soon after birth, lack of social recognition towards her pregnancy which is treated only as the economic service, adjustment to their families after returning home and possibility of violence. There is some evidence that shows that the surrogates lose social and communal identity and are forced to move out of their community. There is limited documentation in India of met and unmet health care needs of the surrogate mothers. The presentation strongly put forth the need for carrying out primary research to document the health consequences (physical, psychological, social) of surrogacy on the surrogate mothers.

There was no discussion due to lack of time and no comments from the chairperson.

Theme 2: Safe abortion services in India: Where do women stand?

PLENARY

Chairperson: Dr. U Vindhya

Dr Vindhya initiated the session with a poignant story from when she was in-charge of a women's hostel. She shared her experience when a girl from the hostel, who was bleeding profusely was taken to the government hospital. The gynaecologist on duty shouted at her 'when you slept with your boyfriend, didn't you think of this?' Dr Vindhya talked about 'being haunted by the guilt, agony, shame experienced by the girl'. She said that abortion is a contentious issue. Women seeking abortion are suspected to have become pregnant out of marriage. And extramarital pregnancies are still looked down upon by the society. Abortion therefore is not only a medical issue but a feminist issue as well.

1. Safe abortion in India: Where do women stand?

Suchitra Dalvie

Dr Suchitra Dalvie presented the context of MTP service provision in India. She highlighted the relevant laws and their evolution over the years till amendment of MTP Act to include use of medical abortion pills in 2003 and the PCPNDT Act of 2003. Despite abortion being legal in India for over 40 years and various modifications to prevent sex-selective abortions, safe abortion services are not easily accessible to women. Unsafe abortions are a public health issue in India, and also a Rights and Social Justice issue. In the last decade 80-89 deaths were recorded per 100000 live births in India. Often poor women are blamed for non-use of modern contraceptives and for using MTP as a way of terminating unwanted pregnancies. However evidence shows that about one-fourth of the modern contraceptive users report unwanted pregnancies despite correct and consistent use of contraceptives. In India abortion is not a right. Doctors are the gate keepers and their perceptions and attitudes towards abortion often determine access to services for women. Since the PCPNDT Act, safe abortion access has been confused due to messages against sex selective abortion and no clear messages about abortion as a woman's right to terminate unwanted pregnancy.

There is a need to recognize the dangers of state /country 'target's being set up for numbers of girl children and to protect the women's right to autonomy and accessing safe abortions. CommonHealth has been conducting Common Ground workshops speaking of sex selection as an issue of gender discrimination and ensuring that safe abortion access is not compromised. Early last year many advocacy groups came together in New Delhi to propose a new campaign which will

work for Gender Equality and Access to Safe Abortions. State level activities are planned along with national advocacy. Dr. Suchitra noted that having more service providers for MTP may not solve the problem – in fact, they become barriers because of absorbed attitudes that consider abortion 'wrong' and a 'sin'. She said that it is important that women be provided information that safe abortion is legal, as well as information on when and where to seek it.

2. Learning from campaign against sex-determination

Manisha Gupte

Dr Manisha Gupte gave a brief history of the campaign against sex-determination through the 1980s till date. The 2000s saw mass ownership of the campaign with increased awareness among people about sex-selective abortions. She shared the challenges and learnings from the campaign. It is important to acknowledge the unexpected outcomes of the campaign which have had an adverse effect on access to safe abortion services. The present campaign must take into consideration the newer challenges – the advocates need to examine their stance on issues of abortion as a right, re-interpretation of MTP Act. The advocacy must consider that it is likely that newer technology for selective abortions is likely to be banned only when it becomes widely available (rich vs poor) or might be used against certain population groups by the state. The efforts should be aimed at advocating for maternal health as a part of universal health care. The focus of the future campaigns must be on gender equality not abortion. There is a need for social transformation to ensure gender equality, only laws cannot help.

Discussion

There was a clarification of the terms 'safe' and 'legal' abortion. The two are not the same. An abortion could be illegal but safe – for example, when conducted by a qualified professional in a well-equipped facility but when the facility is not registered under the law. On the other hand, a a 'legal' abortion could still be unsafe when the quality of care is poor and infection control practices are not adhered to.

The challenges posed to access to safe abortion because of the PCPNDT Act was the subject of considerable discussion. The importance of working on gender inequity and gender discrimination to ensure that sex selection is discouraged was emphasised by many. It was suggested that sex selective abortions and prevention of these should be seen in the context of situation of unwanted

girls. Son preference should be addressed but abortion should be a right. It was pointed out that since the present PCPNDT Act holds doctors responsible for the sex determination, the doctors have responded by denying abortion services, thus driving women to unsafe abortions.

A note of caution about choosing allies carefully was raised by a participant. In the past, efforts were made to include religious leaders as spokespersons against sex-selection. However, religion and culture contribute to discrimination hence bringing in religious leaders on the same platform to advocate against sex selection has actually proven counterproductive in that religious leaders have not only spoken out against sex-selection but also spread anti-abortion messages. Many groups in many countries are working with the interpretation of religious texts and using religious leaders as change agents but in our country this may not be a viable option.

There was an opinion that If abortion is considered to be a right, then it means that one has a right to abortion even after sex selection. The inconsistency involved in saying no to some abortions and at the same time claiming a right to abortion was outlined.

There was discussion on which abortions are 'ok' and which could be considered discriminatory, especially in case of possibility of identifying pregnancies that would result in disabilities or socially undesirable traits in the child. This is relevant because the differently abled are made to feel 'disabled' only by the larger society and often do not perceive themselves to be lesser than any other member of the society unless made aware of their different-ness by the society. Do they have a right to be born and to live? who decides it? What would our stand be if one had a choice and right to abort such pregnancies?

Papers and case study presentations (Theme 2)

Parallel Session 1

Chair person: Medha Gandhi

1. **The abortion debate in the Indian context: Future possibilities to broaden the existing framework**

Bhuvaneswari Sunil

Ms Bhuvaneswari explored the ethical, social, medical and legal aspects and the philosophical debates around abortion. Many of the current debates on abortion pit foetal claims to personhood

against women's agency and right to choose. In the moral realm, 'virtuous' women for whom motherhood is compulsory are pitted against the monstrosity of those who willingly seek or fight for terminating the pregnancy. Her presentation looked beyond pro-life and pro-choice debates and drew attention to the need for locating abortion rights within the context of forced medical treatments, legal and social interference in the management of pregnancy and as a challenge to women's status as citizens. There is need to locate the abortion debate within the framework of the pregnant woman's "personhood".

2. Deconstructing providers' preferences towards offering MTP and EC services to women

Mala Ramanathan and Sunita Chowdhury

Dr Mala Ramanathan presented findings of a study conducted among private obstetrics-gynaecology practitioners (MD OBGY) from two southern districts of Kerala. The study explored the providers' attitudes towards medical termination of pregnancy (MTP) and emergency contraceptives (EC) and limited availability of MTP and EC services in public as well as private sector. The findings showed that general reluctance of obstetricians-gyaecologists for conducting MTPs stems from association of MTP, especially second trimester MTPs, with physically, socially and morally 'dirty work', emotional distress it causes, as well as from lack of institutional facilities to conduct MTPs. Practitioners were reluctant to conduct MTPs due to complications associated with these, but provided emergency contraceptives.

3. Availability and distribution of safe abortion services in Madhya Pradesh

Ali Sayyed

Mr Ali Sayyed presented findings from a study in three districts from Madhya Pradesh that explored availability of abortion services in public and private sector. Less than half of the facilities included in the survey were equipped to provide MTP services, and less than one-third facilities had provided MTP services in three months preceding the survey. While number of facilities in the public sector was higher than those from the private sector, facilities that were equipped to and provided MTP services was higher in private health care facilities. Distribution of such services was skewed with majority being concentrated in urban areas. The paper concluded that unless safe abortion services were made more accessible to rural, remote areas, the goal of Janani Suraksha Yojana of reduction in maternal mortality may not be achieved.

Discussion

- It is important to note that neglect of abortion services as shown in the case of Madhya Pradesh from the JSY services indicates the government's perspective that abortion services are outside of maternal health care services.
- Traditionally, philosophically abortion is linked to uncontrolled sexuality and hence ignored even in planning of health care services. Consequently, morbidity and mortality arising from miscarriages and post-abortion complications are ignored as well. And maternal deaths that could be taking place because of these reasons very early in pregnancy are not counted. There is a need to broaden the definition of maternal death to include those resulting from abortion and miscarriages.
- There is not much literature on availability of abortion services for vulnerable groups like commercial sex workers. Experiences of various vulnerable groups need to be explored.
- There is a need to understand the cultural perspective regarding abortions - the situations where abortion is accepted by the community, and its implications for women's health and health care. For example, community sympathises with the woman who has one or two spontaneous abortions. But with repeated abortions, the woman is stigmatised, she experiences low self esteem. She is blamed for her failure to give birth to a child. The husband, however, is freed of all blame as the pregnancies prove his fertility. Repeated pregnancies legitimise second marriages. Also frequent abortions are often blamed on 'evil eye' cast by another woman from the family / community. Hence a woman experiencing abortion has consequences for not only that woman but for other women in the community as well. There is a need to document how women see abortions, what they think about it. Also, there is a need to make sure that the experiences of the most vulnerable groups are documented. Abortion stigma is an issue that is not well understood and needs research.
- All MTPs are considered 'monstrous' but monstrousness needs to be examined in the context of, say, a PLHIV forced to abort. There is a need to understand the monstrousness – who perceives it and how.
- There was a discussion on social response to abortion. Society accepts abortion where it frees the society from taking on a responsibility. For example, in case of a HIV positive woman.

Parallel Session 2

Chairperson: Dr Suchitra Dalvie

1. Video presentation: Safe abortion as a women's rights issue

Shweta Krishnan

Dr. Subha Sri made the presentation on behalf of Dr Shweta Krishnan who could not attend the seminar.

The video produced by RUWSEC, Tamil Nadu described the situations under which women actually seek an abortion and the challenges they face during this. This was done through interviews with a woman seeking abortion and with field staff of RUWSEC. That women find it difficult to realize their sexual and reproductive rights in their everyday lives was highlighted. The need for access to safe abortion was framed in this context. It was emphasized that public sector provision of abortion services in the primary level is essential to ensure that abortion services are not denied to those who cannot afford to pay.

2. Facing the challenges of a negative impact of sex selection issue on women's access to safe abortion: A qualitative study with private medical practitioners in Western Maharashtra

Preet Manjusha

Ms Preet Manjusha presented findings of a qualitative study from four towns of Western Maharshtra that examined the attitudes and practices of the medical practitioners authorised to provide abortions and reasons for their denying services to women. The data showed that insensitivity of the implementing authorities, cumbersome paperwork, lack of confidentiality for doctors resulting in mistrust between private sector medical practitioners and public sector authorities, resulted in medical practitioners denying second trimester abortions to women. The data highlights the need for reviewing the approach and finding ways of developing synergistic relationship between private and public sector for upholding rights of women and addressing gender discrimination through prevention of sex selective abortions.

3. Barriers to safe abortion in Mumbai and Jalgaon in Maharashtra

Neha Rathi and Sushma Shende

Ms Neha Rathi presented the findings from a qualitative study conducted in two cities of Maharashtra. The study aimed to understand women's abortion experiences to outline the practices on the ground which prove to be the barriers to safe abortion. In-depth interviews were conducted with 26 women and 9 medical practitioners from the selected two cities. Most practitioners insisted on husband's consent to safeguard their own interests. Requirement of documents results in delay

and stress for women. Doctors too see documentation as a 'headache'. Insistence of public sector providers for sterilisation or adoption of temporary contraceptives drives women to non-authorised practitioners or quacks. Women were not aware about abortions being legal, till what point in pregnancy was it allowed. There is a need for generating awareness among women. There is a need for a dialogue with policy makers, government officials and other stakeholders on better / efficient implementation of MTP and PCPNDT Acts without restricting women's access to safe abortions.

Discussion of the three presentations

The various presentations brought out the challenges posed by both laws like the PCPNDT Act and health system issues to access to safe abortion. That public sector provision of services would ensure access was again emphasized. The absence of social support systems for women seeking an abortion was also discussed.

One of the key points emerging from all the presentations was the narrowing of spaces for safe abortion access as well as discourse. There is an urgent need to increase the visibility for this issue given the current environment which is not very supportive of safe abortion as a right.

Day 2

Theme 3: Accountability of sexual and reproductive health in India

PLENARY 3

Chairperson: Prof. Padmini Swaminathan

1. Social accountability for SRHR : What does it involve?

Renu Khanna

Renu's presentation highlighted

a) the concept of social accountability,
b) international and national efforts for promoting Social Accountability for Sexual Reproductive Health Rights and Maternal Health, and
c) what are some action steps that we as maternal health advocates can take.

She explained that accountability is relational, it is about the balance of power between the rights holders and duty bearers, moves towards democratisation and reduction in power imbalance and is dynamic / evolving. Answerability, enforceability and redress are core components of accountability. Being accountable to the rights holders is an obligation of the duty bearers. Accountability can be financial, performance based, political and social. At the same time it can be vertical (outside of the system), horizontal (within the system) or hybrid (combination of the two). Includes community monitoring, participatory planning and budgeting, public expenditure tracking, investigative journalism, citizen advisory boards are some of the ways for increasing the system's accountability to people. A number of international events / movements have been initiated to increase the governments' accountability towards people. Though these have had some positive effect, there are concerns because of influence of large corporate institutions on these international bodies/events /mechanisms. There need to be accountability measures for these new actors. At the national level, there is a weak framework for accountability. Indicators are central to the issue of Social Accountability – what is monitored and how is it monitored - is important. Women's health advocates have since long been demanding a say in deciding the indicators for SRHR. Largely it is the indicators related to family planning and disbursement of funds under schemes such as JSY that are tracked. Other components are not monitored. For example since the focus is on institutional deliveries, not on safe deliveries, access to post natal care is not considered an important indicator. Health care for morbidities related to reproductive health such as mental health conditions or genital prolapse, fistulas, infertility, reproductive cancers etc, is not covered under universal access to care. To change this situation there should be advocacy for indicators that are meaningful and

important reflections of women's reproductive health, use of national and international forums to raise issues. There is a need for sustained efforts for empowerment of affected communities. Civil society should also increase the demands for accountability of private corporate interests.

2. Accountability for reproductive health – using human rights approaches

Jashodhara Dasgupta

Jashodhara's presentation was designed around three stories of women with multiple vulnerabilities – a teenage girl, a tribal woman and a Muslim woman whose reproductive health rights were violated. This presentation highlighted that accountability is often interpreted to be managerial accountability by the government / health care providers from the public sector, where the health care providers are accountable to their seniors in hierarchy, to ministries etc but not to the patients whose rights they end up violating in the process. To ensure that the health care delivery system is accountable to people, there needs to be monitoring of all levels of duty bearers, review of quality of care according to the standards / guidelines, platform to voice grievances and redress and remedy to the grievances with an assurance that the same will not be repeated in future in case of any other person seeking care. Participatory community based monitoring is essential for this. At the same time there is a need to consider ways of monitoring the vast private sector where poor patients often seek services in case of non-availability of services in the public sector.

Discussion

- Accountability for health lies beyond the health sector. Industries causing pollution, unregulated pharmaceutical sector, policy makers that help these to perpetrate are all responsible. Accountability for health needs to be aligned with other issues such as land acquisition, migration, macro policies etc.
- Involvement of corporate interests in policy making groups such as planning for Universal Access to Health in India is of concern.
- Effect of community based monitoring depends on strength of collective of health and social activists out of the system.
- While asking for regulation of services (e.g. private sector) one needs to carefully examine who we are protecting by these regulations. For example, at present there are stringent rules regarding blood banks. These came into play because of the middle class's concerns regarding quality of care. But have resulted in non-access to life saving treatment for those from the rural remote areas as the district hospitals cannot store blood.

- Political origins of health inequity need to be understood clearly.
- Civil society inputs are needed for formulation of Rules for the Clinical Establishment Act – at present it does not mention patient rights and grievance redress.
- Advocacy for standards of care should be cautious. We need to be aware of the influences of global factors. The private sector is not homogeneous – in addition to corporate hospitals, there exist trust/NGO/mission hospitals, in remote areas providing essential health services.
- Universal Periodic Review of the Human Rights Council can be used to create a civil society shadow report.

Papers and case study presentations (Theme 3)

Chairpersons: Leila Caleb Varkey and Anita Rego

1. Accountability and maternal health care: Human Right Watch's work in India

Aruna Kashyap

Ms Aruna Kashyap described the work by Human Rights Watch in India. Based on her experiences gained from discussions with experts, studies in Uttar Pradesh and maternal death reviews of ten deaths in Gujarat she highlighted the denial of human rights in the context of maternal deaths and morbidity, and suggested steps to address these at policy level. She used the story of an adivasi woman Shardaben to illustrate her points.

Need for review of available data and development of more sensitive indicators was discussed. For example, number of referrals behind each institutional delivery, which would present the challenges vulnerable women face in accessing health care services. NGOs could collect this data for areas that they work in. The data on institutional deliveries needs to be analysed geographically to see whether women from the most vulnerable communities – remote, tribal, poor – had access to institutional deliveries and proportion of deliveries that took place at PHC, CHC and district hospitals. Advocacy needs to be planned based on this data.

Strengthening of the referral system is essential. GOI's Assured Referral Guideline and Transport Guidelines can be used to demand accountability. Referral Audits need to be done. All health care providers who form the part of the referral network should be aware of the guidelines. The guidelines should be developed after taking into account the resources and skill level available at each referral points. Documentation including records of stabilising treatment provided at the time

of referral should be improved and made mandatory to ensure appropriate treatment at the referral centre.

Inadequate grievance redress mechanism within the public health care delivery system and inability of the 'social accountability measures to check corruption within the system were mentioned to be important barriers to the success of the system.

Aruna's presentation highlighted some important concepts of Accountability – 'non-recurrence', which relates to picking up the flaws and correcting them, 'constructive accountability' – which relates to no scapegoating of individuals and addressing systemic factors.

2. Dead women talking initiative

Sanjeeta Gawri

Ms Sanjeeta Gawri presented the process that led to 'Dead Women Talking' – an initiative to promote accountability for maternal deaths in rural India. A need for bringing in focus the lived experiences of women and their families against the indicator centred approach of the public health system led to various NGOs / civil society groups coming together in 2012 in Chennai for systematically documenting maternal deaths from rural India. The process involved development of a framework for analysing maternal deaths, and a tool for documenting maternal deaths, with a focus on social determinants of health. The process highlighted the need for addressing the power differentials in the process of maternal death reviews in terms of contents and persons involved. The initiative hoped to move from individual to systemic and community accountability and to strengthen the process of maternal death review by focussing on social determinants. During late 2013 and early 2014, several groups across India have been documenting maternal deaths. In February 2014, 30 participants from 18 NGOs across 10 states met in Mumbai in 'Dead Women Talking 2' meeting to discuss their experiences of using the social autopsy tool and issues emerging from the analysis of these maternal deaths. In response to these following steps are being taken –

- A civil society shadow report is being developed based on the analysis of 125 maternal deaths
- Accountability event like Jan Sunwai have been organized, for example in Gadchiroli District in the state of Maharashtra
- State report of Gujarat has been attached and will be presented to Government of Gujarat in June 2014
- Maternal death case studies are being used in VHSNCs meetings for social accountability

3. Case study PAHEL: enforcing state accountability for sexual and reproductive health services through women leaders

Manju Katoch

Dr. Manju Katoch presented a case study of PAHEL, an initiative of CEDPA India for enforcing state accountability for sexual and reproductive health services through elected women representatives in Bihar. The project reaches out to 1200 elected women representatives from six blocks. They are provided with inputs for capacity building, supported to take actions to demand accountability in response to evidence generated by women and mentored through collective forums called Mahila Sabha. The project has developed accountability checklists based on the IPHS and NRHM guidelines. The efforts have showed results in terms of increased participation of elected women representatives in panchayat meetings, VHSND and number of elected women representatives who have raised SRH related issues at appropriate platforms. The change in their role has resulted in improvements at facility level as well. This presentation highlighted how spaces made available through various government programmes can be utilized effectively to advance systemic accountability for sexual reproductive health of women.

4. Social accountability for maternal health: Experiences from Dahod and Panchmahal districts

Sunanda Ganju

Ms Sunanda Ganju presented experiences of a collaborative project between SAHAJ and ANANDI on social accountability for maternal health. Following a situation analysis, a detailed maternal health care monitoring tool was developed on the concept of safe deliveries from technical as well as women's perspective. A pictorial monitoring tool and a report card was developed after analysis of data collected through this tool. The responses from public health system were varied – from disbelief at the dismal situation to ownership of the situation and commitment to improvement. A repeat exercise after six months showed significant improvement in some of the services such as services provided on VHND / Mamata Diwas.

5. Changing paradigms of women's access to health care – role of private health sector

Nilangi Sardeshpande

Dr. Nilangi Sardeshpande presented interactions between rural women seeking hysterectomies and private health care providers regarding nature of illness, severity, and prognosis which underscored the prevalence of irrational practices in the health sector. The study showed that women were

misguided to accept the surgery and the providers took advantage of their body illiteracy and fear of cancer. The study highlights the irony of a situation where women often do not have access to the health services they really need but somehow seem to have easy access to hysterectomy. The issue of reproductive desires also came into play since the data showed that the vast majority of these women had at least one son and hence considered their family complete. The study points towards need for stringent control of quality of care provided through private sector as well as conscious efforts for increasing women's awareness about reproductive and sexual health concerns including hysterectomies.

Discussion

Following points were raised in the discussion that followed the five presentations in this session.

- It is important to think about ways of addressing power differentials in the context of maternal death review conducted by the health system in order to increase accountability.
- It is important to note that at times medical practitioners become detached from the subjects – there is a need to work with them to ensure compassionate enquiry regarding maternal deaths.
- Interventions for empowerment of women and increasing accountability need to plan for sustained support beyond the project period. CEDPA's work with the Department of Health and Family Welfare in Jharkhand for development of indicators and supportive supervision of elected women representatives was appreciated.
- Participants appreciated the tool used by SAHAJ and ANANDI in Gujarat to monitor the maternal health services.
- There was discussion on non-availability of standard treatment guidelines in the context of maternal health. It was strongly felt that civil society groups should advocate for standard treatment guidelines that have a right balance of social and medical components.
- Participants drew attention to the fact that stringent measures to control the private sector health care services would adversely affect smaller health centres including NGO managed health care centres in remote areas.
- In addition to ensuring standards of quality of care in private sector, there should be measures for addressing similar lacunae in public sector as well. Lack of availability of second opinion, long waiting lists for surgeries such as hysterectomies in public hospitals drive women to consult private sector practitioners.
- Need for civil society to engage in the drafting of Clinical Establishment Act in different states and to proactively give inputs for the Rules for the Central and State Acts was voiced.

Chairperson's comments

The chairperson summarised the session by asking the participants to think about how we can advocate as a group. She also pointed out that the presentations have not looked at whether the government's own accountability mechanisms work, including the grievance redress mechanism. She highlighted the need for more nuanced work. She said that there is a need to explore whether other structures for ensuring better quality of care such as the Rogi Kalyan Samiti work. There is a need for conducting primary research in this area.

Advocating for change: Moderated Plenary Discussion

Facilitated by Renu Khanna, Laxmi Lingam

Feedback from new members

- Got new perspective about abortion, safe delivery vs institutional delivery. Realised importance of taking into account women's perspective (regarding safe delivery, abortions and reproductive health) and not imposing medical perspective on them.
- Realised importance of transportation and care during transportation for safe delivery. (Nursing professional)
- It was a good platform, listening to presentations and discussions was a rich experience. Gained insights. Realised importance of such forums. We can collectively raise our voice for our sisters who die needlessly in childbirth.
- Discussion on regulation of private sector was useful.
- Information from various parts of the country on initiatives for safe delivery was insightful. Provided guidance on what can be done in our area.

Challenges experienced by participants where they would like CommonHealth members to help

Local / micro level challenges

- Despite incentives, only medical officers who belong to the tribal community accept posting in tribal area. Other medical officers are unwilling to provide services in remote areas. (Though raised in the specific context of a district, this remains a national level issue and needs to be addressed at national as well as local level.)
- In tribal area (Maharashtra) there is high proportion of unwed pregnancies. They do not access ANC, or any other medical services. Would appreciate guidance on improving their access to health care for improvement in maternal health.
- In some rural and tribal areas people do not go for sex-selection and abortion. Even today the practice of female infanticide is prevalent. Newborn girls are discarded. Concrete suggestions for addressing this issue would be appreciated.

District level challenges

- MDR committees at District level not functioning adequately, what can be done to make them function?

National / macro level challenges

- There are no urban health policies. Would benefit from discussion in the context of urban health.
- To what extent has social accountability related activities made a dent on forces that shape the health system, on larger political forces? In future the spaces for making an impact will go on decreasing. What can we do to deal with the situation, to influence the forces?

Commitment by participants

- Concrete advocacy on access to safe abortion (U.P.)
- RMNCH has safe abortion within it, Mission Director is supportive and can use this as an opportunity (Orissa)
- Can develop a network of NGOs in Odisha to work on issues related to safe abortion, PCPNDT Act.
- CEDPA would like to initiate a network of members to re-look at available data, plan for additional data and to learn from each other. They welcome CommonHealth members to use CEDPA data for advocating on critical issues.
- NICE Foundation will conduct maternal death review in Andhra Pradesh using the tool developed by'Dead Women Talking.

Suggestions for collective agenda for moving forward

Research, brainstorming, generation of evidence

- Important to understand the various layers and cultural differences while looking at services
- Privatization of health care and its regulation to be looked into
- Various sub-groups of women to be considered while looking at maternal health e.g. urban, working women etc.
- Psychological / mental health component of maternal health should also be considered / researched
- Use of mobile technology / use of modern technology for improvement in maternal-neonatal health care needs to be discussed / explored in depth (There is a need for research about use of modern technology for maternal health.)
- There is a decline in MMR and IMR; however rate of decline is different. There is a need to identify linkages between maternal and neonatal health and health care services.
- Economic development programmes are not clearly linked to health programmes eg roads and transportation. There is a need for analysing these linkages.

Awareness generation, sensitisation

- State level networks of members to sensitise on safe abortions and PCPNDT
- Sensitisation of medical students to social aspects of health, gender sensitive medical education
- Moral perspectives of health care providers to be addressed

Advocacy at local, state, national level

- Recommendations on existing work, meta analysis to be used for collective advocacy (use of available evidence for effective advocacy)
- Policy briefs to be developed
- Guidelines for incorporating qualitative aspects of safe abortion into practice need to be developed
- Some of the problems are politically induced such as bifurcation of state leading to lack of access for the poor. Would it be possible to organise a meeting with government representatives for presenting critical issues and seeking solutions?
- NFHS 4 is being conducted and is going to provide MMR and IMR at district level. Can we advocate to provide data at regional level?
- IIPS and GoI is going to count each maternal death in one district in Maharashtra.
- There is a need to highlight the linkages between development in other sectors such as road construction and transportation and maternal – neonatal health outcomes to reach the point that health outcomes are determined by factors that lie in sectors other than health sector. Hence, accountability in these sectors is essential for improved health outcomes.

Networking

- Network of researchers, access to relevant research to prevent repetition and better use of resources
- Use of mobile technology / use of modern technology for improvement in maternal-neonatal health care needs to be discussed – possibility of a meeting for this? Socially responsible corporate companies e.g. Infosys could be involved to provide awards for socially innovative innovations.

Advocacy proposals: Participants put forth some concrete proposals for advocacy as a group.

1. CommonHealth could develop a statement expressing collective concerns and stating the demands – such as, recording of every maternal death and not just SRS estimates. The group could also develop an accountability framework that can be used for analysing subtle indicators such as contribution of irresponsible referrals or use of communication technology towards maternal health. This would also include developing specific checklists, for example, checklist for documenting what one can expect from each level of health care facility before the woman is referred to a higher facility. It may also include re-examining the need for referral / referral criteria considering the improvement / betterment of primary level health care facilities in recent years. This would lead eventually to development of a charter of responsibilities for safe maternal-neonatal health.
2. Women's health being isolated from women's rights issues or health issues in general. Align with other issues where emergency care is needed. For example, cardiac care, which is an affluent male population issue and probably gets traction, could be used to piggyback EmONC agenda.
3. NAMHHR—building synergies—new government and new office bearers, can we engage directly with them or with those who are in the Mission Steering Group, health in tribal areas, Universal Period Review for India midterm is this year—can we work on a shadow report this year or at the final review time ?

What are the immediate requirements towards moving ahead the agenda?

- More such meetings and with health department, medical associations to influence beyond the civil society.
- Emerging voices: young students below 30 can be asked to write essays giving solutions to problems they found important. Maybe TISS campus can do this?
- Safe abortion:' Students For Reproductive Choice' bodies exist in countries where abortion access is restricted, we need to engage similar groups and involve in a big way, doctors, nurses students.
- Legalities surrounding healthcare—accrediting private sector for insurance but no regulation, where do we get the correct information from, what medicines can midwives give or not?

Conclusion

Summary of the session by Renu Khanna

Summarising the discussion and views presented in the previous sessions, Ms Renu Khanna stressed the need to continue unveiling vulnerable groups, exploring and documenting complex

vulnerabilities women experience. As a group, CommonHealth members need to think about ways of working together for research and advocacy. Referring to the need for inputs expressed by some of the participants of this national seminar, she said that the CommonHealth members need to think of how they can reach out across the states to those who had expressed a need for help in addressing critical maternal-neonatal health issues. She pointed out to the potential for academic institutes such as TISS for engaging with emerging champions.

Summary of the seminar by Sundari

In the closing session, Dr Sundari Ravindran expressed satisfaction about the presence of a large number of new members, an indicator of fulfilment of the seminar objective of expanding the group of CommonHealth allies. She also appreciated the enriching presentations – experiences shared by participants working in different parts of the country. She said that the passionate presentations and interesting discussions that followed, are an indicator of the seminar as a safe space for discussion on maternal-neonatal health and abortion, an objective this seminar had set out to meet. The presentations and discussions over the two days were balanced. A number of challenges were presented through experiences shared on the first day or the seminar. On the second day, the discussion was on opportunities.

She observed that some of the themes were less explored or not explored in this seminar, such as maternal health and other health conditions such as malaria, TB which are known to play a role in maternal deaths. These can be considered in the next seminar and panels of experts can be put together to guide the other members.

Dr Sundari also talked about ways of making future seminars richer in content and discussions. She said that there was a limited response to the call for case studies. There is a need to reach out to more people to ensure more states are represented at the seminar. Language of the seminar too could have been a barrier for some of those working on maternal-neonatal health and safe abortions. In order to reach out to a wider group efforts would be made to break the language barrier.

She specifically appreciated the enthusiastic participation of younger researchers and hoped that the presentations would become resources and provide opportunity for collective actions in future.

Dr Sundari Ravindran then thanked all those who made the seminar a success.

- TISS, Hyderabad
- Dr Lakshmi Lingam, Dr Padmini Swaminathan, Dr U Vindhya
- Mr Suresh and his team for logistics management
- All plenary speakers
- Bhuvana for coordinating with relentless, timeless energy
- Colleagues from RUWSEC
- Colleagues from CommonHealth
- All participants

Participants of the Seminar

xxxxxx

Annexure 1: Schedule of the seminar

	DAY 1	
8.00- 9.00	Registration	
9.00 – 10.30	Inaugural session	**Welcome address: Dr Lakshmi Lingam, Deputy Director, TISS, Hyderabad** **Introduction to the seminar and to CommonHealth** **TK Sundari Ravindran, Seminar Technical Committee** **Inauguration and inaugural address** **Ms. G.D. Priyadarshini, IAS** Director, AMR-APARD *(Confirmation awaited)* **Key note address:** Dr M. Prakasamma, ANSWERS **Vote of Thanks** Gayatri Giri, CommonHealth
10.30 - 11.00	Tea	
11.00 – 12.30	Theme 1**:** Maternal-neonatal deaths and illhealth: dimensions, time trends and determinants.	*Chair:* Pankaj Shah (SEWA Rural) Speakers: **B. Subhasri** : Dimensions and determinants of maternal deaths and ill-health in India **S. Sridhar**: Issues and challenges in neonatal health in India – An overview
12.30 – 13.30	Lunch	
13.30 – 15.00	Theme 1: Papers and Case study presentations	Parallel session 1[1] *Chair*: Lindsay Barnes Parallel session 2 *Chair:* Anagha Pradhan
15.00 – 16.00	Theme 2: Safe abortion: Where do women stand?	*Chair*: U. Vindhya Speakers: **Suchitra Dalvie**: Safe abortion in India –Where do women stand? **Manisha Gupte**: Gender, sex-selection and safe abortion in India
16.00 – 16.30	Tea	
16.30 - 18.00	Theme 2: Papers and Case study presentations	Parallel Session 1 *Chair:* Medha Gandhi Parallel Session 2 *Chair:* Alka Barua

[1] Details of speakers in each parallel session presented in Annexure 2

	DAY 2	
9.30 – 10.30	Theme 3: Accountability for sexual and reproductive health (SRH)	*Chair***:** Padmini Swaminathan Speakers: **Renu Khanna**: Social accountability for health – what does it involve? **Jashodhara Dasgupta**: Experiences in enforcing social accountability for SRH in India
10.30 - 11.00	Tea	
11.00 – 13.00	Theme 3: Papers and Case study presentations	Co-Chairs: Leila Caleb Varkey& Anita Rego
13.00 – 14.00	Lunch	
14.00 -15.30	Open House: Advocating for Change in the National Health Mission: Moderated Plenary Discussion (30 minutes for each theme)	*Chairs:* Lakshmi Lingam & Renu Khanna
15.30 - 16.00	Tea	
16.00 – 17.00	Concluding session: Highlights from the different sessions including open house	TK Sundari Ravindran

Annexure 2: details of speakers and papers in parallel sessions

Theme 1. Maternal-neonatal deaths and illhealth: dimensions, time trends and determinants.	
Parallel session 1 Chair: Lindsay Barnes	
Y. Rama Padma	Improving maternal health: How far are we from the MDG goal? (Focus on Andhra Pradesh)
Sandhya Gautam and Leila Caleb Varkey	Geographies of maternal complication referrals: Providers' responses in four rural communities
Gayatri Giri	Availability of emergency referral transportation for maternal and neonatal complications: A case study from Bihar
Theme 1. Maternal-neonatal deaths and illhealth: dimensions, time trends and determinants.	
Parallel session 2 Chair: Anagha Pradhan	
Madhusmita Panda	Neonatal care practices in a tribal community of Odisha, India: A cultural perspective
Susrita Roy	Community conduits in continuum of care for maternal and neonatal health: Role of ASHA and Yashoda
Padma Deosthali	Domestic violence in pregnancy: A case for routine screening in ANC
Dipannita Chand	Surrogate mothers and their health

Theme 2. Safe abortion services in India: Where do women stand?	
Parallel session 1 Chair: Medha Gandhi	
Bhuvaneswari Sunil	The abortion debate in the Indian context: Future possibilities to broaden the existing framework
Mala Ramanathan and Sunita Chowdhury	Deconstructing providers' preferences towards offering MTP and EC services for women: a study from Thiruvananthapuram
Sayyed Ali, Sarika Chaturvedi et al	Availability and distribution of safe abortion services in Madhya Pradesh
Theme 2. Safe abortion services in India: Where do women stand?	
Parallel session 2 Chair: Alka Barua	
Shweta Krishnan	Video Presentation: Safe abortion as a women's rights issue
Preet Manjusha et al	Facing the challenge of a negative impact of sex-selection issues on women's access to safe abortion: A qualitative study with private medical practitioners in Western Maharashtra
Neha Rathi, Sushma Shinde	Barriers to safe abortion in Mumbai and Jalgoan in Maharashtra

Theme 3. Accountability of sexual and reproductive health in India	
Co-Chairs: Leila Caleb Varkey & Anita Rego	
Aruna Kashyap	Accountability for maternal health: Human Rights Watch's work in India
Sanjeeta Gawri	Dead Women Talking: Case study of an initiative to promote accountability for maternal deaths in rural India
Dr Manju Katoch	PAHEL: Enforcing state accountability for sexual and reproductive health services through women leaders
Sunanda Ganju	Social accountability for maternal health: Experiences from Dahod and Panchmahal districts, Gujarat
Nilangi Sardeshpande	Changing paradigms of women's access to sexual and reproductive health care: The role of the private sector

Annexure 3: List of participants

1. Abhishek Kaushik,
   Master in public health student,
   Asian Institute Of Public Health,
   Bhubaneswar.

2. Ajoy kumar Das,
   Director,
   Integrated Health and Development
   Agency for Weak Community (IHDAWC).

3. Anagha Pradhan,
   SAHAJ,
   Vadodara.

4. Anand Pawar,
   SAMYAK,
   Pune.

5. Anita Rego,
   Head,
   Health Programs, Effective Head,
   Hyderabad.

6. Aruna Kashyap,
   Researcher,
   Women's Rights Division,
   Human Rights Watch.

7. Balasubramaniam,
   Director,
   Rural Women's Social Education Centre,
   Tamil Nadu.

8. Bhavana Milind Jadhav,
   Professional Social Worker.

9. Bhuvaneswari Sunil,
   Research Scholar,
   Tata Institute of Social Sciences,
   Mumbai

10. Bijayalaxmi Rautaray,
    Social worker,
    SAHAYOG,
    Odisha.

11. Dipannita Chand,
    Ph.D Scholar,
    Indian Institute of Technology,
    Kharagpur.

12. Gargeya Telakapalli,
    Student,
    Tata Institute of Social Sciences,
    Mumbai.

13. Gayatri Giri,
    Public Health Professional, Consultant.

14. Hymavathi,
    Nice Foundation,
    Hyderabad.

15. Jashodhara Dasgupta,
    SAHAYOG,
    India.

16. John Wesley,
    Nice Foundation,
    Hyderabad.

17. Karthik G,
    Nice Foundation,
    Hyderabad.

18. Kuruvamma,
    Nice Foundation,
    Hyderabad.

19. Lakshmi Lingam,
    Deputy Director,
    Tata Institute of Social Sciences,
    Hyderabad.

20. Leila Caleb Varkey,
    Independent Public Health Researcher,
    Currently working on JEEVA project ,
    hosted by CWDS.

21. Lindsay Barnes,
    Social worker,
    Jan Chetna Manch,
    Jharkhand.

22. M. Prakasamma,
    ANSWERS.

23. Madhusmita Panda,
    Consultant,
    UNICEF,
    Odisha

24. Mala Ramanathan,
    Additional Professor,
    AMCHSS,
    Kerala.

25. Manisha Gupte,
    MASUM,
    Pune.

26. Manju Katoch,
    Manager - Monitoring and Evaluation,
    Centre for Development and Population Activities.

27. Medha Gandhi,
    Advisor Policy,
    Ipas India

28. Mithun Som,
    Independent Researcher.

29. Monali Misra,
    Master in public health student,
    Asian Institute Of Public Health,
    Bhubaneswar.

30. Neha Rathi,
    Lawyer,
    SNEHA,
    Maternal Health Task Force.

31. Nilangi Sardeshpande,
    Research Scholar,
    Tata Institute of Social Sciences,
    Mumbai.

32. Padmini Swaminathan,
    Professor,
    Tata Institute of Social Sciences,
    Hyderabad.

33. Pankaj Shah,
    SEWA Rural,
    Gujarat.

34. Preet Manjusha,
    Research Associate,
    SAMYAK,
    Pune.

35. Puttoju Rajeswary,
    Nice Foundation,
    Hyderabad.

36. Rahul Sadashiv Bawankule,
    Student.

37. Rajdev Chaturvedi,
    GPS,
    Azamgarh.

38. Rama Padma Y.
    Indian Institute of Health & Family
    Welfare,
    Vengalarao Nagar, Hyderabad.

39. Ramya Anand,
    Consultant,
    Rural Women's Social Education Centre,
    Tamil Nadu.

40. Renu Khanna,
    SAHAJ,
    Vadodara.

41. Sagun Mohapatra,
    Student, Master in Public Health,
    Asian Institute Of Public Health,
    Bhubaneswar.

42. Sandhya Gautam,
    Health Activist,
    The Jeeva Collective.

43. Sangeeta Macwan,
    Programme Coordinator,
    SAHAJ,
    Vadodara.

44. Sangeeta Sharma,
    Master in public health student,
    Asian Institute Of Public Health,
    Bhubaneswar

45. Sanjay Kumar B,
    Nice Foundation,
    Hyderabad.

46. Sanjeeta Gawri,
    Public Health professional,
    Oxfam India,

47. Sayyed Ali,
    Public health researcher,
    RD Gardi Medical College,
    Ujjain, Madhya Pradesh.

48. Shilpa Desai Shroff,
    Public Health Professional,
    Asia Safe Abortion Partnership.

49. Shishir Kumar Biswas,
    Master in public health student,
    Asian Institute Of Public Health,
    Bhubaneswar.

50. Sridhar Srikantiah,
    Technical Director, CARE,
    Bihar

51. Subhasri,
    Doctor,
    Rural Women's Social Education Centre,
    Tamil Nadu.

52. Suchitra Dalvie,
    Doctor,
    Steering Committee Member,
    CommonHealth.

53. Sumeet Porkharnikar,
    Researcher, CEHAT,
    Mumbai

54. Sunanda Ganju,
    Program Manager,
    Maternal Health Accountability Project,
    SAHAJ,
    Vadodara.

55. Sushant Garada,
    Democratic Action,
    Odisha.

56. Susrita Roy,
    Centre for Policy Research.

57. TK Sundari Ravindran,
    Professor, Sree Chitra Tirunal Institute
    for Medical Sciences and Technology,
    Tiruvanathapuram.

58. U. Vindhya,
    Professor,
    Tata Institute of Social Sciences,
    Hyderabad.

xxxxx