Coalition for Maternal-Neonatal Health and Safe Abortion
General Members Meeting Minutes
September 5, 6, 7 2007, Sarvodaya, Goregaon, Mumbai

WELCOME AND INTRODUCTION OF PARTICIPANTS

REVIEW OF MEETING AGENDA AND ASSIGNMENT OF TASKS

GENERAL UPDATES AND SHARING

Sundari as Chairperson

MANJU NAIR, SRI CHITRA TRIVANDERUM

- She used to work at the primary health care level, first as a service provider and then as a programme implementor within government services. Now she is a researcher.
- She also collaborates with Streevedi, an informal network of women's organisations. Earlier, health was not a primary area of concern for Streevedi, but now health is coming out as a primary issue. They recently held a state-wide seminar on women's health, which highlighted challenges, opportunities and gains.
- She is concerned about gender-based violence in Kerala. A three district survey on gender-based violence was done for the government, but is still not yet published.
- She has helped to draft a manual for PHC institutions for maternal-neonatal health issues from a feminist perspective. This will be published next month.

SHOBHA MISRA, PSM DEPARTMENT BARODA

- In the last year, she has spent 6 months deputed to Rajkot. She lectures undergraduates, postgraduates and interns about NRHM, maternal and neonatal health issues.
- She been involved in 8 training programmes for government health workers: AWW, ANM, lab technicians, medical officers on IMNCI, which emphasises early registration, early breastfeeding, home visits, etc.
- She is involved in adolescent outreach school health programmes on sexual and reproductive health. Questions about safe abortion and contraception come up on anonymous slips for discussion.
- She also encourages her students to work in urban slum areas. She worked in a project with 300 AWW that followed 30 women until PNC. Critical areas of health seeking behaviour were understoond. For example, nutritional advice is needed, while ANC is not 100%, women do access AWW, postnatal care is very less.

PADMAJA MAVANI, KIMS MEDICAL COLLEGE

- In October 2003 she joined the Gender and Medical Education meeting in Trivandrum. This opened her eyes and impacted her a lot to reflect on how as health providers, we are falling short. She is not engaged in community level work, but is interested in addressing gaps in teaching in medical colleges. She is working with CEHAT and FPAI on a gender and rights workshop and developing a resource book on reproductive health.

SUNITA SINGH, CHSJ

- She heard about the Coalition from being a Making Pregnancy Safe alumni. She previously used to work with Cehat. More recently, she has been involved in carrying out social audits in UP on maternal health, carrying out public hearings with ASHA and village women to enquire about access to Janani Suraksha Yojana. She is also involved in CHSJ efforts to support community monitoring for NRHM.

SUBHA SRI, OB/GYN, RUWSEC, MACARTHUR FELLOW

- She is working with communities on safe motherhood as part of right to health care. In Tamil Nadu services exist, but there are still important gaps, most notable with regards to quality of care.
- She is exploring how to work with women to improve quality of care as part of right to health care and reviewing evidence based practices for post partum haemorrhage.
- She also provides clinical services in a rural hospital in RUSWEC.

SUNIL KAUL, THE ANT, ASSAM

- He undertakes field interventions on one district, Chiran but also carries out capacity building across all states.
- He has been concerned about maternal mortality, since they first undertook a small study across 20 villages with the help of TISS interns. This was spurred by the death of two weavers from post-partum haemorrhage. They then found that in these 20 villages, out of 143 births, 6 women had died, two from post-partum haemorrhage.
- They published the results in the papers, held protests. However, the response from officials was that their sample size was too small and these deaths were thus seen as one off events. They need the backing of macro data to be more effective. How many women have to die before their deaths are taken seriously?
- In the last year NRHM has really taken off. Before they had 3 ANMs, now there are 16 ANMs. Many of their health workers became ASHAs. They formed an association of ASHAs. All three district managers are ex-TISS people and this has helped work progress. They have issued identity cards for ASHAs. As a result, within one hour the women get Rs.1400. in the three districts they work in. Every ASHA has mobile numbers of the five member team at The Ant to ensure that even Rs.500 for transport gets disbursed.

SANDHYA, SUTRA, HIMACHAL PRADESH

- She has been documenting neonatal deaths in one area. Presenting the data led to being involved in more formal verbal autopsy processes. Their work documenting neonatal deaths even in institutional settings shocked the authorities. Their work has led the authorities to ask them for further help.
- Earlier ANMs were not looking at this data. Now because of the trust developed with SUTRA staff, the ANMs rely on SUTRA to act as a medium for voicing their concerns to government doctors.
- Although Himachal Pradesh has an extensive health system, the quality of care of ANC is poor. Only recently have instructions been received to replace ANC instruments.

RAM KISHOR PRASAD, GENVP, BIHAR

- They are mainly known for their work on RCH and HIV. They also work with PRIs and the Women and Child Department on child trafficking.
- They have designed innovative training programmes for
    - 12-14 age group
    - eligible couples with 0-1 children and 1-2 children
    - in-laws, with special prizes for ‘good’ in-laws.
- They hold ‘welcome’ programmes for newly weds every year, which includes a five hour module with theory and games about RCH.
- They hold ‘Nukkad’ plays.
- The have a mobile van staffed with two doctors that conduct village camps.
- They try to do convergence with HIV.
- They have provided training of quacks on safe abortion. ‘Health Promoter’ certificates were handed out to them by the CMO.

SHRUTI PANDEY, INDEPENDENT LAWYER, NEW DELHI

- She has 14-15 years as a lawyer working in the High and Supreme Court. She sees law as an instrument of social change. She has been engaged with issues concerning reproductive rights, disability and HIV.
- She was involved in the case regarding the lack of GOI policy implementation around sterilisation, leading to unsafe and coerced sterilisations. Citing the right to life, the Court went beyond guidelines and lay down guidelines for consent, insurance policy, etc.
- Other cases that she has been involved with include the rights of HIV positive people to get ARV drugs from the public system, the rights of trafficking victims during rescue, under age

marriages and the implementation of the Child Marriage Act, sexual harassment and implementation of Vishaka guidelines.
- She is also concerned about assisted reproductive technologies.
- She has published a book on judgements regarding disability rights, collaborated with others on a book on reproductive rights and population policy and is presenting a paper at the Women Deliver conference.

SANGEETA, SAHAJ SISHU MILAP, BARODA

- On the basis of a baseline survey they have noticed differences in maternal health seeking behaviour between Hindu and Muslim populations in the Baroda slums. While Muslim women take medical services for ANC, they rely on home deliveries with the assistance of dais and quacks that give them injections.
- The situation of the urban poor is very grave. Half of them survive on a hand to mouth existence and yet have to rely on private health care services which cost a lot.
- They have encountered difficulties in seeking services for adolescents in government hospitals. Various visits are needed. Nonetheless, some doctors have responded in a helpful manner. They need to evaluate why this is so. Is it the presence of a NGO representative?
- They are working with adolescents to raise awareness about early marriage and early pregnancy. They go from slum to slum to present their skits.
- They have set up community development committees in 16 slums with the aim of empowering people to get services. This involves 10-12 people suggested as volunteers by the community to discuss about the issues, their experiences and suggestions. While these processes take a long time, as the core groups becomes stronger, change is possible.

DEEPA, SAHAJ SISHU MILAP, BARODA

- There are many questions from adolescents about safe abortion and contraception during the workshops on pre-marriage and early pregnancy. Three years ago, at the time of the baseline survey, girls wouldn't even speak to their mothers, but now they are speaking up and discussing things like RTIs with the SAHAJ fieldworkers.

BHARTI SHARMA, CMS, IIMA

- The Centre for Management Systems, works on various issues including urban health, HIV, maternal health. It focuses on management and training in different states.
- One of their projects focuses on promoting midwifery and EmOC, in collaboration with Sweden where they have a strong midwifery cadre. Sweden, brought down their maternal mortality rate 200 years ago within 40 years due to a midwifery cadre supervised by medical officers. They undertook systematic diaries of case histories done by midwives. Midwifery in Sweden has evolved into a professional cadre. All women go to a midwife for pregnancy, not to a doctor. Doctors are only involved for complications.
- IIMA is the coordinating agency working in collaboration with TNAI, Dr. Prakasamma (Society of Midwives), White Ribbon Alliance.
- Midwifery training in India is very weak and is only covered during 6 months in the nursing curriculum. They are working with three centres for midwifery training: West Bengal, Andhra Pradesh, Gujarat. They sent staff from medical colleges to Sweden to learn about evidence based practices and inter-personal skills. This one month in Sweden is complemented with 2 months of training in India. Now they are training 20 others in India. 3 such batches.
- They are undertaking research on operationalising EmOC, management skills, PNC, etc. What is the management structure in nursing in these states, which is the best structure? As a profession are midwives autonomous?
- A research study is exploring health policy in Vietnam, China, and India to review how far is evidence used, are policies integrated, are health system constraints taken into consideration, are there links to nutrition and other policies linked to SBA, abortion, adolescents?
- The Chiranjivi scheme promotes specialist care, so midwifery becomes irrelevant, 2 lakh rupees earned. ???

LEILA CALEB VARKEY, INDEPENDENT RESEARCHER, NOIDA

- She works for Vistaar which is a USAID project working in UP and Bihar aimed at taking evidence from knowledge to practice. It is a five year process. It has sought to focus on successful programmes in the area of maternal-child health and nutrition. It turned out to be difficult to find programmes with outcome or impact indicators and to find information on how to scale them up within NRHM. The issues they focussed on included anaemia, complementary feeding, home based neonatal health strategies, operationalising village health committees and delaying age of marriage. There are some programmes at the block level, but sometimes evidence is only available at a smaller level. Although they tried to include government programmes, most government programmes focussed on implementation without outcome indicators. They used a methodology to get experts to arrive at a consensus on the evidence base. It is not yet clear on how the evidence will translate into policy. Key indicators include effectiveness, efficiency and expandability. The have a manual documenting the methodology.
- Although the demand for public health nurse is high for the rural and urban poor, even upper class women find difficulties in seeking competent midwifery services that support birthing women, even with the advent of boutique nursing homes.
- Nursing schools are in a poor conditions resulting in poor role models. The situation of nursing is really alarming. The nurse patient ratio is warped. She found that only 1-2 nurses are posted to a labour room for 12 women. The expectations is that students will do all the work.
- In the private sector, nurses are further marginalised as women want doctors to attend them, as a result nurses maintain few skills.
- The plight of women in hospital where women are expected to give up control is extremely disconcerting.

RENU KHANNA, SAHAJ, BARODA

- Urban health is neglected. Although it was mentioned in RCH-2, this attention has not been followed through at the policy level. Baroda is among the Jawarhalal Nehru National Urban Renewal Cities, however there is no mention of health or education.
- Her organisation is working at the basti level in Baroda. They are currently feeding back the baseline survey results to community development committees for follow up action.
- JSA Gujurat after an invitation from the Government of Gujarat has been working on the Public Health Act, which aims to make the right to health care is justiciable, provide minimum gaurunteed services within state backed by redressal mechanisms.

LINDSAY BARNES, JAN CHETNA MANCH, BOKARO

- She has been reviewing how JSY is being implemented in her area. Often the money is delayed. The national norm is not being followed. Her own nursing centre is accredited for childbirth, so women receive Rs. 700 for giving birth there.
- There is an active Jharkand women's network: Matri Suraksha Adhikar Manch.
- There is a social audit of JSY in 5 districts being carried out with 200 beneficiaries.
- She visited the Dai Sangantan in Gujarat to know what their experience of Chiranjivi scheme has been??
- October issue of EPW??
- Prashant Tiwari has documented100 maternal deaths. This is about to be written up.
- She has helped to draft the safe motherhood module for the ASHA programme and the SBA module for ANMs.
- Governance and corruption are two key issues in Jharkand. Two civil surgeons have burnt their fingers due to corruption, as a result of which money is now being sent back unspent.

SHARAD IYENGAR, ARTH, RAJASTHAN

- ARTH focuses on service delivery, research, training and advocacy.

- They are undertaking a continuum of care service model that tracks a woman until one year after delivery. This enables them to more effectively address maternal morbidity rather than accept it as a part of motherhood.
- They are supporting their own ASHAs to be a resource for women who have difficulty with their pregnancy status. They provide counselling after testing, it is a sort of village level pregnancy advisory service (GPAS or Gaon ke pas).
- They undertake research regarding policy and programme implementation in Rajasthan.
- They are also involved with district level verbal autopsy efforts. While NGOs are able to do this, it is much more difficult to get government to do this.
- They have been researching neonatal practices linked to delivery through qualitative and quantitative data on irrational and traditional practices. Thus far they have observed 4 home deliveries and 4 facility deliveries.
- They undertook a situation analysis of 2 sample districts on abortion for the Abortion Assessment Project. They are now updating this work with secondary data on how many doctors and facilities registered for MTP
- They are involved in training nurse midwives, in an effort to try to minimise the reliance on doctors.
- In Rajasthan, JSY is not being provided for private organisation that do not have specialists.
- In terms of committee participation, at the district level they are on every committee; at the state and national level they are part of the steering group for NRHM, the ASHA mentoring group, the Advisory Group on community; at the international level they are part of the WHO advisory gender panel.
- An aim of theirs is to reduce overmedicalisation. Some level of medicalisation is good, but overmedicalisation sustains monopolies and waste.

SUNDARI RAVINDRAN, TRIVANDERUM

- She has three primary roles: 1) Honorary professor at the Achuta Menon Centre, 2) consultant for WHO and 3) founding member of RUWSEC.
- She has led the Making Pregnancy Safer courses.
- She has also led the Rights and Reforms training courses, in India, Indonesia and South Africa. The one in Indonesia involved Human Rights Commissioners of the South East Asian region.
- As part of WHO's gender and reproductive health systems course she has been involved in training the Government of Malaysia. This has involved working with specialist consultants, MOs, midwives and ANMs working as a team to critically examine how to improve maternal mortality where it is only 30. They looked at management practices and gaps in respecting the rights of women, especially unmarried women.
- She is interested in the intersection of reproductive health and mental health. She is collaborating on some courses on gender and mental health in Pune.
- With RUWSEC she has been involved in a study on equity issues in mental health and its links with caste, class, gender and reproductive health. They found that SC and low income groups used public institutions a lot, which were significantly cheaper than the private sector, even if they paid something to get access.
- She developed information packs on medical abortion in a question and answer form, which is on the website for the International Consortium for Medical Abortion.
- She is trying to help meet the gap for credit for rural poor women. In Tamil Nadu, JSY is Rs.6000, Rs. 3000 for ANC and Rs. 3000 for delivery. RUWSEC gave money to 10 self help groups to see what reproductive health needs could be met. 65% goes to RH, 35% other family emergencies and child health, everyone has been repaying 12% interest.

ASHA GEORGE, INDEPENDENT CONSULTANT, COCHIN

- She is part of a research team at IIM working with Mahila Samakhya in Koppal district, northern Karnataka on safe motherhood. While she was living in Koppal, she started to

document obstetric emergencies. In 6 months she documented 12 case studies of which 9 women died. Almost all these women were younger than her and died despite accessing multiple health providers.

- This research has subsequently been used as the basis of a street theatre campaign. It is a three day process, where the play is delivered in instalments in the evening with lots of other entertainment and village level activities involving maternal health and social work. Nobody knows whether the protagonist Kusuma dies or not until the last evening. So this is a form of ongoing debate during the campaign process. Finally when she dies, Yama stands next to her and explains that she is not to blame. He calls out one by one each person that was linked to her, who failed to take responsibility for her health and life. It is a powerful communication tool that emphasises the morality of maternal mortality and women's rights. It is also a powerful way of feeding back research to communities.
- She also has started to review verbal autopsy tools. The Government of Karnataka revised its forms, but it relies on a two page form that is very inadequate. UNICEF Raichur is piloting the MAPEDI tool.

ORGANISATIONAL ISSUES

Sharad Iyengar Chairperson

SHARAD

The Coalition formally came into existence in January 2006. Although the Coalition functions as a unit of ARTH, ARTH's governing board has delegated the management of the Coalition to a separate Steering Committee.

GENERAL DISCUSSION

If we assume that in Udaipur during January 2006 was when the original SC was constituted, they are already half way through their term. Four new members need to be elected so that a total of nine members can be included in the SC. Renu, Sundari and Dileep will be renewed. Sharad and Asha are ex-officio steering committee members. There is a need to formulate election procedures for the sake of transparency.

Members can list the Coalition as an affiliation when they are fundraising for themselves. If state chapters raise their own funds, they need to administer it themselves.

We should encourage membership, rather than discourage it. Individuals working for funding agencies can join as individuals, but not as organisations and they cannot be part of the SC. The only current exception is Population Foundation of India, which acts as a funding and implementing agency at the same time.

Although it is important to have even representation according to region, age, sex, caste, etc., we will not impose quotas, but rather keep these needs in consideration.

Currently, it should be mentioned that the office of ARTH will retain 4% as admin charges. No need to put, it is a budgetary decision??

Procedures for annual general meetings need to be formulated stressing that accounts be presented x days in ahead of time.

An organisational task force was set up to further develop some of the emerging suggestions:

- Membership
  - Donors can be individual members, but not organisational members
  - Nature of membership: coalition should encourage membership. One will still need introductions and pay a membership fee.

- Listserve should be broader than membership, but separate the two. A separate listserve will be started for members only to discuss and share organisational related issues.

- SC
  - Either elect 7 new members or ratify 3 members and elect 4 more members.
  - Need to ensure the participation of younger people
  - Need for by laws specifying how elections are held, how meetings are run, how many from one organisation can be members, etc.
  - ARTH can not be office bearers
  - SC will meet twice a financial year
  - Financial transfer of money still needs to be sorted out
  - Coalition not a legal entity, need some years as pilot

- Discussion about travel, accommodation, and location of the meeting:
  - Those who can't cover the cost of their travel the coalition will cover the partial cost, or accommodation or the cheapest air fare.
  - The announcement of the meeting should be made as soon as possible so that people can raise the fund for their travel.
  - The location of the meeting should be shifted and move around the places.
  - The meeting could be organized in central places where we can get cheaper places and easier to travel.

Asha made a presentation of the current grant proposal, listing out the main activities proposed and the donors approached. So far IWHC has provided partial funding of USD 50,000 for two years. We are still seeking support from Sir Dorabji Tata Trust and the Packard Foundation. The MacArthur Foundation said they would be interested but only in their next funding cycle. The budget was circulated and is annexed to these minutes.

Sharad mentioned that there is seed funding from the International Consortium for Medical Abortion for regional networks. There is interest in supporting a South Asian network (India, Nepal, Bangladesh).

Sundari asked about how we balance the need to respond rapidly with the time required for democratic consultations? How will we balance reactive responses with proactive activities. The Coalition will gain visibility through its Steering Committee, the membership, participation and hosting meetings, rapid response. How will we manage the expectations others may have of us?

Leila added that perceptions about the Coalition by outsiders might be different from the perception of its members. For instance, outsiders have noted that it is a group of researchers, not those involved in advocacy.

Sharad was concerned about the perception that the Coalition is not talking enough. Leila countered that visibility was not the reason why she joined the Coalition. The opportunity to link with others was more important. Sunil asked whether we aimed to form a coalition that was moving collectively towards a goal or wanted to build a network for peer support? Does the mission become the vision? Or are we held together by pure optimism? Subhasree felt that the two functions need not be mutually exclusive. Shruti added that one's work will speak for itself, which will take its own time to develop. Leila agreed that a common activity will galvanise interest and active membership, as people will feel good at being part of something. Sandhya agreed that we need common issues to take things forward. Lindsay suggested that when we make our position clear on certain issues that will attract or detract people.

Sunil suggested that others may be better able to present an issue than us. For example, Amartya Sen. We would then need to plan for this. ??

Renu wondered whether we are building local level coalitions or national level coalitions, and whether national is being equated to being in Delhi. Sharad felt that it was important to keep presence at both national and state level, as the centre can only offer guidelines, after which states have substantial discretion over implementation. Leila added that the reason why the centre had not put bedsheets in its guidelines was because it left them open to the expectations from states that the centre would fund that too. Asha suggested that we don't need a base in Delhi for us to be in Delhi. We could instead be more strategic in the way we ally with others and share our information. Lindsay concurred that with the White Ribbon Alliance, they are emphasising setting up state level chapters, as being based in Delhi can be seen as a weakness.

Manju stressed that her interest was in state level advocacy, as the context of Kerala cannot be compared to other states. She felt that the function of bringing together different constituencies was very important. For example, in her own work she is part of the women's movement and at the same time is a government doctor. Shruti also agreed that what she liked about the Coalition was its diversity of skills, expertise and geography. Leila agreed that she also felt the Coalition had linkages across the nation, especially linking those in the north with the south, which is not usual. Bharti felt that it was very important to work with different stakeholders and she felt that the Coalition could enable that.

Padmaja asked whether she should be a part of this forum, since she doesn't do either community level, state or national level work. She works at the level of hospital administration, which might be too micro-level for this Coalition. Sundari disagreed as she felt that tertiary care issues were very important given JSY, institutional deliveries and quality of care concerns. Sharad agreed with Sundari, as he felt that a reason why oxytocin injections are used in rural areas, is because people are learning from the way in which oxytocin is delivered via drip in hospitals. Furthermore medical students need to learn about issues like maternal mortality.

Renu asked that if this is our vision, then how do we expand membership? Asha suggested that RCH officers may be an important group. Sharad agreed that they may in fact be better advocates than us, if the issues appeals to them. At the primary health care level in Rajasthan they found that women were being discharged soon after delivery and enduring uptp 20-30 pelvic examinations. Thise is not good practice. Subha Sri mentioned that positive women's groups are concerned about health care, our issues might appeal to them. Sundari suggested that the Coalition will grow gradually from all these different groups.

Sharad stressed that the ability to communicate in English over email is important along with the ability to see the relevance of state and national level work. Lindsay stressed that perhaps email is not good enough. Sundari suggested setting up a system that x person calls up y number of people. Shruti stressed that communication cannot be one way. Members need to reach out to each other. Leila asked about the different possible structures that could facilitate more communication. Renu and Sundari suggested that this might mean resources to support visits to one another.

ELECTIONS

The terms of Sundari Ravindran, Renu Khanna and Dileep Mavalankar were renewed. Nominations were sought from the floor. We also circulated a notice for election via email prior to the meeting to ensure inclusion of those who could not attend. Abhijit Das was the only one who expressed his interest over email, although he could not attend the meeting due to another professional commitment. After nominations were finalised, four new Steering Committee members were elected: Leila Caleb Varkey, Lindsay Barnes, Sunil Kaul and Abhijit Das.

The election tally is as follows:

Shruti 6
Sandhya 7
Padmaja 5
Abhijit 12
Lindsay 14
Lindsay 14
Sunil 10

Election ByLaws? for the Coalition

Elections for seven Steering Committee members (as 2 of the nine being ex-officio) will be held every two years (or more frequently as per necessity) by the General Body. These will be organized by the Coordinator.

At least 3 months before the date of an Annual General Body Meeting, vacancies arising out of the turnover of SC members will be notified to all GB members by post and by email. Alongwith, nominations (incl self-nominations) from all GB members will be sought. Written acceptance from nominees seeking election will be sought before the date of AGBM. Based on this feedback, a letter will be sent to all GB members one month in advance of the AGBM requesting them either to be present at the AGBM for electing the nominated GB members to the SC against the vacancies OR send a written letter authorizing another GB member (by name) to vote on her/his behalf. Members not exercising any one of these options will forfeit their right to elect members to the SC.

At the AGBM, the elections to the SC will be held at a time that ensures maximum participation and will be held by secret ballot that will be opened and counted in the presence of the GB members. Membership present at the AGBM will meet the quorum for the elections.

2-3 vacancies will come up for elections every two years. No SC member can continue for more than 6 years and the minimum tenure will be 3 years from the date of the first AGBM.

The list of SC members whenever revised will be displayed on the website and notified to all GB members and funders at the earliest.

SAFE ABORTION

Leila Caleb Varkey Chairperson
Leila introduced the session as one that is neglected due to ideology, as well as socially silenced by shame for women.

GROUP SHARING

ASHA

- She was struck how when one works on maternal health, one can easily neglect safe abortion, even when one is not ideologically opposed to it. She hasn't worked on safe abortion issues yet but she had two primary concerns: abortion is primarily accessed through the private sector which is completely unregulated and the framing of sex selection is threatening to restrict women's rights to access safe abortion.

SUNDARI

- We need to work towards humane abortion providers. There is an impression among medical students that abortion is only done by heartless and money minded doctors. The younger generation of doctors needs to be trained and motivated to perform abortion. Some providers only do abortions if it is associated with family planning and in the interest of the country. All other abortions are deemed to be not ok. Those who do provide abortions can be ruthless in

charging for them. We need to work with health provider's attitudes. One young doctor in a Tamil Nadu nursing home proudly explained how she counselled women seeking abortion by showing them the fetus in the ultrasound and asking them if this was the baby they want to kill.

- Currently, women's access to abortion is not guarunteed as it is dependant on medical providers. However, both women and providers are using varying methods of medical abortion, this is changing the possibilities of accessing abortion.

SHARAD

- The role of civil society is a source of considerable embarrassment. As civil society we are either ignorant or we don't care. Safe abortion has never been on the table enough. Whenever I make a presentation on safe abortion, people still need basic definitions. In order for us to be effective, we need to know more than the little bit that we currently do. Currently, women's rights to safe abortion generates evasion rather than a movement.
- In Udaipur due to the heavy rains, aborted female foetuses were found floating in the lakes. This has led to huge controversy and a dangerous blurring of sex selection and abortion.
- Anti-choice elements are active in Udaipur. There is a PIL in Rajasthan that challenges the MTP act. Religious groups coming together on this issue. They are not yet very organised, except for their consensus against sex-selective abortions.
- -Providers can be highly pragmatic. When we tried to hire a doctor to provide safe abortions, during her interview she explained how she discourages women from abortions. When we explained that the objective of our services was to address women's needs to access safe abortion, she turned around and said that wouldn't be a problem.
- Right now government bureaucracy is more supportive than civil society. Bharti responded that the bureaucracy is perhaps neither supportive or not supportive, they are doing their job in a routine casual manner. Renu suggested that maternal mortality is the larger issue for bureaucrats, not safe abortion. The Joint Review Mission for RCH2 highlights the neglect of safe abortion.

RAM KISHOR

After Haryana, Bihar is one of the states that has one of the highest numbers of sex-selective abortions. Sex-selective abortions are due to gender discrimination. In the state mostly people are going for ultrasound to find out if the fetus is boy or not. The main concern is to stop sex selective abortions. Due to non availability of sex selective abortions at the private and government hospitals people are approaching quacks to get rid of the girl fetus. There is a need to identify such abortions and to take them to the registered centers. It is evident that even registered providers do the sex selective abortions. The ultra sound is done in one center and abortion is done in another.

LINDSAY

- Bokaro district has 40 registered abortion facilities. We have a very active MTP committee of which I am a member. Other districts have no registered facilities. Ranchi the capital city has somewhere between zero to 40.
- None of the govt hospitals are providing abortions, though the same doctors are providing these services in their private centres. It is a money making enterprise.
- Women don't know that abortion is legal. Nor is there any counselling for contraception. Women don't know the risks involved with repeated abortions and the doctor is the last person to tell them due to profit incentives.
- The Church is quite strong and people can walk out when you raise the issue of abortion.
- With restrictions on late second trimester abortion, young girls are going to be hit the hardest. Private providers are charging them Rs.10,000.
- Some providers see sex-selective abortions as social service that helps to avoid the further pressure on women and daughters.

BHARTI

- When working with policy makers her experience is that issue of abortion is not monitored at all. It is very casually treated in review meetings.
- At the facility a woman seeking an abortion has to register her name in 10 places, so there is no possibility of confidentiality. Relatives are also asked to give consent, which is problematic.
- A lot of questions are being raised by the state about sex selection, so there has been a decline in abortions. First trimester abortions are mainly in the private sector, while second trimester abortions are mainly in government facilities.
- There is a place where women go to worship and they provide abortion services for free as they have nurses working there. ???

DEEPA

- Adolescent girls get married early. They can't afford private abortion services so they go to the government hospital, but the provider attitude is very bad as a result adolescents are made to go from one table to another and get harassed. As a result, they end up accessing quacks. If their uterus gets damaged, then they can't conceive again. We need to aim at improving government hospital services.

SANGEETA

- Even a Chiranjeevi doctor got in the papers for sex selection. So who do we trust?

BANEEN

- She participated in a Youth Coalition advocacy training workshop in Delhi last April.

RENU

- Access to safe and confidential services is crucial. Mothers are willing to spend money and travel even 100km away with their young daughters for confidential services so that no one knows that her daughter needs an abortion.
- We need to emphasise that getting a safe abortion is not a criminal activity. What is contained in the MTP act is important to know at the community level.

SANDHYA

Advocacy issues are:

- Abortion is linked to family planning
- Due to sex selective abortions, MTP is being put at risk. Doctors are being blamed most of the time. There is an overlap of MTP and PNDT.
- Unmarried girls and access to safe abortion.
- Monitoring and tracking of each pregnancy, do woman want this?

ANUBHA

- She has been looking at implementation of the law or working on issues from a legal perspective. She has worked on the pending PIL at the Supreme Court addressing safety in sterilisations.
- We need to address the link between PNDT and MTP.
- The attitude of judges needs to be addressed. A recent Supreme Court judgement stressed that it was mental cruelty to the other spouse if a woman resorted to abortion in order to refuse to have children.
- The media should be addressed and guided into not using certain antiabortion words.

SUNIL

- Women seeking abortions are looked upon with suspicion. Society both looks down on them as well as profits from them. Women end up paying Rs.1000 per month for abortions.

- What are the human rights of the foetus?
- Medical abortion is available but expensive. Three tablets cost Rs.1000. So women use only one tablet, risking incomplete abortions that subsequently require hospitalisation.

SUBHASRI

- Recently there was a meeting in Tamil Nadu between state government officials and a network of organisations working on sex selection with the aim to review the MTP act. They wanted to add restrictions on second trimester abortions for unmarried women. They want the sex of foetus to be documented and be made public. The only abortion that is acceptable to them is if contraception failed. Sex selection groups are talking about the right of the unborn child, discussing when does the child become viable. Anti-abortion elements were participating in the meeting. One retired OB/GYN who is a government professor stated that ethics and MTP do not go together right at the beginning of her presentation.
- For government officials, abortion is only seen from a family planning perspective, not as a women's right to abortion.

PADMAJA

- Even in government facilities, services are not free, due to the lack of supplies. Women end up paying Rs.700-1000 for first trimester surgical abortion by paying for prescribed gloves, polydrips and antibiotics. There is no doctor's fee as such.
- Abortions are provided at the convenience of the provider rather than of the patient. Women have to come multiple times, pass an anaesthesia fitness test. Comes to OPD then 2 weeks later, anaesthesia fitness. If a woman is anaemic, her abortion is delayed until her haemoglobin improves, by which time she finds herself in the second trimester of pregnancy.
- Women's dignity is not treated as important. They are seen simply as a pelvis with pelvic organs.
- Providers are divided into two groups in the hospital. One group is more liberal, they offer abortion services but do not talk about sex selection. However, there are coercive practices with regards to contraception. Nonetheless the number of abortions and tube ligations has gone down. Technically if no contraception is not used, the abortion is not legal under the MTP act.
- Procedures are done and taught by the most junior doctors, so wrong practices go on. This also applies for deliveries, forceps, use of uncharted drugs, all leading to complications.
- Journalists who expose the name of a unit where complications occurred make doctors go on the defensive; it is not a constructive move.
- Sterilisation should be done with recanalisation, but they do the procedure to ensure no failure. This is a violation.
- The plight of adolescent girls in the hospital is terrible

SHOBHA

- She is concerned about adolescent girls and abortion. There are many reproductive health issues that need to be addressed for adolescents, especially after garba time as girls go out with guys more at this time.

SUNITA

- She is concerned about unmarried girls and abortion. She found that in UP and Bihar, as these women are not married, they are denied services. Society questions why they get pregnant and believe that they need a harsh abortion to teach them a lesson. Needing an abortion is seen as a punishment for enoying sex. Being pregnant is seen as a gift from God. The film Silent Scream makes abortion very disturbing.

SHRUTI

- There is a lack of facilities in government that provide access to abortion, due to fees or denial of care.

- Women face a lot of stigma and are not aware of their rights.
- The right to abortion has not been articulated within women's and reproductive rights movements in India.
- Women's autonomy in pregnancy overall is constrained in India, whether it is with regard to assisted reproductive technologies or coercive population policies.

LEILA

- Working within the context of USAID maternal health programmes one is not able to talk about safe abortion openly, so it is hard to push government to improve. Donors not supporting safe abortion leads to neglect by governments, as bureaucrats are not always aware of the subtleties.
- Checklists to ensure quality assurance of PHCs and CHCs was successfully developed. We need to ensure that safe abortion services are included in this.
- depro provera research study in Parivar Seva Sanstha operations research to analyse how many doses, large number of one injection use post-abortion use, so understood only in this context????
- When an unmarried woman is brought in by a married man of some relation to the girl, or it is very early in the relationship so it is not possible for her to negotiate contraception. Even when men are present, they are not recognised as a couple, as the main focus is on the woman. These are missed opportunities.

PRESENTATIONS

- Padma presented findings from the Abortion Assessment Project
- Sharad provided an overview on safe abortion
- Shruti presented on the issue of safe abortion and sex selection

GENERAL DISCUSSION

Sundari clarified that we should not use the term foeticide, as it suggests that abortions are acts of homicide.

Asha asked whether we should advocate for women's rights to abortion or something broader that advocates for women's rights, reproductive autonomy, right to self-determination. A broader platform that affirms their rights to privacy, dignity, safety, quality, affordable services etc. The right to abortion is very narrow and assumes that other enabling conditions are given, when they are not. Renu agreed that arguing for a right to abortion may be counterproductive. She stressed the need to frame safe abortion as a public health imperative. Sundari suggested that abortion also needs to be seen as an issue of gender bias, because only women need safe abortion services, so if these are denied, it is an issue of gender discrimination.

Shruti argued that government is relying on legal measures to address a social issue. We need to address the social response to abortion and not short cut to legal measures. Even if abortions are made illegal, they will continue, so we need to broaden the base for legal abortions. We need to use all arguments. She felt that we shouldn't take this issue to the judiciary right now, but if we do later, we need to frame it as right to health.

Sharad felt that it was good to focus more broadly on women's right to autonomy or self-determination, as women are always being blamed, whether it is for sex-selection or still births.

Sharad noted how social norms have changed. Infertility and having daughters only are no longer things that we leave to fate. There is a popular understanding that these are things that we no longer have to accept, they are things we can control.

Sharad suggested that there were three strategies to address the abortion and sex selection issue

1) Address the anti-abortion elements in the sex-selection group
2) keep sex selection and abortion separate
3) use momentum of sex selection to ensure access to safe abortion. Argue that until and unless safe abortion is accessible and regulated, sex-selection won't decline.

Sharad sought to clarify to the group whether they think an abortion is defined by the viability of the foetus or by it being an unwanted pregnancy. Is there a right to be born? Although we have illegal sex (rape) and illegal marriage (under-age marriage), we do not yet have illegal pregnancy. Yet some times even the most basic conceptual distinctions get blurred.

Sharad also stated that off-label use is not understood as illegal. Another key concern is that safe abortion is not covered by health insurance plans.

Leila raised the issue of how access to safe abortion has become more restricted now that post-partum centres have become discontinued.

Lindsay reflected on her experiences of using medical abortion in her clinic. She felt that medical abortion did not work well in comparison to manual vacuum aspiration. The cost is around the same for both. Women are anaemic and so are worried about medical abortion. Furthermore, with medical abortion 2-3 visits are required, whereas women want one visit. They want to be assured that the abortion is complete and do not want to monitor how much they will bleed.

Sharad responded that there is a learning curve when using medical abortion. If women and communities are used to manual vacuum aspiration first, they prefer it, as otherwise bleeding continues and interferes with women's ability to cook, increases husband's complaints etc. However, in a second clinic in a more prosperous area, medical abortion was introduced as the only available method. Women in this area wanted a pill as they wanted to avoid surgery. Also to do manual vacuum aspiration, a woman's cervix needs to be primed with misoprostol, which can take two hours. If a woman arrives close to closing time it is difficult to provide manual vacuum aspiration, while it is still possible to provide medical abortion. Anaemia is more dangerous at time of delivery than for abortion.

There was a discussion about what distinguishes between an induced abortion, spontaneous abortion and miscarriage. Padmaja noted that in the hospital, according to the MTP act abortions take place only prior to 20 weeks. After 20 weeks it is called as induced labour.

Leila asked whether we have evidence in India that abortions are causing maternal deaths. Or is it that most current abortions are illegal but safe?

NEONATAL HEALTH

GROUP SHARING

ASHA

- It is striking that some of the things that have been proven to have a big impact on neonatal outcomes, are very simple actions done within the home. However, they are very hard to change because of traditional and cultural practices, e.g. norms around breastfeeding, bathing the baby after birth, keeping the baby separate from the mother, etc.
- Some of these things are even hard to research. Everyone knows the politically correct answer and responds that they initiate breastfeeding within 30 minutes of birth, but this is not necessarily actually done. So awareness is there but it hasn't changed practice.

SHOBHA

- Neither immediate nor exclusive breastfeeding happens. Nor is kangaroo care followed.
- Gender issues start at birth as male babies are admitted faster than female babies.

PADMAJA

- We compartmentalise maternity care so that the OB/GYN is free of responsibility for the neonate, who is looked after by the neonatologist. If the later specialist doesn't arrive in time, no one looks after the baby.
- Information has to be there that in-utero transfer is better than delivering early if referral is required for the neonate. But then there needs to be a good network of central and peripheral facilities.
- When we undertake an audit we need to have the peripheral facility staff there too for learning and better practices to be mainstreamed.
- Health providers assess the potential financial burden and force parents to not intervene because the baby is not going to do well. How far should that financial burden be eased?

SUBHASRI

- Providers are not trained in the basics of neonatal resuscitation.

SUNIL

- -Infant mortality is still important, despite the current concern about neonatal health.

SANDHYA

- -Awareness levels have to be addressed among programme managers and implementers
- How do we change cultural practices?

RENU

- Continuity of care is essential. You can't split who is helping the woman to deliver, from who is looking after the child. There is need to integrate these.
- Neonatal deaths are often not registered, this results in under-reporting.
- Traditional practices need to be documented and validated from different perspectives. For example, warming the placenta is one way to resucitate the baby. What are the traditional practices that have worked, can we document these?

LEILA

- From the Vistaar project she learnt that the best interventions work at small scale working closely with communities. Scaling up is therefore a challenge.
- There is a disconnect between neonatal care for which policy makers are focussing on home based interventions and maternal health which is shifting to facilities. Institutional births are meant to be safer for mother, but what happens to the baby during the 6 hours spent in transport and with no continuity of care after reaching home.
- In 1999 she did some work using participatory approaches for communities to understand neonatal deaths. She learnt that neonatal deaths are linked to supernatural and religious beliefs. Yet medical practitioners don't engage with this world of the evil eye, nazar, etc. There is a big gap between traditional practice, home practice, medical practice

BHARATI

- There is a shortage of paediatricians. At least with OB/GYN, medical officers are being trained to caesarean sections.
- Even in hospitals evidence base practices are not being followed.
- High numbers of still births are macerated due to complications and the poorly functioning referral process.

SHRUTI

- There is an over emphasis on institutional delivery in NRHM. In urban areas there is no support due to the lack of TBAs.
- Practices like apgar and testing cord blood are not done

RAM KISHOR

- In Bihar only 4% of deliveries take place at the PHC level, none take place at the subcentre.
- Training of health functionaries happens in name only.
- Disposable delivery kits are sold at a subsidised rate to TBAs, who use them as a source of income. It also helps to collect information on neonatal deaths??

SUNDARI

- Currently, the best link between maternal-neonatal health is low birth weight, We need to build the evidence base to expand beyond that. Need to look at the impact of the mother's mental health on the neonate. For example, what happens in those cases where women don't want another girl child? What are the impacts of neonatal outcomes on the health of mothers?

LINDSAY

- We need to document better the use of oxytocin during labour and its impact on neonates through for example, birth asphxysia.
- The problem of referring for neonatal care is acute as there is no neonatal care unit in district. There is a hospital in West Bengal, but doctors resent poor patients from Jharkand and don't attend to them properly.
- In the Chiranjivi plan, it's the dai that provides continuity of care as she accompanies women to the facility.
- Mothers who have still births are given the least consideration. They are denied the protective traditional practices that usually take place around birth. They have to get back to work immediately and are blamed for the outcome. The still birth is seen as her fault for eating certain food or going to a particular place.

LEILA

- Her doctoral research examined the effect of gender on postnatal outcomes. She found that parity matters when contributing to gender bias favouring the boy child.

PRESENTATIONS

Sharad provided an overview on neonatal health

Sandhya spoke about the experience of SUTRA undertaking neonatal verbal autopsies as a Mother NGO in two districts:

- Mother's ages ranged between 20-30 years mostly with first births.
- All mother's had at least three ANC checkups and all had institutional deliveries.
- Yet between May-December these births resulted in 16 neonatal deaths, 12 of which were male. Government officials seem to look at these figures from a demographic perspective.
- There is a shortage of specialists at the district hospital and equipment is not used.
- The quality of antenatal care is not well documented. Postnatal visits do not happen.
- According to private doctors, dais bring women in a too late stage of labour.
- Neonatal deaths and still births are sometimes not reported, as it can turn into a blame game. Government health system can feel threatened by the data. System starts to react once someone starts asking questions. Highlighting positive cases is also important.

GROUP DISCUSSION

Sharad expressed concern about how much of midwifery training includes neonatal care. TBAs cannot provide neonatal health, as it takes 8th or 10th standard education.

Lindsay asked whether focussing on home based care without back up from facilities is a cop out? Sharad responded by saying that home-based neonatal care is able to show improvements in health outcomes without improving health systems.

MATERNAL HEALTH

VERBAL AUTOPSIES

Sunil wanted to know more about verbal autopsies for maternal deaths. How do we determine cause of death? How is it done properly to ensure that it reflects maternal mortality rates?

Asha shared some of the tools that she had been collecting and spoke about what she understood about the UNICEF MAPEDI tool. She felt that it was something that had many tensions within it. On the one hand it was meant to be a tool for communities to use to spur local action, on the other hand it is a quantitative tool that draws its strength from aggregation at the state or national level. Her own experience of undertaking qualitative work documenting maternal deaths for local change, was that the strength of the process is not determining the biomedical cause of death, but highlighting the process of seeking care and identifying key things that can change at the local level to prevent the next emergency.

Sundari commented that SUTRA was tracking every pregnancy with a format. This enabled them to document the process of seeking care, irrational care and the cost of care.

Leila reported that she had worked on a research study that resulted in a large study on maternal morbidity for central UP. A study on PPH and one on oxytocin use has been written up.

GROUPWISE SHARING

GROUP 1

- Lack of quality services in facilities is a major concern, whether it be staff, equipment or drug shortages.
- In Jharkand 90% of deliveries take place at home, but they are now supposed to aim for 100% institutional deliveries: where are the facilities?
- In urban Gujarat slums, home deliveries take place with the assistance of untrained personnel. Programmes like Matre Diwas that aim to provide antenatal care at your doorstep are not functioning.

GROUP 2

- The needs of special groups need to be addressed.
- The status of women influences how seriously their maternal health is taken.
- In Tamil Nadu the attitude of health providers is a critical factor with respect to quality of care concerns.
- In urban slums so much of health care is in the private sector leading to high amounts of out of pocket expenditure.

GROUP 3

- There is a concern about the consequences of taking such a blanket approach to institutional deliveries, especially when facilities are not ready.
- Quality of antenatal care leaves a lot to be desired.

- There are various loopholes in the NRHM document.
- Need to link JSY with the right to food.
- JSY faces different problems in different states.
- The needs of dalit women are not addressed.
- Mass programmes are undertaken without understanding people's realities.
- Not enough attention to women's own understanding of their bodies and experiences.
- Violence against women in the labour room needs to be addressed.
- We need to examine budgets better.
- Use and misuse of oxytocin needs to be highlighted.

GENERAL DISCUSSION

Sharad asked whether we are concerned about implementation of JSY without considering whether institutional delivery by itself has any impact on maternal-neonatal health outcomes. Renu felt that JSY should be a maternity benefit delinked from institutional delivery and provided at the time of antenatal to ensure maternal nutrition. We also need to distinguish between what is a safe vs. institutional delivery, they may not always be the same thing.

Lindsay noted that the Supreme Court mandates Rs.500 of JSY for food. However, the issue in her district is not what the amount is allocated for but getting it in time. She also felt that JSY could be a distraction since it might not contribute to maternal health improving. There has been a lot of frustration from people in the community monitoring of NRHM in trying to access JSY. Would it not be better to just focus on improving service delivery?

Sunita wondered what was left for women to receive in the end after everyone gets a cut of JSY. Leila clarified that JSY was devised to address three concerns: nutrition, and the costs of transport and institutional delivery. But as a government scheme it will change through its implementation and then new schemes will come and go. So lets focus on the issues.

Sharad felt that it is unethical to use public money for deficient services. He also noted that in order for skilled attendance at the time of delivery to be effective it needs an appropriate environment. We need more evidence about comparing skilled attendance at home vs facility. Some homes don't even have water.

JSY could also be counterproductive, if women access bad quality of services because of it. Bharti concluded that JSY and family planning were similar in their passions and in their mistakes.

Neglected issues in maternal health, such as maternal morbidity, women's nutritional status, etc. Should also receive attention.

Sundari summed up the discussions on maternal health by linking them to health system functioning. Maternal health requires a range of inputs, ranging from soft managerial aspects to infrastructural elements. Both determine quality of care. More resources are required but they also need to be spent properly. Is JSY the best use of existing resources? Costs of care and the irrationality of certain health practices are also a worrying trend. Finally the concerns of vulnerable groups, like those living in urban slums, dalits, younger women cannot be forgotten.

WALLPAPER

MATERNAL HEALTH

Advocacy Issues

- Delink institutional delivery from JSY

- Maternal health of vulnerable groups
- Accountability of providers
- Affordable and accessible maternal health care services
- TBA as key providers
- Verbal autopsy involving NGOs
- Monitorable action plan for improved nutritional status of women and child

Trainings
- EmOC
- Attitudes of health care providers
- Midwifery model
- tBA training

Study/ Evidences
- multi centric data collection on maternal mortality, near misses
- Costs
- Costs of skilled birth attendance
- Systemic barriers
- Examples of positive outcomes

SAFE ABORTION

Advocacy areas
- Wide use of safe technologies for medical abortion
- Bring together those against sex-selection or working for the implementation of the PCPNDT act and those working for women's access to safe and quality abortion services so that there is a convergence on advocacy
- Implementation of MTP act on ground level
- Health provider attitudes
- Create advocates among doctors
- Long term effects of unsafe abortions
- Improve the status of women and improve their right to abortion
- Society's right to curtail women's rights to abortion should be curtailed, women are the sole decision maker
- Advocate with media about women, abortion and reproductive rights
- Against monitoring pregnancies as a means of curtailing abortion

Evidence
- Assess the teaching practices of safe abortion
- Availability of infrastructure
- MTP and sex-selection abortions
- Women's perceptions of medical abortion
- Document individual cases of violations
- Son preference in society

Training
- Upscale training in safe abortion for providers all levels
- Raise awareness of communities on safe abortion and availability
- Adolescent girls (adult girls) for accessing safe abortion

NEONATAL HEALTH

Advocacy

- Set minimum standards and protocols on care for neonatal health systems for referral systems
- Implementation of IMCI
- Advocacy for strengthening PNC
- Home based neonatal health care
- Continuum of care

Evidence

- Strong links between maternal and neonatal health: integrated care model
- Link between poverty and neonatal health care
- Irrational use of oxytocin and neonatal health
- Oxytocin and ints impact on health and institutiona;
- Socio cultural attitudes and customs
- Stauts of neonatal health services and provider skill at all levels of health care
- New born complications and long terms outcomes
- Deliveries under JSY and non JSY comparing outcomes
- Gaps between policies and implementation

Training

- Health service providers for neonatal home care

GROUP DISCUSSION

Renu asked which were the points on which individuals might want to do on their own and which were the issues meant for collective action.

Sharad suggested that even if we are not able to work on all these issues, we need to articulate our position, so that others can take the agenda forward. Sundari suggested a broad framework of accessible, affordable and accountable services. Lindsay added that any position statement should mention women friendly, quality of care issues. Sharad wanted more specific details.

Leila noted that the group already had a consensus that JSY was distracting attention from improving services and addressing the needs of maternal survival and well-being despite obstetric complications.

Lindsay wondered whether we should talk about safe or safer. She argued that sometimes gold standards are so removed from ground realities, that they become obstacles to better care rather than facilitators of it.

Sharad wondered whether our focus is on changing law and policy or addressing access to services.

TASK GROUPS

1. National abortion campaign and advocacy workshop
2. Advocacy for maternal-neonatal health
3. Organisational issues

SAFE ABORTION

(Leila Caleb Varkey, Renu Khanna, Sharad Iyengar, Ram Kishor Prasad Singh, Anubha Rastogi, Padma Deosthali, Asha George)

1. As a first step in developing a position statement or paragraph on the Coalition's stand on safe abortion, we started outlining certain key assertions:
   - Cast the right to safe abortion within a broader frame of reproductive autonomy/ agency.
   - Acknowledge concern about the declining sex-ratio and call for the implementation of the PNDT act. At the same time call attention to keeping MTP separate from PNDT.
   - Efforts to curtail abortion, whether by providers counselling women against such an action or by restricting services, does not mean that women will not seek abortion. It means that women will be further jeopardised by resorting to more dangerous and expensive methods of abortion.
   - Women most in need are those whose rights are most easily violated, because of their age, caste or class background. Protecting their reproductive rights is a moral issue based on our belief in social equality.
   - Women can't be compelled to continue pregnancy against her will or to abort against her will. We need to regulate the users of technology, not increase the control over women.
   - Include public health perspective which stresses the safe outcomes of pregnancy whether abortion or live birth, the right to health, the need to prevent and treat the consequences of unsafe abortion.
   - Operationalise a rights perspective to safe abortion/ reproductive autonomy or agency within public health practice.
   - Need to refer to legal stands that support our position (Right to life, liberty and security, Right to equality before law and equal protection, Self-determination and bodily integrity, Vs. mental cruelty?)

2. Expand the membership in coalition to include:
   - more people working on safe abortion
   - those working on maternal-neonatal health, not working on safe abortion, but could be
   - people working on sex-selection (UNFPA, Tej Jat Ram, Narendra Gupta, Sabu George)

3. Making abortion safer by engaging providers. This means following two strands of advocacy: a) values (rights: gender and sex-selection, consent and conditional MTPs) and b) over-medicalisation (technical). Need to explore linkages with Gender and Medical Education and map other groups are working on this.

4. Review how safe abortion is discussed in health, life skills and sex education modules. Develop modules for different groups.

5. Investigate why the All-India Hospital Post-partum programme was stopped.

6. Review the various assessment exercises that are in force or being developed to monitor government services to ensure they address safe abortion adequately (quality of care frameworks, 24 hour facility checklists, JRM3 to look implementation issues)

7. Work with the media on safe abortion issues, in particular with respect to the Supreme Court judgement that defined a women's refusal to have a child grounds for divorce on the basis of mental cruelty.

8. Identify cases for legal action that could broaden MTP.

9. Write to the JSA Public Hearings group linked to the NRHC and propose that denial of MTP and quality of safe abortion services in hospitals be taken up as an issue. Renu Khanna has already written to a list of people on September 8th putting forward CMNHSA's suggestion.

10. CMNHSA advocacy workshop will focus thematically on safe abortion. Need to form a working group that can take the lead on preparing for this.

11. CMNHSA has Rs.300,000 from IWHC over two years for a national campaign on safe abortion.
    - Need to not work in Rajasthan or Maharashtra as these states are already well funded through the Safe Abortion Consortium.
    - Need to complement this work by supporting our members in other states, like in Bihar, Jharkand, Gujarat, Himachal, TN. Need to write a two page concept note and seek matching grants to support this.
    - Two efforts could be supported in each state
        - Media workshop & fellowship
        - NGO partnership: policy consultation
    - Ideally get state level work up and going so that it feeds into national meetings planned later this year/ beginning next year (is this still feasible?)

12. Coordinating with other actors working on safe abortion

State level
- Sept 13th MTP committees in Maharashtra are meeting
- End October: Rajasthan is hosting a meeting on MTP and Sex selection convergence and conflict

National level
- October 18-19 Mumbai CEHAT as the nodal agency for national level abortion advocacy for the Safe Abortion Consortium is convening a meeting
- HRLN is planning a national safe abortion consultation Dec 2007
- CEHAT is planning a national meeting Feb 2008
- HRLN& Consortium & Coalition will endeavour to coordinate efforts for these national meetings
-

13. Create safe abortion cell within the Coalition to provide follow up. Abhijit, Leila, Padma, Sharad and Anubha were nominated to lead this cell.

MATERNAL-NEONATAL HEALTH

(Baneen, Lindsay, Padmaja, Sandhya,, Shruti, Shuba, Sundari, Suneeta,Sunil)

We assert the right of every woman to choose to be pregnant & to continue it, to go safely through pregnancy & childbirth and to access the best chances of being healthy and having a healthy baby.

While we recognize the role of various social determinants that influence the fulfillment of these rights the the coalition current focus is to advocate for the right of all women (every woman, especially every woman) especially those who face discrimination in society, to get \affordable, acceptable, accessible, care during pregnancy, childbirth and after childbirth that is of the highest attainable quality/standards.

TASKS

Through and then framing a position.

WHAT	**HOW**	**Modality**	**WHO?**
Taking position on "what are the standards of physical, emotional and technical care – before during and after childbirth – that are necessary to reach a healthy outcome	Activities that involve evidence building collectively, analyzing it collectively through docuemntation	Collect existing studies, NGO documents share them, Look for lists of standards Involve local	Coalition members Lead taken by ??

		players in the study to build a coalition	
Write a position papers on What are gold standards? What is Safe Motherhood What we mean by skilled attendant What we mean by Institution? Inappropriate use of misuse, On monitoring of pregnancy outcomes			
Involvement of other stakeholders, specifically health providers (Existing and potential Coalition members) Young Medical students Nurses	Above and below Survey for systemic barriers for providers during their stay in rural areas Surveys for experiences	By	
Studies on costs	Costs of over medicalisation Costs of optimal care from non-profit and profit making hospitals Costs of community based care		SUTRA Lindsay
Training on minimum standards & services required for maternal health along with training on advocacy from a gender and women's rights perspective	MAKING PREGNANCY SAFER course		Public health professionals, managers and providers from coalition
Postnatal – study of effect on mothers because of poor pregnancy outcomes like stillbirth, physically/mentally disabled baby,			??
Study of infections/ deaths amongst children born at home vs those being born at institutions			??
One activity of the listed ones per member			
Advocacy for rights of minimum standards	Legal actions??? against violations		Member plus HRLN/Shruti

ORGANISATIONAL ISSUES

- List serve membership will not be not limited to coalition membership, as long as the mails do not pertain to strictly organizational business

- Institutional membership for donors will not be entertained. Individuals applying from donor organizations may be considered by the SC, on the basis of their past history on the coalition issues.

- Activities at the AGBM –Reports on
    - activities of the coalition and its members;
    - presentation of annual accounts;
    - elections if necessary;
    - planning for the next year;
    - passing the annual budget

- The year for the coalition would be co-terminous with financial year (1 April to 31 March)

- Travel facilitation for members to attend AGBM - Convenient location of the meeting venue – by rotation among regions

- Sufficient advance notice for the meeting – preferably same month every year, with 3 months notice for the meeting, dates and venue.

- For members coming from more than a certain distance, assistance with travel cost or for those not supported by organizations, on request (Partial travel subsidies for geographical and other representation at meetings) To be worked out by SC.

- Budget for travel cost in proposals

- Membership fee para 1 (ii) – ratified. The membership may be discontinued after one year of non-payment of fees after one reminder.

- The SC should not have more than one member from the same organization

- Proposals for activitied for which members want the coalitions' participation need not necessarily be routed through the secretariat, however the finalized, approved proposal and budget need to be shared with the financial advisor and at the next AGBM 1 (ix). Still not decided – for discussion.