National Advocacy for Maternal - Neonatal Health and Safe Abortion
16-18 January 2006

Organized by: Coalition for Maternal-Neonatal Health and Safe Abortion

Background

A group of health research, programme and advocacy persons came together to promote greater attention to issues concerning maternal mortality, neonatal mortality and access to safe abortion, within health policies and programs in different parts of India. They tentatively called the group "Coalition for maternal-neonatal health and safe abortion", constituted themselves into a Steering Committee and decided to take the idea to a larger group of persons involved in health research, training and services.

The Steering Committee convened a meeting in Udaipur during 16-18 January 2006, bringing together a wide range of actors interested and working on issues related to health, and specifically in maternal and/or neonatal health. The meeting was hosted by Action Research & Training for Health (ARTH).

The objectives of the meeting were:

1. To arrive at common understanding on (develop consensus on) the need for (multi-state initiative for evidence based advocacy for maternal – neonatal health & safe abortion
2. To identify priority areas for maternal health, neonatal health & safe abortion requiring
    - generation of evidence
    - information & dissemination
    - advocacy
    - capacity building at different levels

3. To develop objectives, approaches and activities to be undertaken as part of the initiative

There were 24 participants from 15 states (Himachal Pradesh, Sikkim, Assam, Orissa, West Bengal, Kerala, Jharkhand, Andhra Pradesh, Gujarat, Rajasthan, UP, Karnataka, Tamil Nadu, Maharashtra and Delhi). They represent diverse backgrounds including community health researchers, health service providers and managers, health economists, medical doctors, gynecologists, etc. This report summarizes salient discussions and resolutions of this meeting.

<u>Day 1: 16 Jan 2006</u>

Session 1:
On the first day, the meeting started with introduction by the participants. After the introduction, Sundari Ravindran briefed the participants about the objectives of the meeting and an overview of the program over 3 days. She discussed that a coalition can be an alliance between entities, during which they co-operate in joint-action, each maintaining their individual identities; often temporary and time-bound, or a coming-

together of entities for working towards shared goals, because working together will enhance the ability to achieve these goals.

Session 2: Advocacy

Session 2 started with all participants reading out their own definitions of advocacy. It then proceeded with a presentation on a conceptual critique of advocacy by Renu Khanna, followed by discussion. She presented various definitions of advocacy, public advocacy and public policy. Renu went on to discuss the relationship of advocacy to IEC and mass mobilization, and other strategies for advocacy, what effective advocacy is, and what are the ethical dimensions, challenges and dangers of advocacy. Towards the end she presented our concept of evidence-based advocacy, which should influence several levels- vertical and horizontal, using evidence from primary and secondary research.

Session 3: Core issues in maternal and neonatal health

The session started with a presentation by Asha George on core issues in maternal health. She suggested that maternal health could be thought of as being located within overlapping spheres of entitlements, from the individual to the nation state. In terms of interventions, maternal health may be improved through a dual strategy- with a focus on maternal mortality and morbidity on the one hand, and on affirming maternal well-being on the other. The first would call for promoting universal access to skilled attendance at birth, emergency obstetric care, and ensuring safe abortion. The second would imply upholding women's rights, dealing with reproductive morbidity, providing women with preventive care through birth-spacing, nutrition, antenatal care; and developing linkages with neonatal health and survival, so that women do not have to go through repeated childbearing. She discussed the role of gender biases in poor maternal health, and the role of accountability, going beyond individual providers to health systems. She discussed that referral can be empowering experience, as well as disempowering. While integrated health systems are needed, what we have today are crumbling government system, and a varying private sector ranging from un-regulated, unqualified practitioners to highly qualified practitioners.

This was followed by a presentation by Sharad Iyengar on neonatal health. He discussed the history of maternal- neonatal- child care strategies over the past 2 decades. In 1985, there was the recognition that maternal health care was being ignored in MCH programmes and a review of maternal health strategies that have shown that TBA training and high risk approach does not work. In recent years there is also recognition that child health programs focus on child health, while maternal health programs were focusing on MH, while neonatal health was getting ignored by both. In recent years, there have been attempts to redress imbalance of NH not getting enough importance through integrated MNCH (instead of MCH) and IMNCI (instead of IMCI). He presented the data on high proportion of neonatal deaths worldwide, and in India, and their contribution to infant deaths and under 5 child deaths, that perinatal period suffers the most – birth & first week are most critical He presented the data on statewide NNMR, its primary causes, and emphasized that majority of these deaths occur in first 7 days, especially in first 24 hours. He discussed the strategies at family community level, outreach services and facility based care, and highlighted the importance of integrating

neonatal and maternal health, since rebound pregnancies occur to compensate for the loss of a child, and contributes to MD.

Following the presentation, there was a discussion on whether relying on institutional deliveries in situations without facilities or with only poor quality facilities, without referral linkages, was a sound strategy. Poor QOC in institutions can be as bad as home with unskilled person. It was suggested by one participant that certification process should be there for institutions. Birthing centres should be considered as an institution.

Another issue was whether volunteer-based programs, for example the new cadre of neonatal-care workers being experimented with were a good idea. How far was it possible to handover that responsibility for preventing neonatal deaths to a village worker, usually a local woman with limited schooling and only a brief training? The bulk of neonatal deaths take place when NN is looked after by family, hence it is important to involve the family in neonatal care. All volunteer based programs have high penetration, however they involve an enormous cost: for training, supporting, supervision. In these ways managing volunteer programs can be more expensive than managing fully trained workers.

Sharad drew attention to a recently released report entitled 'STATE OF INDIA'S NEWBORNS' which gives a comprehensive overview of major issues in neonatal health [1].

Session 4: Priorities for safe abortion

Bela Ganatra, IPAS made a presentation on priorities for safe abortion. She described the background under which abortion became legalized in India, and the strengths and weaknesses of MTP Act. She however highlighted that unsafe abortion still continues to be a cause of maternal deaths & morbidity in India, since the process of becoming from unsafe to safe, abortion has become highly medicalised procedure, done by specialised doctors, & there are only 250 training centres all over the country. It is done only in specific facilities, did not become women's right. Access at primary care level is very limited (less than 15% of PHCs are functional) because of limited provider base, leading to a demand for alternative services; while outdated technology & poor quality continue. There are newer challenges too, which lead to opposition of safe abortion, because of gag rule, and links with sex selective abortion -- anti sex selection advocacy in India has partly become anti- abortion. But we have opportunities in form of medical abortion, and changes (leading to liberalization of) in MTP Act. Bela described various priorities for advocacy, among communities, with providers, with program managers and as a coalition.

This presentation generated a lot of discussion especially on medical abortion. Currently, medical abortion also needs the same legal procedure, while it is much safer. There is advocacy that drug should be banned- every schedule H drug is sold in the country over the counter, but there is advocacy only about this drug. Medical abortion is being

[1] This can be ordered from : National Neonatalogy Forum, 803, Northex Tower, A-9, Netaji Subhash Place, Pitampura, New Delhi – 110034
scennf@vsnl.com

medicalised more than necessary, and this may be because the specialist obstetrician-gynaecologists fear a loss of control. In many countries, nurses and midwives provide medical abortion, and they are required to have good referral links to specialist care should it become necessary. In India, because provider-requirement for surgical and medical abortion is the same under the MTP Act, access to services may not increase because medical abortion is introduced. This is an important issue that those wishing to promote access to safe abortion needed to note.

There was discussion on whether the drug has lots of side effects? In countries where abortion is illegal, MMR from abortion has gone down since medical abortion became available. We will not advocate for its unregulated and unsupervised use, but we will advocate for its availability at primary care level. Backup is however needed because 5% women will need surgical intervention. It would be useful to remember that even if women took it without medical supervision, the ensuing health risks would be lower compared to use of other unsafe invasive methods to terminate a pregnancy.

Another point of discussion centered on unwanted pregnancy and male responsibility for pregnancy prevention. Participants from Tamil Nadu and Andhra Pradesh noted that men appeared to believe that abortion was a simple and routine procedure. Many of them did not support their wives' use of reversible methods of contraception, nor did they use contraception themselves. In case of an unplanned pregnancy, they wanted their wives to go for an abortion. Participants agreed that what we wanted to advocate is for access to safe abortion, along with men's responsibility in preventing an unwanted pregnancy in the first place.

After this, there was some discussion on the name of the coalition, where whether or not we should mention 'safe abortion' in its title. While some participants were of the view that we should look at how the existing dept. of H&FW defines MH & SA? We should go in line with existing definitions by the country. It is part of RCH. However, after a lot of discussion the consensus was that it should be separately stated upfront because of political reasons, and anti abortion climate. Moreover, several MH programs ignore abortion, so safe abortion needs to be mentioned. It is strategically important to mention it. It also underlines the coalition's interest in affirming women's rights when calling attention to neglected issues within maternal-neonatal health and safe abortion.

Session 5: Financial barriers to women's health

In the next session, Dr Vardarajan presented the issues related to financing of maternal health care. He mentioned that the govt. expenditure on health care has reduced over the years. He described the urban rural disparities in health investments, and that especially for women, purchasing power, decision-making and autonomy was very limited. He advocated for strengthening primary health care system, innovative financing options, SHGs etc. He also presented preliminary findings from a women's health savings group scheme he is working on in Karnataka.

Other countries with highly privatized services have come to focus on controlling escalating costs through cost-efficiency measures. Such moves towards regulating supply-induced demand have not started in India. No one questions that services are

too expensive. The process is left entirely to market dynamics. The coalition should look into costing good maternal health care within a rational framework in order to set a benchmark for future comparisons and discussion.

Both the central govt and state govt need to invest (and not withdraw from) maternal health care. When a central government scheme was introduced to give women a small stipend for each delivery, the Andhra Pradesh state government withdrew a state scheme meant for women below the poverty line.

What are some cost issues that the Coalition should look at?
The societal as well as health-system cost of lack of access is high. Since people cannot afford health services they delay seeking care until their health condition is very severe. This then requires more expensive treatment to resolve the problem. There are also the indirect costs of health care related to transport, missed wages, etc. In some countries, govt funding (on MH) is much more. Coalition needs to advocate for more govt funding, we can afford rational care.

Sundari called attention to the fact that although out of pocket expenditure is often termed as private expenditure, this is actually another means by which the public is contributing to the national health care expenditure. So when governments argue that households need to pay more for health care, one need to be able to throw the ball back into their court and point out that the public is already paying for 80% of the health care budget out of their own pockets.

Sundari also commented that despite the current policy attention being paid to community insurance schemes; this may not be an avenue for financing appropriate for maternal-neonatal health and safe abortion. Health insurance is mainly viable for health care events that have a low probability but high cost.

There is a need to understand the opportunity costs of time and how that influences irrational preferences for interventions during delivery. Families also may not want to spend a lot of time in hospitals waiting for a labouring woman to deliver. In this sense inducing labour through oxytocin and epidocin brings the time costs and costs of staying at a hospital down from the families' perspective.

Corruption in health services is also a result of the chronic under-funding of government services. Health workers use the shortages of supplies as an entry point on which to base their own rent-seeking activities.

Day 2: 17 January 2006, Tuesday

On day 2, initially Sundari presented a background of the coalition, its vision, its ideas & plans, structure & modalities. Sundari outlined the need for advocacy to go beyond policy makers at national and state capitals, and include key actors at various levels: health service providers within the public and private sectors; among researchers; civil society organizations working on health, members of local government at village, taluk and district levels.

Without such mobilisation, progressive policies and legislations that are developed and adopted flounder at the stage of implementation. Neither those responsible for implementing the policies, nor those who train them, or the intended beneficiaries or their elected representatives are aware of the significance of the policies. There is therefore no pressure from below to ensure policy implementation

She then went on to outline some ideas for activities that this Coalition might undertake. This included a series of advocacy initiatives at the 'ground-level', creation of evidence-base to support such advocacy and capacity-building and networking activities to make effective advocacy possible.

Subsequently, individuals made brief presentations on ideas that they want to work on. Following persons presented ideas for work that they would like to carry out in the area of maternal/neonatal health and safe abortion, as members of the Coalition. These presentations took up the rest of the day. Participants discussed each presentation and made suggestions for modifications and changes. The process was very useful also in helping Coalition members debate on contentious issues, clarify their own positions and to get a sense of how membership in such a Coalition could help individuals and organizations.

1. Dr. Keerthi Singh	Advocacy on maternal & child health issues through Panchayat training in districts of Rajasthan
2. Ms. Sandhya Gautam	Research & education on unnecessary hysterectomies in Himachal Pradesh
3. Dr Raj Prabha	To disseminate the findings of a study among women seeking emergency obstetric care in a referral hospital in Sikkim, especially 3rd delay analysis i.e. association of time period of delay fetal and maternal outcome
4. Dr Sunil Kaul	Ways to build advocacy into existing service delivery efforts within the political context of the NE
5. Dr. Biswajit Modak, CINI	Working for reduction of infant and neonatal mortality through community and government health system in Orissa
6. Ms Piyali Ghosh Banerjee	Increase knowledge and practices to ensure safe motherhood and child survival through better case management, behavior change communication & linkage with others.
7. Dr Aarati Khambate	Researching and advocating for women's rights within the sphere of infertility treatment in Trivandrum, Kerala
8. Ms. Lindsay Barnes	Document and research women's Experience of Pregnancy, Childbirth & Motherhood in Rural Jharkhand. Advocacy to make health services more women/poor friendly; to change delivery practices to address more than the 5 cleans; and empowerment strategies.

9. Dr G Rama Padma	Ways to develop advocacy on the various academic research projects on women's health that have already been undertaken at her institute.
10. Dr. Shobha Misra	Verbal autopsies of maternal deaths and near misses, ad use it as a tool to identify problems relating both to health seeking behaviour and health service provision in urban slums and rural areas around Vadodara district
11. Ms. Sunita Singh	To document the maternal Morbidity and Mortality related to Gender-Based Violence among pregnant women, in a crisis centre for women & to develop referral linkages. Also to find out how inequities in maternal health by caste, class, place of residence plays a role
12. Ms. Leila Caleb Varkey	Working with the private nursing home and nursing school sector in Noida on improving safe delivery practices with a special emphasis on asepsis and upright birthing position
13. Dr. Kirti & Sharad Iyengar	Decentralised advocacy in Rajasthan through an advocacy team, at various levels including administration, health department, and medical & nursing colleges etc. The purpose is to
14. Ms. Asha George –	Focusing on bringing a blood bank or blood storage points to Koppal district, north Karnataka, as none is available in the region and haemorrhage is a leading cause of maternal death. Need to work with RMPs on improving maternal health practices
15. Dr Senthil Arasi	To carry out state and district budget analysis and efficiency in utilization of resources in Tamil Nadu, to document the health sector reforms and to study its consequence in access to and utilization of health service To form an advocacy group at state level to analyze secondary data already available with the govt, identify the major problems & probable solutions; and to develop indicators to help top and middle level programme manager to supervise and monitor effectively and efficiently
16. Dr Varatharajan D –	Will advice on proposals related to financing for maternal-neonatal and safe abortion services
17. Dr Vikram Gupta	Will provide support from PFI projects and incorporate learning on maternal-neonatal health and safe abortion into this work
18. Dr Sundari Ravindran	Will be interested in advocating for access to medical abortion; and on addressing financing issues in maternal health services that will make services (especially EOC) affordable to low-income women.

19. Ms. Renu Khanna	Interested in working to improve maternal-neonatal health and safe abortion needs in urban slum areas of Baroda in partnership with other local actors

Day 3: 18 January 2006, Wednesday

Session 1: Vision, mission, strategies, structure and funding of the coalition

A small group of persons had worked on the original vision and mission of the coalition -- in the first session, there was a presentation of this. This was followed by discussion and feedback in the plenary. Participants expressed their views and suggested modifications, and these were incorporated. This was later finalized by the steering committee.

The structure and membership of the Coalition were discussed. It was decided that the Coalition would have both individual and institutional members. However, institutions have to designate a specific person to represent it in the Coalition's meetings.

When individuals who represent an organization leave the organization, they may if they so wish continue as members of the Coalition. The concerned organization will also be requested to nominate a new representative to the Coalition.

It was also agreed that a membership form would be developed and sent to all participants. Membership will not be presumed, and those who wish to become members should fill-in the forms and send it to the Steering Committee.

There will be no 'membership-drive', but members of the Coalition will be encouraged to introduce the Coalition to those colleagues who are likely to be interested.

Members of the Steering Committee will share responsibilities for different activities of the Coalition. ARTH will serve as the Coalition's secretariat.

Session 2: Presentation on other initiatives

In this session, we requested some of the participants who were members of other initiatives in the field of maternal-neonatal health and safe abortion to tell us more about what these other initiatives were doing, in order to explore possible collaboration and avoid duplication.

Jashodhara made a presentation on some of the other initiatives that she is involved with. One is Health watch UP-Bihar, which has been advocating on various issues especially on population control policy.

Sahayog started its work by working with women to examine their health rights. They sought to translate these rights into reality by bringing about change through various avenues, pressure groups and advocacy tools. They collected local level data which included case studies where rights to maternal health were violated. They have used

their research for advocacy at various levels: panchayat, service delivery at the sub centre and PHC level, at district, state and national levels.

In December through WHRAP they have held a national level dialogue with the media, planning commission, Ministry of Health, UN agencies to raise attention to the policies that have yet to be adequately implemented and to the policies that need to be changed. This is an open platform and anyone is welcome to join the initiative.

Sahayog has been working with an organisation in Uttaranchal on undertaking a social audit of maternal health services with local panchayats. This led to a dramatic increase from a baseline of no interest to active concern by gram and block panchayats in monitoring what is available, monitoring maternal deaths and keeping track of service providers. This work done in conjunction with the health department and a report is available from Sahayog's website.

Sahayog has also developed an advocacy manual and training module in Hindi which is also available on their website.

Lester

Lester gave a brief overview from his position from the Packard Foundation, which focuses on Bihar and Jharkhand. It is concerned with increasing access to reproductive health services, particularly in the areas of improving access to contraceptives and reproductive health services to young people. It tends to focus on funding innovations, like public-private partnerships, and up scaling them, as well as paying attention to advocacy. The latter is important as a core concern is the right to safe abortion, especially since internationally donor support for reproductive health and for abortion in particular is waning. With respect to this it has co-funded along with SIDA a consortium on safe abortion, which among its goals will introduce medical abortion in government services, get mid-level providers to provide MVA, advocate for changes in the law around medical abortion and fund operations research. Other parts of their work focus on advocacy with elected representatives on moving away from coercive population stands, providing fellowships to journalists to write on reproductive health issues, train young people as advocates on this issue. In terms of contraception Packard is funding a group called Advocating Reproductive Choices that will work on standards, quality and pricing of injectable contraceptives and moving the agenda forward on emergency contraception. Another concern is being critical about how money under the National Rural Health Mission will be spent.

His one request was for the coalition to partner with at least one organisation in Bihar.

This was followed by Leila Caleb's brief introduction to the White Ribbon Alliance, an international NGO working on Safe motherhood that is very active in India.

The (International) White Ribbon Alliance was launched in August 1999 with an initial 35 participants, with the aim of raising awareness of the need to make pregnancy and childbirth safe for all women and newborns in developed as well as developing

countries. **A white ribbon was selected to represent and memorialize all of the women who die unnecessarily during pregnancy or childbirth**.

India was one of the first countries to start its own alliance the White Ribbon Alliance for Safe Motherhood, India (WRAI) was launched in India in Nov. 1999. Today, the alliance in India has 64 organizations, which include NGOs, UN agencies, development partner agencies, individuals, etc. Currently there are five state level WRAs – Rajashtan, MP, Orissa, Gujarat, and? Uttranchal.

Some of the key activities in the past 7 years have been : A National Conference on Safe Motherhood in the Home, An Advocacy walk from the Taj Mahal and commemoration of Safe Motherhood Day – 8th April every year by the WRAI with Govt. of India MOHFW. A post-card and Media campaign has also been launched.

WRAI has brought out several useful publications including one on safe motherhood at the community level, a Best Practices Field Guide (available from WRAI in multiple languages), "Guidelines for Emergency Obstetric care and facilitating EmoC in the PHC/SC by ANM/MPW and Doctors" published by GOI - MoHFW. WRAI is also being increasingly recognized as a reservoir of experts and like minded individuals that work on safe motherhood, and are often called upon by the MOHFW. Members have been volunteering representation at National and International Safe Motherhood forums and committees. Currently there are 65 Institutional members and more individual members – more are welcome! [2]

Session 3: How are we going to contribute? What do we need?

During this session, all participants briefly discussed how they could contribute to the coalition and what they need from the coalition. The contributions that participants could make varied widely, depending on their background and experiences.

Session 4: <u>Next Steps</u>

In the last session, it was decided that the next steps for the coalition could include the following:

1. Advocacy activities by Coalition members will form the core of the Coalition's work in the immediate future. Many of those who had presented their ideas the previous day were interested in pursuing these as part of the Coalition's activities.

   There was some discussion on the Coalition's role in funding these proposals. Members of the Steering Committee indicated that they would facilitate the process of finalizing a proposal through a peer-review and feedback process. A final selection o proposals meeting the objectives of the Coalition will be made. The Coalition (Steering Committee) would get in touch with potential donors. Further negotiations will be between the donor and the implementing

[2] Contact details: The White Ribbon Alliance for Safe Motherhood India. Secretariat c/o Dr. Aparajita Gogoi, CEDPA Office, C-1, Hauz Khas, New Delhi. For info go to website: www.whiteribbonalliance-india.org

organization, and funds will also be received directly by the implementing organization. The Coalition also envisages providing ongoing technical support through its members and other experts for the implementation of the proposals.

In the case of individuals who are not attached to any organization, there were two options: they could identify an organization through which to apply; or apply as individuals, in which case the Coalition (the secretariat) may have to receive funds on their behalf and disburse it.

2. It was decided that those members who plan to implement advocacy activities would send their pre-proposals (4 pages) by 15 Feb (Vikram would send by 15 March)

   Pre-proposals will be sent for peer review to members of the Coalition who had volunteered to be reviewers and to other experts, depending on the topic. A list of criteria for evaluation will be developed to help the review process. Comments from reviewers will be sought within 3-4 weeks. Based on these comments, members may proceed to develop detailed proposals for submission to potential donors.

3. A draft proposal for support of the Secretariat functions and support activities of the Coalition will be prepared by the steering committee; steering committee might need to meet before end of March to finalize the core activities (possibly ~ 10-16 March). It will be sent out to coalition members by end February, who will give comments by 1st week of March. The final proposal will be sent to funding agencies by end of March, it will initially be for duration of 2 years.

4. A workshop on advocacy skill development will be conducted by the coalition by July/ August 2006. A meeting to develop a curriculum / module on advocacy training will be developed by early May 2006. Lester indicated that Packard may consider supporting the curriculum-development meeting and possibly also the workshop itself. In order to develop the curriculum, we would look at other advocacy training in the country. e.g. Abhijit & Usha Rai have developed some modules on advocacy—some resource persons could be brought in for advocacy training/ manual. In addition, one advocacy skills workshop will be conducted in September 2006 by SPITFIRE, a group based in US. One- two persons from the coalition could attend this and train others.

5. E-group: The feasibility of an E-group for Coalition members to keep in touch was discussed. In order to avoid the problem of unmanageable e-mail traffic that often accompanies membership in e-groups two options were discussed: either all replies go to the moderator who then sends substantive information (summarized) on to everyone. This would mean having a moderator who knows the issues and also has enough time to keep the discussion vibrant and alive. The second option was to work though BLOG, which does not need a moderator, but requires someone to set it up, and is not a very secure system. Asha volunteered to explore the e-group option further.

6. Website: It was felt that a website could be established approximately six months from now, and that it could be one of the support activities. It would be essential to identify the unique niche that the coalition's website would occupy: what would it contain that cannot readily be obtained from other websites (although providing useful links to other sites would also be one of its functions). Some examples of useful information that the Coalition's website would contain included information on the role of panchayats in promoting maternal- neonatal health and safe abortion, advocacy experiences from different places including those by Coalition members, information on developments in maternal-neonatal health and safe abortion policies and programs within the framework of reproductive rights, useful research papers from the country; It would be important to include materials in Indian languages. Vikram and Asha volunteered to work on it further.

7. Lester volunteered to help with receiving documents and other research materials from members and making CDs or hard copies for everyone and mailing these to all members of the Coalition. To begin with, Sundari will be sending him soft copies of several useful advocacy manuals which he will circulate to everyone as CDs.

8. The report of this meeting will be prepared in 2 weeks time (by 1st week of Feb).

9. Meetings of the Coalition will be conducted once a year. The next meeting will be in January 2007.