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# TOOL DEVELOPMENT WORKSHOP FOR INTEGRATED MONITORING OF SRHR AND SRH SERVICES



**CommonHealth**

**July 14-16 2017**

**Venue: Asha Nivas | 9, Rutland Gate, 5th Street, Chennai**

**Tamil Nadu 600006**

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## **ABBREVIATIONS USED**

AAAQ	Availability, Accessibility, Acceptability and Quality
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	
CBO	Community Based Organisation
CH	CommonHealth
CHC	Community Health Centre
CHSJ	Center for Health and Social Justice
COPASAH	Community of Practitioners on Accountability and Social Action in Health
DWT	Dead Women Talking
FCRA/FRR	Foreign Contribution (Regulation) Act/Foreign Contribution (Regulation) Rules
FGD	Focus Group Discussion
GST	Goods and Services Tax
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRBA	Human Rights Based Approach
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
JSA	Jan Swasthya Abhiyan
MDR	Maternal Death Review/Mid-term Review
MH	Maternal Health

MO	Medical Officer
MTP	Medical Termination of Pregnancy
NAMHHR	National Alliance for Maternal Health and Human Rights
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NHSRC	National Health Systems Resource Centre
NHSC	National Health Service Corps
NRHM	National Rural Health Mission
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act
PHC	Primary Health Centre
PNC	Post Natal Care
POCSO	Protection Of Children From Sexual Offences Act
PPIUCD	Postpartum Intrauterine Contraceptive Device
QoC	Quality of Care
RCH	Reproductive and Child Health
RSBY	Rashtriya Swasthya Bima Yojana
RTI	Reproductive Tract Infections
RUWSEC	Rural Women's Social Education Centre
SATHI	Support for Advocacy and Training to Health Initiatives
SAHAJ	Society for Health Alternatives
SDG	Sustainable Development Goals
SHG	Self Help Group
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health and Rights

TB	Tuberculosis
UNFPA	The United Nations Population Fund
UPR	Universal Periodic Review
USG	Ultrasonography
VHND	Village Health and Nutrition Days
VHSNC	Village Health Sanitation & Nutrition Committee
WHO	World Health Organisation
WRAI	White Ribbon Alliance, India

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## TOOL DEVELOPMENT WORKSHOP FOR INTEGRATED MONITORING OF SRHR AND SRH SERVICES

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**Organized by CommonHealth, at Asha Niwas Social Service Centre, Chennai. July 14-16, 2017<sup>1</sup>**

### **WHY THIS WORKSHOP? BY SUBHA SRI B**

CommonHealth is the Coalition for Maternal-Neonatal Health and Safe Abortion. This is a membership based network of individuals and organisations from across the country. The journey of CommonHealth began in the year 2006. There is a review of CommonHealth's journey in the last ten years being conducted by an expert group of friends. This is to understand what we have accomplished and how do we leverage our work given our past experiences in the upcoming years. There is plenty of information available at CommonHealth's website for access. Kindly visit: [www.commonhealth.in](http://www.commonhealth.in)

This workshop is planned to be a small group workshop with very specific objectives. CommonHealth has been working on Sexual and Reproductive Health (SRH) issues. One of our main objective so far has been advocating for Sexual and Reproductive Health Rights (SRHR) and influencing at the policy level. We have been able to do this through our collaboration with other member partners spread across the country. Collecting and documenting information at the ground level has helped in advocating for the SRH issues. However so far, our focus had been with very specific issues that involved data collection through meticulous techniques and procedures to document evidences. Some of them include: documenting the maternal deaths, quality of maternal health services, contraceptives and availability of services based on users' perspectives and monitoring the availability of safe abortion services and its quality. Now, we feel it's time to move forward to look SRH services more comprehensively with a rights perspective.

This workshop is intended to give insights on the scope of expanding SRH issues comprehensively, address the methodological challenges, operational issues and also about handling the information obtained. Another point is the incorporation of accountability aspect for SRH across the discussions. **The main objective of the workshop is to simultaneously raise and sort out the concerns, find possible solutions. This should enable us to come up with a broadly designed tool that could be used by the CH members at their field areas for monitoring the SRHR and SRH services.**

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<sup>1</sup> We acknowledge the support of our funder- International Women's Health Coalition, New York.

Rapporteur: Bhuvaneswari Sunil

[The speakers introduced themselves connecting themselves and their work experiences to the workshop. Refer Annex-1: participant details]

### **THE JOURNEY SO FAR AND THE LARGER CONTEXT BY RENU KHANNA**

**Why this session?** Renu's involvement with CommonHealth since 2006 as a founding member, as well as the long journey in terms of acquiring knowledge and acquaintance at the field level, civil society, national and global level engagements in the last several years situated the context for this workshop. Given that everyone is looking for opportunities amidst different contexts of struggles she placed the concrete reasons for this workshop.

Renu emphasized the need for understanding the context at the policy, global, legal fronts and also engagement of civil society given the changing global and national policies and the political climate. According to her amidst the shrinking spaces, civil society is one window where several opportunities exist.

One of the first context in common for all of us here, is the people's health movement in 2000, both at the global and local levels that galvanized for the "Health for All" movement through the Alma Ata Declaration. This is one event from where it was possible to take the work on civil society accountability forward in a concrete and collective way.

Second is the public hearings conducted with the NHRC during 2005. It was because of this forum there emerged a possibility for engagement for more than a year's time between NHRC (guardian institution), Jan Swasthya Abhyan, civil society and the Government of India. This gave the opportunity for different stakeholders represented in those regional and national consultations be able to listen to each other. The importance in referring this at this juncture lies in the "creation of spaces for dialogue" in that process –such consultative engagements were at the peak until the pre-NRHM and NRHM period. It is very important to make visible that the entire discussions on the process of the NRHM framework for implementation and the communitisation and community based monitoring came up during that time and many of us were part of that consultative process. For instance, the Gujarat Public Health Act came up because of the NHRC, and Gujarat government's engagement. The commissioner invited JSA at that point of time along with many other stakeholders to work on a Public Health Act for Gujarat. Again, incorporating NHSC, VHSNC, block and district level committees in NRHM came through the Gujarat example. It was at that point we involved the panchayat raj members, service providers, women, people with disability, people from different marginalized section who were incorporated into it.

Since post 2014, there is a closure of all spaces. We are seeing a situation in stark contrast to pre NRHM and NRHM period, post 2014 – the forums being dissolved and progressive civil society like us not having our space. Power is being wielded by larger consultant



organizations like Ernst and Young, JHPIEGO, in the technical space John Snow, Inc and many others. These were the original spaces that were available for civil society but that which is shrunk now. Thus, within the shrinking spaces who wields the power to provide technical inputs is important to recognise.

Yet another context is the onslaught of reproductive rights – which needs to be recognized and countered. There had been in the last one year several court cases seeking medical termination of pregnancy, which are actually part of the legal framework. A 20-week termination is within the legal premise and still women are denied services and this necessitates to go to sessions or high court and ultimately to supreme court as well. Coercive population policies are another area of concern. For example, the Assam population policy that has been put up, the PPIUCD program and the way it's been taken forward, the country's commitments for FP2020 without a recognition that the country's fertility is going down are all areas of concern.

There are also other new developments –the government seems to be acting very fast and sounds like actions are happening at the same time iffy too. For instance, new National Health Policy 2017, says private doctors are going to provide services in public health facilities. Thus, the focus is a total move towards privatization. The earlier policies and drafts that mentioned the right to health aspects finds no mention in the present policy. While the HIV-AIDS policy, the disability, mental health policies have come out recently, an occasion for celebration, but the content of these policies needs to be carefully looked at.

POCSO and its impact on SRHR of adolescents is another grey area – it implies that any sexual activity below 18 is illegal (crime and violation) even if consensual. This has an impact on access to services – will one be able to provide ANC services to teen mothers who are most vulnerable?

Some of the other concerns include - GST on sanitary napkins at 12 per cent, does it mean that these are luxury items? What is happening with the censor boards? Infotainment being one source of reaching masses. These spaces are also stifling.

Role of civil society at the policy and program level – There are interesting kinds of galvanizing happening with the use of technology and mobilisation – For instance through 'Not in My Name' a lot of discussion on menstruation through media is being able to visibilise taboos regarding menstruation. Some of these are extremely positive. On the other hand, **what is the nature of civil society we are talking about? The civil society needs to be disaggregated. Civil society is very fragmented and varied. Civil society falls on different parts of the spectrum. Some of the battles they're taking up are our battles too but should we align with them or how do we navigate?**

Yet another thing is the issues with FCRA, FRR in which rights language cannot be used anymore. There is a need to camouflage the language when it comes to the sexual and reproductive health and rights.

At the global context, with the gag rule in place, the funding has stopped for organizations doing abortion work in anyways. At FP2020, although there are groups involved in the talks of rights based approaches and communities, the question about who are the partners - largely technical organizations; what is the conflicts of interest between stakeholders are all issues of concern.

As CH, JSA there are some spaces such as SDGs, UPR where engagement is happening. **There is a need to recognize which are the spaces where we could engage ourselves.**

To conclude, we have been at CommonHealth recognizing these changes over the last few years. Thus, following a large meeting in Delhi, in December 2014 we decided to move out of our silos beyond maternal-neonatal health and safe abortion and engage with other groups. Such as those engaged or struggling for right to food, right to information, dalit women, HIV groups, mental health groups. These are the other campaigns and movements that are happening, through whom we need to listen. In 2016, we had yet another meeting in Pune where several of these groups were represented. Thus, we decided if we make a tool, it cannot be homogenized or invisibilised or unique but that which is inclusive enough to capture the reality of these groups especially.

#### **FLOOR DISCUSSION CHAIRED BY SUNIL KAUL AND LINDSAY BARNES**

Multiple perspectives emerged from the floor and brought the gravity of contextual changes happening in the recent years across the country.

- At the Financing for Development Process, there is a consensus among member states that in order for them to achieve the Sustainable Development Goals without the private sector is not possible. Even at the SDG process the sequence of presentation was first the member states followed by the private sector, then the NGOs. This indicated who gets to speak first. For instance, at the Monitoring and Evaluation Conclave, there were many people who introduced themselves as representing such and such companies from the private sector. There was a sizeable portion of people who recognize the profit motive involved in these initiatives too. Yet again, there are several ‘companies’ who help in advocacy and to design how to strategize the advocacies for various health programs. There is lot of financial inflow in these newly emerging sectors, where it is perceived that the efficiency is high in corporate modes of working rather than involving the NGO sector. Need to think more seriously about private sector involvement– changing scenarios, new actors, for profit companies who are present in all/most meetings. Clarification from the floor that: ‘companies’ – not all of them connote as for profit, since many erstwhile NGO’s are registering themselves as companies under Section 8]
- Therefore, the issue of funding for rights based, community based work is drying up. Example: Recent move by Tata’s to fund their own programmes themselves, rather than involving NGOs.

- The funding support for social science research is being curtailed to a great extent across many universities. Further at present, there are multiple tiers of funding cut for higher educational institutions with layers of stipulated norms and conditions within the government funding provisions. The social science courses are directed towards moving to management oriented courses that inculcates ‘feasible skills’ tailored to the market changes. The future workforce is being tailored to market needs of neo-liberalism and the knowledge space for evolving social scientists is curtailed. This is a real concern.
- Need to study Niti Aayog documents and many newly emerging documents in details – many of these documents suggest privatization is ‘the’ solution to all problems especially health and nutrition. While it’s not just within the domain of health, there are other domains such as labour laws, the wage code, the social security law that’s all-in place. Most of these documents were put up on public domain for two weeks seeking comments. While these are huge documents and requires detailed scrutiny, two weeks is insufficient for feedback. But it’s not about dealing with those domains in silos. For instance, the new labour code is looking at radically overhauling labour laws which will be disastrous for informal labourers, most of whom are women. The role of unions is becoming nil and has no place for table discussions. **There is more and more centralization happening across sectors including education. There is a need to be vigilant and learn to address it in totality unlike the piecemeal approach that is presently the case.** The government is driving it and we are having almost no role for setting the tone or the direction. Where is the space to talk, and there is no audience to listen at the higher levels, unlike the lower levels to drive policy.
- In the development sector, there is lot of work happening concerning adolescent health. ‘Sexual health’ – with what perspective is it being spoken about? Sexual health and adolescent health programs in many development sector contexts only looks at menstruation and body change. They do not move beyond these lines of thought. There is a need to look at this with concern.
- The legality gaps in POCSO versus the issues concerning marital rape, adolescent marriages etc is another area of concern– India has almost 2.7 million married girls below the age of 18 according to surveys. While legal gaps exist, how do we address these issues?
- Need to look at some of the positive models as well – such as *mohalla* clinics

**CONCLUDING THE SESSION:** There is a need to focus on having multiple strategies to address at different levels. We clearly recognise that there is a SRHR onslaught, particularly of ‘women’ which is not just one group but from different groups. At CH when we wanted to strategize ourselves a few years ago, we came to a conclusion that national advocacy is not our focus and decided to gather force at the ground level and organize them. This effort is to build accountability by building tools that can be used by people, shared amidst people. This should also influence at the national and global level. There is

need to build accountability within the people's perspective. People need to realize that they have rights and entitlements. Thus, the need to focus our energies on communities and build rights literacy is more important rather than focussing at the moment only on policy advocacy.

#### **WHAT DO WE MEAN BY RIGHTS BASED MONITORING? BY TK SUNDARI RAVINDRAN**

The earlier session was more around the political conversations in context. In this session, Sundari Ravindran put forth what human rights based approach means within the framework of sexual and reproductive health services as said by WHO, UNFPA and so on.

In continuation to the discussions in the previous session, Sundari shared her personal position about the context in which this meeting is happening. She said *“one can be paralyzed when everything is going wrong or do something meaningful. At this moment, a monitoring exercise that tells us where things are is more meaningful. However, there are several questions one has to raise and answer including the fundamental aspects”*.

Primarily, the human rights based monitoring is a reasonable set of principles to which one can add and modify. However, there is a need to understand what is out there and how do we evaluate the same. In a Human Rights based approach the two major features are:

*“It takes a position that ensuring access to education and health care and other basic needs and amenities for all its citizens are not acts contingent on the good will of governments, but obligations that they are required to fulfil as signatories to international human rights standards<sup>2</sup>”*

a) The above reinforces entitlement. It implies that it is not that government will do or make sure it is done, IF it has the money or IF it has the inclination to do or IF it is cost effective. It reinforces that the government has an obligation which they have signed and are thereby accountable. The rights perspective also adds that, what has been done this year could not be cut off the following year, for which the government is answerable. For example, for all the economic, cultural and social rights there is a commitment to progressive realization where the countries will make step by step efforts to move in the right direction, even though the countries may not be well resourced to do all. It does not mean that the countries can go back, since it is progressive realization. The second is based on certain principles it gives us a tool or pointers for monitoring or track the progress. Thus, we are familiar with the language that says **“HRBA considers all persons as rights-holders, while the government and its agents are duty-bearers with specific obligations to fulfil”**.

Therefore, what are they (the government/country) duty borne to do is what they have committed to do. So, one has to fight for it. In the area of SRH services the first question is: How are bodies such as WHO and UNFPA in terms of SRH services been guided by

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<sup>2</sup> Paragraph 12 b of General Comment No. 14 (Committee on Economic, Social and Cultural Rights, 22nd session): The Right to the Highest Attainable Standard of Health – article 12 of the International Covenant on Economic, Social and Cultural Rights (CESCR). Geneva: United Nations Economic and Social Council; 2000 (E/C.12/2000/4, accessed at <http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En>

when they speak about maternal health services, contraceptive services etc?. They have been guided along mainly two axes namely, 'Right to health' and 'Right to health care'.

'Right to health' includes rights to all the determinants of health and 'Right to health care' which is spelt and monitored with clarity. Those pertaining to the Right to Health Care include availability, accessibility that includes physical, economic and social, and acceptability of and high quality SRH services. Here there is a need to understand how do we spell out the indicators to monitor these. Also, there is a need to separate out 'quality as a right' and 'quality as a management standard'. These two are very different. 'Quality' as a rights indicator is the right not to be abused, the right to be treated with dignity etc. The WHO indicators put 'dignity' as part of accessibility. Therefore, abusive services could go either as against quality or against accessibility of services both of which violates right to healthcare. These are the standards. The principles for the SRH services are drawn out from the broader human rights based framework. These are right to: non-discrimination, informed decision-making, privacy and confidentiality, participation, and accountability

**The right to participation and accountability:** Here are the subtle aspects when it comes to participation and accountability rights. When we say, I have the right to participate, it also means that there are structures and mechanisms that are in place, accountable, transparent, known to all, through which meaningful participation can happen including traditionally excluded and marginalized groups. Similarly, the rights to accountability includes the right to transparency. For instance, on a feedback given on government policies, the failure to acknowledge the inputs accepted and for what reasons rejected is a violation of right to transparency. Accountability also includes mechanisms for grievance redressal that clearly spells out guidelines on who does what and using fair measures. It also includes, regulation of private entities such as private health care providers, insurance companies, pharmaceuticals etc, so that their actions do not violate citizens' right to health. All these could become additional axis to monitor the services.

Sundari raised several questions for everyone to think through in the forthcoming sessions and also gave certain pointers as lead to move ahead.

Now moving ahead, how could these principles be translated to tool development? One is when we are listening to the tools used by different people here, could we note points to look at a) if these tools are in consonance with the rights based approach? Is the data collected in a way that fulfils these principles, and also give information on not just ante natal care but also answers who, why, how and have the ability to answer the issues of discrimination etc. Tools are developed to gather information on specific indicators. Therefore, there is a need for clarity in objectives for developing the tools for monitoring.

Monitoring what? Are we wanting to monitor the rights to determinants of sexual and reproductive health or condition for it to be fulfilled, or right to services are fulfilled? or

one first and the other next? Or are these two so much intertwined that we cannot do just one leaving the other aspect?

Are we measuring the services? Or right to enjoy good SRH services and all the three conditions necessary for it? Or the right to have the SRH services or both? Whose rights and how disaggregated do we want information. The stratifiers one may call are the meaningful stratifiers, such as age and population groups beyond the regular stratifiers such as rural-urban, male-female etc.

We want to do this for two reasons. One is the process through which we gather this information will itself mobilize and create awareness. It can be done through modalities that can have an impact. The second is that, the information would be used as ammunition in our strategy to challenge what's going on even at the community level. I assume that there is a group of people who are fed with this kind of information which could eventually change the thinking and win the support of various groups who then will become part of the movement to change the things. The big elephant in the room, is the challenge to design the tools to get information about what's happening in the private sector. Community based information gathering has the potential to give that kind of data, since the community access both public and private services. There is a need to detach from the low ground level interactions such as ANM and ASHA's alone, which is the most common at present and identify and recognize the others who are also involved at different levels.

#### **FLOOR DISCUSSION CHAIRED BY LINDSAY BARNES AND SUNIL KAUL**

- There is plenty of information soon to be available from the NFHS-4, that could be used after the desired segregation happens. There is district level data and many SRH indicators available for analysis. Given that so much of resources are spent for gathering this kind of data, there is a need to articulate why do we need this monitoring tool?

In response to the above question, several noted points emerged on the floor.

- There is a lot of problem with the NFHS-4 data. It says in Bihar, the female property rights are the highest. Further, it shows a huge decline in child marriage. It indicates that the child marriage issues soon will be out of discussion both legally and in policy context. Therefore, a need to focus on narratives needs emphasis.
- There is also the same problem with the data filled by the grassroot workers at public health facilities where there are huge discrepancies from reality. We have witnessed how these data are filled.
- Lot of the qualitative aspects does not emerge from NFHS-4. For instance, the users' perspective on quality of care. There is a need for us to emphasize the loop holes in the existing tools and indicators which are used to inform policy making. The regular existing tools and data such as the NFHS, RSBY used for policy making should be regularly monitored and one should be able to critique it with a right based perspective and also bring it into the public domain. While the

availability of such information is recognized, it is not free from limitations (recall of out of pocket expenditures in the NFHS data, that happened 3-5 years before) and does not many times reflect the reality.

- For example, there is hardly any data available on the migrant population neither with the government nor with the NGOs. Similarly, the *Maldhari's* - the transgender people.
- Government's new ways of collecting data through electronic media is another concern area. One has to doubt the ways in which these data are filled, the reliability of these data. There is always discrepancy encountered when we make field visits and the government figures of certain indicators. How do we monitor that?
- Need to underline the fact that, monitoring is not just about collecting data through indicators. It goes beyond, firstly a process and then the politicization through the process. Advocacy at multiple levels is possible, however, it is important to emphasize that the politicisation to speak up for one's own right, the power at the community level is more important. The politics of evidence is very different. What is considered as an indicator and what is collected as an indicator matters a lot. For instance, at RUWSEC, through the women's voices process, there came up 13 dimensions about safe delivery. **There is a need to give emphasis to women's voices and need to challenge and be able to say, these are what women say vis-à-vis the policies and programs.**
- It is not feasible for us to collect huge data. **But it is possible to keep ourselves open to documenting stories, narratives and be able to see it beyond sample size and representativeness of the data as seen in quantitative studies.** There are court hearings, where a woman's testimony differs in perspective and always challenges what the providers are trying to prove. This is one way we could constantly challenge the large data sets such as NFHS.

## CONCLUDING REMARKS

Given that, there is a lot of data already available people are going to question the purpose of such data collection process. Through a critical review of the last 15-year studies on Health equity research in India it's been possible to come out with questions such as: what it can't do due to data limitations, sample size etc. Secondly, it is only able to answer what are the gaps but unable to explain why there are gaps and how are these gaps filled. **Therefore, one thing is to keep on collecting data and find gaps, and go beyond and say who are all affected, why someone is more affected than others, what are all the factors that affect them and how different from others. The narratives emerged as very important methods for information gathering from the discussions.** But there is need to be balanced, with a spectrum of scenarios represented rather than focusing just the worst or best or average case scenarios. This will help us to pull out from the tool that can help us give more qualitative, descriptive information representation of various realities.

## EXPERIENCES WITH DIFFERENT TOOLS



During the afternoon session six individuals/groups presented a specific tool in which they were either a part of the tool building process or used the tool or involved in all or at some level of the tool development and implementation process. In this section, I brief some of the core points of the presentations and simultaneously incorporate the clarifications and discussions that emerged corresponding to each session.

### **QUALITY OF CARE: MONITORING TOOL FOR MATERNAL HEALTH CARE SERVICES – GUJARAT**

*Presented by: Sunanda Ganju*

This tool development was part of the project on ‘Enabling Community Action for Promoting Accountability for Maternal Health’ carried out by SAHAJ, MacArthur Foundation, CommonHealth.

The critique of the Maternal health policies and programs in India emphasises the importance for institutional deliveries rather than ‘safe deliveries’ and inadequate monitoring of quality of MH services.

**Project location:** The project was situated in Gujarat with two partner organizations namely,

- ANANDI in 2 tribal districts – Dahod and Panchmahal (four PHCs) covering 25 villages
- Kaira Social Service Society (KSSS) in an advanced district - Anand (two PHCs) covering 20 villages.

#### **What was monitored?**

- Safe Deliveries’ both from technical perspective as well as women’s perspective
- Quality of ANC and PNC based on the NRHM standards.
- The tool was filled for every pregnant woman in 8<sup>th</sup> month and up to 20 days after delivery.

#### **Details about information and services monitored:**

- Primary information about the pregnant woman - like age at marriage, obstetric history.
- Details about pregnancy, delivery and postnatal period (including new born care)
- Place of delivery - institutional or home delivery; private or government
- Services and entitlements received - including information regarding high risk symptoms and birth preparedness and nutrition.
- Expenses incurred - for services in the hospital and transportation,
- Referral services – type of health facility referred to.

#### **Data Collection and Analysis:**



*Field level data collection:* By trained community health volunteers/ field officers of the partner organizations.

*Respondents:* Pregnant women and their family members.

*Data entry and analysis:* Data entry operator at SAHAJ entered the data in a coded excel sheet. The analysis was done by the District Program Coordinator at SAHAJ.

### **How was the data used?**

- Data from all forms was compiled in a PHC level Report Card every six months.
- Phase I (2012 to 2015) - four report cards in tribal districts and two in advanced district
- Phase II (2016 to 2017) – three each in three districts
- Shared with panchayat members, women's *sangathans*/Self Help Groups
- Report Card used by community leaders for dialogue with block level health officers
- Block level Report Cards used in Public Dialogue proceedings presented to District Health Officer.
- Also disseminated and used as a tool for advocacy.

### **Tool making Process**

- Two Training of Trainers (TOT) trained at project partners in March 2012 and August 2012
- At the end of four months, project partners tested and finalized the draft tool
- Draft tool testing – A total of sixty forms were filled (30 in each project area covering three trimesters) and reviewed for further changes in the content
- Discussions on women's perceptions of safe delivery resulted in the incorporation of the perceptions in the tool.
- Participatory exercise – discussions were held with sangathan members. They helped in finalizing the pictures and the questions associated with them.
- Thus, a pictorial tool from the women's perspective for Dahod /Panchmahal district was finalized.

- As the literacy level in Anand district is higher, the Anand team made a simple tool without pictures.



### Validation Procedure



**FIGURE 1 DISCUSSIONS ON WOMEN'S PERCEPTIONS ABOUT SAFE DELIVERY**



**FIGURE 3 RANKING EXERCISE CONDUCTED IN TRIBAL DISTRICT (DAHOD AND PANCHMAHALS)**




**FIGURE 2 DAIS DISCUSSING THE TOOL**

સુવાવડને કેટલા દિવસ થયા : \_\_\_\_\_ માહિતી લેધેલ તારીખ \_\_\_\_\_


**વિભાગ ૩ – પ્રસુતિ પછી માતાને પુછવાના પ્રશ્નો**

સુવાવડ ક્યાં થઈ :



ઘરે

\_\_\_\_\_



દવાખાને

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અન્ય \_\_\_\_\_

- જો દવાખાનામાં થઈ હોય તો વિભાગ ૪ના પ્રશ્નો પુછવા
- જો ઘરે થઈ હોય તો વિભાગ ૩ના પ્રશ્નો પુછવા

**વિભાગ ૪ – જો દવાખાનામાં થઈ હોય તો નીચેના પ્રશ્નો પુછવા**

- તમારી સુવાવડ ક્યા દવાખાનામાં થઈ હતી ? \_\_\_\_\_

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**FIGURE 4 THE PICTORIAL TOOL**

**The Final tool:**

- Period taken to finalize the tool was seven months, from 15th March 2012 to October 2012.
- One month to collect pictures from various sources, 14 meetings with project partners, dais and technical consultants, 6 meetings with designers and printers.

**Rolling out the tool at the field level:**

- Maintaining village wise list of all pregnant women
- Training: In Anand - Health workers (including ASHAs) employed by the Dairy Cooperatives worked as volunteers. In Dahod and Panchmahal, a pair of dais and young literate girls (*Ganeli* (wise) and *Baneli* (literate)) were trained to fill the tools.
- Supervision: Field officers from partner organizations through review meetings ensured that data is filled correctly. Mechanisms of quality control included selecting 10 percent of the filled-in tools were randomly selected for verification.

**Course Correction of the tool:**

- During review meetings, the tool was further modified in terms of language, recommended time period for each service and additional information like EDD, sex of the baby, postnatal care and so on.
- However, maternal health services including women's perception about safe delivery with a Rights perspective could not be captured in the tool in its entirety.
- Capturing quality of services was an issue – for example cleanliness, behaviour of the staff and so on.
- Mid-term Review (MTR) was done by Dr Rajni Ved (evaluator for MTR). She commented that the tool was:
  - Serving multiple interests and functions - action research, empowerment, system feedback, reminder trigger
  - Length and complexity are issues
  - Needs to highlight out of pocket expenditure and delays more effectively

- More focus required on service guarantees
- A whole range of tests like urine, abdominal check-up, height, breast exam, sickle cell, TB, sonography, iron sucrose injections were deleted.
- A section on birth preparedness and nutrition was deleted since the information yielded was uniformly identical for each woman.
- Inclusion of components that are not part of the existing package of services. For example, the inclusion of USG could mislead community members into believing that USG is an indicator of high quality services and therefore deleted.
- Another example – how many stitches during episiotomy? Does not necessarily add value in understanding access and quality issues.
- Thus, from 25 pages, the tool was reduced to nine pages after MTR.

### **Outcomes**

Report Card sharing has made the health system more responsive and has prompted community action. [The colours green, red were more attractive depicting the situation prominently]

- Maternal Health Services have improved significantly. Restarting of services including VHNDs that had been previously suspended.
- Weekly antenatal clinics more consistent due to more regular attendance of government providers.
- The Health system acknowledges and appreciates that this program has helped them to understand “what people’s expectations are and what government services are available” and most importantly it has helped them to reach out to the most marginalized communities.
- Through the tool, we created a climate for awareness and demand for better maternal health services in the most deprived communities in Gujarat through the mothers-in-law, sisters-in-law, husbands, neighbours.
- Tools from the project have been disseminated and adapted by other organizations.

### **Challenges incurred**

- Continuous addition and deletion of information impacted the quality of Report card
- Quality checks – In Anand (with TF - previous partner) about 500 forms had to be discarded because majority of the responses were uniform and presented a rosy picture about the maternal health services given to women.
- Ethical considerations while filling the tool - Should information be given about services and entitlements if the women had not received any?
- Attrition amongst field level staff and volunteers
- Need for frequent training with newly hired staff
- There are still corrections going on with the tool.

## Questions from the participants

1. Was it a government funded program or your own money?

*Self-funded program.*

2. Could you share the experience of reactions to report cards?

*During the second phase of the programme, there were questions like why do we need a tool, why do we use a Mamta card? Some of our colleagues compared the Mamta Cards and the tools of the particular women to see the gaps. Ultimately the idea was to build a systemic tool, Mamta card is essential. Some of the rights aspect were not captured in the mamta card. We started with rights perspective and the original tool had several questions pertaining to it, and many questions got knocked out.*

*The story of the first report card was produced for 2 PHCs together. When presented, the block medical officer was curious and said, "I want to see the report card to know what has come out for my PHC". Then we disaggregated the data at PHC level for medical officers. While there is a lot of interests among the Medical officers after the introduction of the tools after the initial resistance and denial. However, now they look forward to see how they could move ahead in terms of colour indicators red, orange and green.*

3. How did the decision -making using the report card change the marginalised situation?

*The report card was taken to the block medical officers. For instance, in Anand, when they did the pregnancy tracking, there was very low antenatal coverage. So we started looking at what is happening at the Village Health and Nutrition Days (VHNDs). It was one of the triggers to strengthen the VHNDs and also started monitoring of the VHNDs. Yet another outcome was understanding that in the agricultural fields, the population moves with the seasons and during those times, no VHNDs were being held. The monitoring effort made efforts to send NHNDs to those other places and now we have an additional tool for VHNDs.*

## QUALITY OF CARE OF INSTITUTIONAL DELIVERIES IN THREE STATES

*Presenter: Leila Calab Varkey*

The White Ribbon Alliance Safe Motherhood aims to prevent any maternal deaths or new born deaths due to preventable causes. WRAI works in the area of maternal health and is focussed on ensuring that the quality of services for the vast majority of women are at least of the standards set by the government.

The process: Being a national alliance the WRA was allowed to focus on three states through a competitive bid from the states. Along with national alliance and state alliances we decided to monitor the quality assurance process. Although a complex process, using a

facilitation guide and visit to health facilities whether all types of quality measures are in place was assessed.

The first decision was that health services covers the whole gamut of services at all levels from PHC, CHC and district service providers etc, and therefore we focussed on MH services.

Which area of Maternal Health? There is enough attention and many are involved in the antenatal care. Post-natal would mean visiting many homes and complexity involved. We felt that the biggest impact would be if we are looking at institutional delivery services in three districts across three states - West Bengal, Rajasthan and Jharkhand. The initial idea was to look at a range of facilities from PHC, CHC to district hospitals over a period of time and help understand the flow and also understand the referral services. However, this was not possible given that the membership is diverse and not all come from a background of research expertise. To match with what was happening at the ground, we had members coming in to help us in building the tool. One of our strong members is JPHIEGO with work experience across several places and others were UNICEF and SAHAJ. We looked at the tools shared by them. UNICEF had more of an advocacy approach – ‘who you want to influence to choose your tool’. JPHIEGO had a supportive supervision tool that looked at the quality of maternity services with more of a clinical based approach. WRA itself had a checklist and a report card process based on its earlier work that looked at ensuring entitlements.

Based on these existing tools a shorter tool was developed. But even that was felt to be difficult since it was found to be more technical when it was tested. So, we had to start from scratch to develop a fresh tool. WRA wants to provide not just the critiques but solutions to health system and it tries to balance the need to work with the system and as well outside the system, which the tool reflected.

The Tool: It is called the ‘quality process and client assessment’.

Components:

1. Facility Assessment Tool

- a. Facility identification and Maternity Service Availability were observed
- b. Self-assessment of QoC reported by health service provider
- c. Quality Assurance and Supervisory visits
- d. Rogi Kalyan Samiti (RKS)

It first looked at what is available in the health centre itself. The quality was looked at with a perspective of human resources, infrastructure and budgets. This has to happen within a day where three people go do it and come back the same day. So, the basic questions included such as ‘Does the approach road to the facility display a signage giving directions to the facility?’, ‘Is a Citizen’s Charter displayed? Insert details in guideline’. ‘Is the duty roster displayed at the facility?’ etc. **The innovation in the tool this time was that we took photographs, apart from the yes or no options.** The presentations were able to give a picture

of the very good suggestion box to a rusted suggestion box to a suggestion box that did not even have a door. The same with the toilet that were good to clogged toilets. A lot of these were observations and only where it has to be asked they were asked. The rigour of this was not so much about someone else validating it but about who is taking the photograph. There was some negotiation that happened with the government in order to go through this process. It is actually, part of the process where we are ensuring that in the engagement process itself its seen and understood and when results come out it does get seen.

The other aspect was to seek perceptions of both providers - whether they like to seek services or not? It was interesting to find that some of the providers were happy about the services they provided but in West Bengal providers themselves did not feel satisfied about the services they provided. **At this moment, such kind of evidence gathering could be brought on board where doctors could be able to say that they need infrastructure to provide services in the situation of privatisation of public health care services.** There were even providers who said they do seek money for offering services. However, it was very challenging to analyse in the absence of any quality assessment records, to even check if there has been any follow up, when it was almost nil, and there were no records of the same. The system was complex that the quality assessment records were not in paper and functionally needed several changes.

Thus, there was one question that asked whether any newborn or maternal deaths that happened in the last three months and were they recorded? and if 'yes', where was it recorded. In Jharkhand, this question was taken for further investigation when they said, there were no deaths. Then we realised that it went from one table to another but nowhere it gets reported, since nobody wants to report. Then, we went to the Asha's after a discussion at the next level and got to know about the maternal deaths and got the facility to investigate the reasons for maternal deaths. This made the administrators and health care providers in facilities realise that they cannot shrink their responsibility. So the Maternal deaths section looked at the register, the grievance mechanisms in place, and has it been opened and who looks at the grievance box, how often it is opened?

Component 2:

## 2. Post-Partum Inpatient Woman's Schedule

- a. Verification questions
- b. Services received
- c. Quality of Care during current stay for delivery

There was also interview with the women to know about whether they paid for any services? about the cleanliness and several other quality measures. We also learnt about the Rogi Kalyan Samiti and associated measures. A very few women who had delivered at the facility but with the longest number of births were chosen, just prior to their discharge.



They were asked about their experiences on quality parameters, for some kind of comparison with the provider perspectives.

The tool was a utilitarian tool, that galvanised the WRA members in those states to discuss these operational bottlenecks with the authorities. In some cases, it was resolved at the lower level but in some cases it had to be taken at the higher level. For instance, in Rajasthan, it was possible to

work with the legislative members and some of the bottlenecks were resolved. In West Bengal the WRA is just like a campaign is neatly associated to safe motherhood day and through media been able to address a few issues. In West Bengal crowding is the major problem that curtails provider to provide quality services.

Component 3:

## 2. Knowledge of Facility's Budget and Budgetary Process for fostering QoC

The questions in this tool were addressed to facility in charge/ medical officers. The knowledge on sources, funds flow mechanism, sanctioned budget, utilisation and non-utilisation etc were discussed. We also went one step ahead and looked at whether they understand budgeting? their awareness for bottlenecks for getting funds etc and the importance of utilisation certificates. But the entire process was more of a collaborative process rather than watch dog role.

Queries from the floor?

### 1. How was the data collated and analysed?

A: We decided specific level of facilities will be included since, we wanted those facilities to be those providing services. "In WRA's QoC facility assessment, the analysis' focus was on delivery points and accordingly the facilities assessed were grouped as mentioned in the three districts selected in each of the three states". A team of three people, members from the alliance, the NGO members who are already working in that region collected the data. Around 10 sub centres at the L1 level, 59 facilities at the L2 level comprising block level PHCs and CHCs, and 23 facilities at the L3 level comprising sub-district and district level facilities were included. Although not a very collaborative process, there was negotiation about the facilities we wanted and they wanted to give us, since some of them did not work for us. There was also a lot of discussion on the discrepancies of the definition of Level 1,2 and 3 facilities and their understanding.

The local monitoring was happening through the state secretaries. The analysis came back to the Secretariat. Finally, we had to list to our secretariat at Delhi what were the facilities given. Most of all, we wanted to show the level of services available. The state and national requirements were different and hence needed to be tailored to those expectations. Language was a big issue and needed back and forth corrections and edits with the help of available experts.



2. Where disseminated and what mechanisms? What were the fora of discussion that allowed action to be taken?

A: The dissemination happened at three levels. One was locally at the district level. And second was bringing it at least at the state level among the alliance members to recognise where are we heading ahead with this information in hand. The alliance members at different states took a slightly different decision with what they wanted to do with this information, given that they are all people working in the area of maternal health. For example in Jharkhand, Ekjut is one of the members and they talked with the other members such as CINI and they chose maternal mortality and MDR and wanted to take that ahead. In West Bengal overcrowding was something we noticed and they wanted to take that ahead. At the national level, we systemically use an approach to identify, to see whom within the policy has the capacity to internalise and make changes in the policy. There are standard partners in this area, who regularly consult with the governments who make the manuals and guidelines such as the NHSRC and the people within NHSRC who work on quality guidelines, the large donors, the media especially who write on maternal health. Although this work was not taken to the Members of Parliament (MP), we have tried this at another level. We believed that technology would attract the MPs and an app was created where the HMIS data of the MPs constituency was developed and shared. When the MPs were called for a forum to discuss these issues, they were far more sophisticated in use of this, but said that they were not aware of these details. When they said, why do you not say what's happening, we suggested atleast a trend should be able to imply the situation. But they were not too interested in their constituency data rather in the aggregated national level data. But our focus was more on the budgets, funds flow and utilisation etc rather than ground level nitty-gritty.

3. Who made the decisions for tool development and what processes were involved?

A: The initial exploratory part of the tool was very participatory where the conversations were through the emails, people from the WRAI came in. The people involved in all the three regions were included in these conversations by default. The work is done nested at one place at the respective NGO's and everybody else is allowed to contribute to it.

Once the draft was ready, the secretariat of the alliance at New Delhi, finalised the draft, and sent it to the respective teams in the states. Then it was pilot tested and sent back to us in the excel format. Second time the tool was again simplified and sent back to them, and they themselves trained their people and no one from the secretariat went. The monitoring was done by the state secretariat themselves who have expertise in doing research and advocacy often.

#### **DEAD WOMEN TALKING SOCIAL AUTOPSY TOOL, COMMONHEALTH**

*Presenter: Sanjeeta Gawri*

This is a tool developed for assessing the maternal deaths. The concerned individuals came together to address the disparities in maternal deaths and about the transparency because

some of the maternal deaths occurring in certain pockets were not known at all. The second objective was to look at the Verbal Autopsy form, developed by the NHSRC and used by the government to assess maternal deaths. In 2012, there was a 2 days meeting and the purpose of the exercise, was to re-look at the NHSRC tool and add the social determinants of health through the initiative of Dead Women Talking Series. Thus, the social autopsy tool was added as an independent tool.

The aim was to capture the background conditions of the women, poverty status, power-relationships with others and negotiation abilities, the education status of women and other household members, the nature of her roles and responsibilities to understand her burden of physical work, the access to water, behaviour, her experience of violence etc which are also influencing factors in a maternal death. The reproductive history of the women was also captured. The challenge was to collect these information through others in the absence of the women herself. So, who could these respondents be and identification of those respondents was yet another challenge. This was a holistic and an ambitious tool.

The data was collected along with the observations. The methodology included the aspects on how could the form be filled. Through the respondent's initial storytelling, the tool shall build upon further to enquire further. Then the period of death during the pregnancy had several separated sections and tools. The referral sections and some of the background information were some of the common details collected for all.

It was piloted in the states of Maharashtra and Gujarat. The second round of consultations followed by pilot testing had more adaptive changes brought into the tool. The tool was used by 23 organisations between 2012-2015 and multiple layers of iterations were made to make it more suitable at the field level. For instance, the medical and non-medical out of pocket expenditure came out as prominent barrier to access and was later incorporated within the tool.

One of the sections also looked at gathering information pertinent to the health rights within the family and at the health system level. However, finally at the dissemination level, in the report the social factors layered less since the health system bottlenecks were much more prominent.

The monitoring of the organisation's was not that feasible and homogenous given that they were spread across different geographic locations. All these organisations were trained by CommonHealth on how to collect the data. Most of them who attended the training were community workers and were all doubtful if there is a need for technical expertise such as medical degree to collect certain information. The SSR framework was used to analyse the data – the science, social and systematic factors were then collated by the organisation that collected the information into an excel sheet and data was analysed. For each woman the biological, social and systemic causes of deaths were analysed.

A detailed guideline was formulated for data collection and analysis. The hurdles of blaming the other in the entire process for the cause of death, was triangulated through

different sources such as marital and natal family, ASHA, health system functionaries, ANM Records where the detailed guideline played an important role. Multiple visits were required to come to a conclusion. The observations at the health facilities also proved to be useful to triangulate the causes for death.

The MDR process gave a sense of empowerment to the community members since they themselves collected this information. After the data analysis process, at the community level this information was used for local, state and district level advocacy efforts. At the national level, in January 2015, there was consultation in New Delhi which brought together the government officials and NGO's to disseminate the information.

**Floor queries:**

Q: Did the tool fail to capture the social factors, why the emphasis was only on systemic factors, when it was aimed to capture the social factors?

It did capture the social factors. the systemic factors were so overwhelming that we decided to focus on the systemic factors. Two factors emerged here. One was the report that emerged meant for the advocacy efforts and by design to focus on the systemic factors which were overwhelming. For instance, although the social factors did not get fed into the report, there were other levels it was taken back such as the gram Panchayats or within the *sangathan* in Gujarat. This was because the whole process was nested along with the maternal health project and it was a vibrant action. The action at local levels were not homogenous across states, depending on the people involved.

Q: How was the subjectivity of different people collecting the information addressed?

Although different people collected it was a team process. The data from multiple perspectives was collected from family, data sources available in the health facility and validate with experts, whatever stories were heard we made sense of the data and capture what we thought was the story. The organisation and the team involved at field finally built the narratives of the stories. The methodological approach we followed is the Roshomon effect, used by many others to validate. The process of having three different consultations was to bring all organisations together and discuss the issues to understand how to make sense of the data and other issues.

**UP SAFE ABORTION ACCESS AND AVAILABILITY TOOL, COMMONHEALTH**

*Presenter: Rajdev Chaturvedi and Alka Barua*

Few institutions working on Maternal health issues in Uttar Pradesh following two consultations about unsafe abortions along with information on MTP Act, and PCPNDT Act came together. Dr. Alka Barua, in coordination with these organisation developed a tool. It was a 360-degree social assessment tool on the awareness on MTP Act, PCPNDT Act and how it affects the community. The tool had a detailed informed consent process. The NGOs which conducted these interviews had been given semi-structured interview guides but had never been engaged in this kind of process. Except two organisations the

tool was used as a structured tool and ended up with ‘yes’ or ‘no’ responses without much probing exercise.

FGDs were conducted at the community level. Four to five different organisations collected data. But the data is not conclusive and going on. A thorough training was conducted for the community workers to conduct these in-depth interviews that included the ethical procedures, understanding the body language and beyond.

The data that has emerged based on the provider interviews that were actually not very useful. However, even among the two respondents whose interviews are complete (the district medical officer and the Medical officer) their knowledge of the MTP Act is nil, including so many other responses, which is ‘No’. So, we are wondering is it a genuine lack of information or is it because of the way the questions were raised. Because these are facilities where induced abortions are happening.

### **Queries from the floor**

1. Were the persons who were trained, also who did the interviews? Because this was not exactly happening in the maternal health care monitoring in Gujarat.

Although mock sessions were incorporated in the training and how to document the information, either it did not work because the same people did not go for data collection or they did not take it seriously.

2. The question arose on the concern for rigour of data collection process in such sensitive issues beyond training and the data collector’s skill sets.

A: It was shared by sundari that it is not about data collection or collectors, it is about the monitoring of the process of data collection, validation procedures, the rigour with which it is being collected. Even if it is collected by village women, guided along these process, it could still be very good data. Renu added that, it is not only about the monitoring, it also about the documentation skills of the organisation. The maternal death stories from Anandhi are very rich stories but their documentation is very poor. Lindsay added that, I wrote 25 stories (case studies) of women who underwent abortion and it had such great impact and feedback without any research vigour or methodology aspects. Priya John concluded that there is an understanding that there is some level of expertise required in talking to people, and identifying what to capture in that conversation. As a researcher, when I am interviewing, I am also observing around, even those that are not shared by words. There is a need to differentiate documenting vs research.

Mandakini added that, in her organisation the peer educators sensitise the community members on HIV. They have observers, when a conversation takes place between peer educator and community members, based on the conversation content the SRH tools are developed and ‘frequently asked questions’ are developed. This could be one method of data collection

## **THE TAMIL NADU COMMUNITY ACTION FOR HEALTH (CAH) TOOLS**

*Presenter: Rakhal Gaitonde*

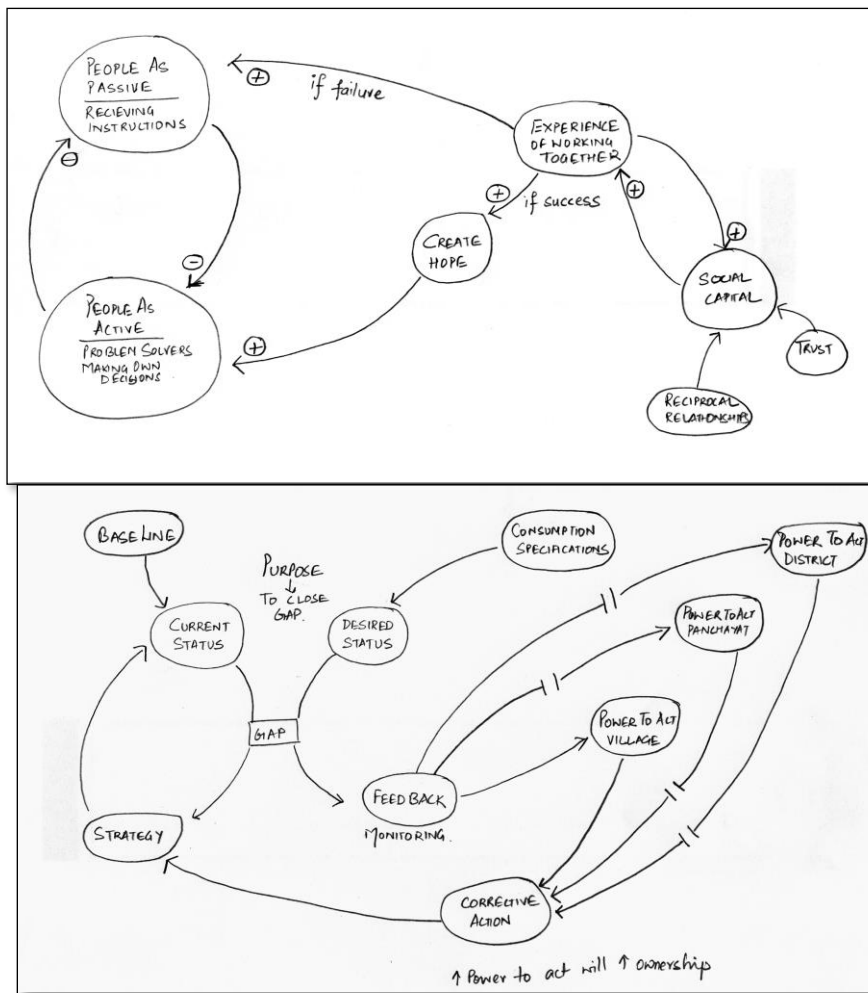
Rakhal was earlier associated with SOCHARA and acted at the capacity of Project Manager in the implementation process of the CAH project in Tamil Nadu. He shared his experiences through this presentation.

The NRHM has emphasised community involvement as one of the key pillars. This was an NGO run project supported by the government order to implement the process. There was a state level NGO that did the overall project coordination. There were also district and block level NGOs. The block level NGOs had appointed, one block coordinator and large number of facilitators who drew a part-time salary and there were also Village Health and Sanitation Committee's involvement.

We first realised that the understanding at the state level and that down the cascade were not a shared understanding. Therefore, it proved important to philosophise, rationalise the process and developing itself at the block and district level during the training process. Thus, it is not wise to assume that it is a shared understanding at all levels.

How did it evolve as a philosophy that guided the decisions pertinent to tools?

We first ask ourselves do we see people as active (problem solvers and manage own decisions) or passive (receiving instructions). If we see and believe them as active, why are they passive today? is how the Tamil Nadu government took it. They are passive today because they have lost hope given the structures etc. Then the idea is to build hope. The below diagram was collectively developed by the five district NGOs through a collective process after a year of pilot tests. We could create hope by bringing people together and experiencing it even in the smallest possible ways. In essence in any village we would assess the current status and the desired status. This would help us to create a tool to measure this gap. This gap would be fed back to the appropriate levels where change could be brought up. The important message at this juncture was 'it is not enough to feedback at one level rather multiple levels'. And then the corrective measures leading to a system or village level strategy could solve the gaps.



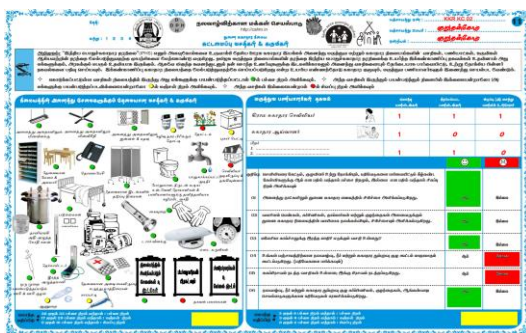
Secondly, tools were seen as consciousness building, organization and mobilizational strategies and it was very explicitly put out. Therefore, in Tamil Nadu tools were a way of working together and moving ahead for problem solving. Thus, tool was not seen as a robust one that would match the statistical criteria. It was made clear that the data should be believable enough. Therefore, the negotiation happened with the district and state level authorities, about believing the data, even if it is from five people or ten people.

### What does the tool monitor? What are the dimensions it captures?

The tool was for all the services covered under NRHM such as immunization, ANC, delivery, PNC, ICDS, school health, adolescent health, rural health services and TB. These services had separate tools for all these segments and for the HSC and PHC level separately. The equipment survey was done at the HSC/PHC level. The domains of the monitoring included: *availability* of the service at village level, *health education* (why are the services provided and awareness is important) and *quality* (the only thing the government wanted to know. It assumed that the facilities have 101 percent availability of







*In terms of dimensions the key issue was addressing equity.* We had the dominant caste, the dalits and among the lowest caste, the minorities. We picked up and showed the differences between the dominant and the Dalits, whether being served or not?.

### What level of service/programme is monitored?

The community based survey tool to assess the outreach of services existed. Through which the cleaning of water tanks, malaria prevention activities were all incorporated. There were three rounds of survey, by the end of the second round, many people commented that we are covering only a partial population accessing the public sector, and nearly 50 percent go to the private sector for maternal health services. This led to developing a tool to assess the private sector through the community based monitoring, without visiting the private hospitals.

### Who collects the data? Who responds to the data?

It was basically the Village Health and Sanitation Committee members who go to collect the data. Anybody who so ever has used the services in the last six months, in order to validate that it is not just an opinion but an experience was the criteria for respondents.



### Who collates and analyzes the data?

The village health and sanitation committee members, supported by an NGO level facilitator initially did the data collation and analysis and was found feasible to continue. It had very simple range parameters and guidelines to calculate and segregate the responses under the colour scheme of red, yellow and green. Nothing more than addition was required. The raw data was

transmitted through SMS in a readymade excel sheet format. The original idea was simply to generate graphs and send it back to the community although it did not fructify later.

### What processes were required?



a. Tool development was a participatory process and followed a top-down approach. It was a participatory process which included FGDs in the community, interaction with several experts such as doctors, activists and went through iterations with government officials, NGOs, unions of VHNs etc. It discussed what were the appropriate questions to talk about availability, quality, education. The draft was circulated among the whole public health department and ANM association and anganwadi association. Bringing them on board gave a lot of suggestions.

b. Training of persons collecting data – this was a long drawn out process. The Trainer of Trainers method, mock interview methods initially failed. Later we included the NGO facilitator first accompanying the members for the first two rounds as observers and gradually encouraging them to do more and more of the data collection and in the third round they were almost independent – this process took one and a half years including various training and learning on the job. **There is a need to invest lots of energy, resources and time in intensive training if quality data is what is expected.**

c. Supervision required – There were roughly one supervisor for one NGO facilitator for four to five villages. There were again block facilitators, state team of about 5 people and district level facilitators. This was crucial not only for the actual filling of the tool, but more importantly to ensure that they were filled and used with the ‘spirit’ behind the process – the way it was envisaged. This was done both by a respective NGO facilitator who is responsible for five committees and occasionally by block and district level NGO staff.

Mechanisms for quality control/ethical checks also included monitoring. Ethical checks were not explicit – but there was extensive debriefing of all issues in the fields at multiple levels. Backlash on communities especially the more marginalized communities was actively looked for. We planned for the expected and preventive actions at the field level.

Outcomes: The availability was higher in Tamil Nadu, but with less quality and education during the first round. By the third round all the indicators moved up high. **It was expected that this would ultimately lead to more accountable health systems and the evolution of bottoms-up state level health plan. However, the process remained as an NGO project in the eyes of the state and all changes were limited to the area – mostly for the time of the funding.**

## **THE CONTRACEPTIVES SERVICES MONITORING TOOL AND ADVOCATES GUIDE**

*Presenter: Nilangi Sardeshpande*

CommonHealth developed this tool a year back and it is yet to be tested in the field. This tool is intended to be used to monitor the contraceptive services at the PHC and village level. The tool is derived from the advocates guide developed by CommonHealth on ‘Monitoring of Rights based provision for contraceptive, information and services’. The London Summit and the FP2020 played an important contextual role in coming out with this tool. We understood from there that since India has given a huge commitment for

contraceptive service utilisation, it is invariably going to come as coercion. Given that numbers and targets are a huge jump and big, it may be difficult to have it as a participatory and informed process. The PPIUCD experience is an evident example of this. Next, the WHO document on, ‘Ensuring human rights in the provision of contraceptive information and services’ published in 2014, formed the basis for developing an ‘An Advocates Tool for Monitoring Rights-Based Provision of Contraceptive Information and Services in India’. This a simpler version created by Dr. Sundari Ravindran and Dr. Renu Khanna with funding support from Arrow. This was published by SAHAJ in partnership with CommonHealth. There were discussions amidst a group of people in 2015 around the experiences of contraceptive services in our respective field areas. This guide begins with calling it contraceptive services rather than family planning. This is clearly envisioned to encompass all sections of the society, inclusively. This helped to make adaptations to the guide and a few sections was pilot tested by few NGOs. Thus, the tool was finalised based on the comments that arrived through these pilot tests. The guide has a checklist on several domains to use it at the field level with a rights’ based lens added to it. Access the guide at: [http://commonhealth.in/advocates-tool-for-monitoring-rights-based-provision-of-contraceptive-information-and-services-\(1\).pdf](http://commonhealth.in/advocates-tool-for-monitoring-rights-based-provision-of-contraceptive-information-and-services-(1).pdf)

Renu added that, during the Pune meeting held by CommonHealth in 2015, several people working with several marginalised communities presented their issues. When we introduced the tool, many people, even the CommonHealth members were not aware or thought through about the provisioning of contraceptive services. The first thing they wanted to know was the situation in their own field areas. A step back, then they wanted to use the respective part of the tool suitable to their field area. But many were interested to use the adolescent part. The technical information about the use of contraceptive is found to be very useful both during the training and the scope of using these tools.

#### **Floor additions:**

Alka added that contraceptive counselling as a service is one of the biggest gaps from my experience working on PPIUCD. The consent procedures are not clear.

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## **WALKING THROUGH SOME OF THE TOOLS FROM THE FLOOR**

### **QUALITY IMPROVEMENT FOR EMERGENCY OBSTETRIC CARE**

Prof. Bharati Sharma presented the tools overview for assessing ‘readiness’ in emergency obstetric care.

The tool since development has gone through several changes. I present here the latest tool available for ‘Quality improvement for emergency obstetric care’. This is prepared by EngenderHealth and Averting Maternal Death and Disability(AMDD).

Access tool at: <https://www.engenderhealth.org/files/pubs/maternal-health/qi-for-emoc-toolbook.pdf>

This tool has several components such as case review, register and record review, client flow analysis and tools for information gathering and analysis. Each of these components have independent and a detailed tool. I choose ‘EMoC assessment’, which is more clinical in aspects and ‘Client and family interview’ – a qualitative component of the tool, which has more relevance for today’s discussion.

The EmoC assessment looks at: Preparedness for care, equipment and supplies, monitoring systems, clinical procedures during normal labour and emergencies, monitoring complication rates and infection prevention.

In client interviews, there are series of questions pertinent to: Access the tool at: <https://www.engenderhealth.org/files/pubs/maternal-health/qi-emoc-toolbook/qi-emoc-toolbook-03.pdf>

- a. Client’s right - to information and informed choice; privacy, confidentiality, dignity, comfort, and expression of opinion.
- b. Staff’s right - to facilitative supervision and management; information, training and development; Supplies, equipment, and infrastructure
- c. Facility in general – electricity, paint etc.

There were 22 questions covering the aspects of client and family interview. It includes: a) health problems, reasons for choosing a facility; b) details of health problems; c) information provided, behaviour of staff and pain management; d) quality of care, waiting time, cleanliness; e) suggestions for improvement.

#### **How can these be used and by Whom?**

- The facility itself, if the objective is self-improvement; could be a baseline
- By supervisors periodically if purpose is evaluation
- By researchers
- Some sections of the EmOC assessment tool could be institutionalized such as the records and registers

#### **GOVERNMENT OF INDIA TOOLS**

Dr. Alka Barua presented the Government of India tools. She began by sharing her opinion that most of tools presented are focussed on and restricted to maternal health and relatively less focus on SRHR, with very little focus on contraceptive monitoring and safe abortion.

Within the government, monitoring happens at multiple levels. There are tools for programme implementation and facility preparedness, service availability and coverage. There are several tools for programme implementation at the community level where availability and accessibility are monitored. There are also tools for community response to the program, that looks at whether the services were used, acceptable and the extent of use of specific services.

At the block-level it is the health supervisors who have to monitor. There are committees at the sub-district level for quality monitoring and at district level, the hospital monitoring committees are in place. There is internal monitoring at the RKS or VHSC level for quality of care monitoring. All these are to assess the quality of services. At the sub-centre level there are several tools and to a large extent also being monitored. But these monitoring are mostly guided by their targets and their achievements. There are several checklists available. The monitoring of RCH services is largely restricted to maternal care and family planning. Barely any questions on SRHR or RCH is included. There are questions on consent, maintaining the privacy, confidentiality in the tools meant for exit interviews, that covers some rights aspects. The maternal death review forms are elaborate, they do not cover the social aspects. The hospital level HMIS system has a tool to monitor the SRH services within the community. The National Family Health Survey and the District Level Household Survey tools also covers- SRHR, RCH, reproduction, marriage and cohabitation, contraception, fertility preferences, ICDS, to some extent sexual life, HIV/STD/STI, contacts with community health providers and many more indicators.

While there are many tools available within the government, there is no tool or structured tools to look at the geriatric age group, adolescent health except a few such as RKSK, but are not good enough. Some of the tools from the government could be used for a comparative data analysis and could be easy to use for advocacy as well.

#### **RAPID ASSESSMENT TOOL FOR SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES**

Priya John presented the ‘Rapid assessment tool for sexual and reproductive health and HIV linkages’ published in 2009 by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives. This tool was developed with a purpose to identify linkages between SRH and HIV and AIDS. This tool aims to provide a guide for assessing linkages that can be used to develop country Action plan., The people who developed this tool identify that HIV infections are sexually transmitted and are related to pregnancy, childbirth etc. This is one of the reason why it is important to identify the linkages. It is a generic tool and this needs to be contextualised depending on where it is going to be used.

Although the focus of this tool is the health sector, it is also recommended that it can be adapted and used for other sectors such as education, labour etc. This tool can be used as a standalone activity or incorporated into a larger review process.

The sections in the tool are: policy, systems and service delivery. For the policy section, a desk review is recommended following individual and group interviews. For the rest of the two sections individual interviews are ideally suggested. It would also benefit with other methods such as observation, surveys, clinical records review which is fairly open to contexts.

In the policy section, the overall questions focus is on “What is the level and effectiveness of linkages between sexual and reproductive health and HIV related policies, national laws,

operational plans and guidelines?”. The suggested method is to first conduct a desk review of available reports and other documentation. Then conducting informal key informant interviews which can help in setting the scene and preparing for the group discussion. Next, it suggests. 2 or 3 day retreat with key policy and decision-makers and stakeholders to develop and record consensus answers. There are two sub-sections of policy. One is the political positions of the national guidelines and policies and the second is the funding and budgetary support. They suggest that the questions should be bidirectional, which means that, does the HIV policy have SRH concerns and vice versa.

The second section is about the systems and the overall question focusses on, “what extent do systems support effective linkages of SRH and HIV?”. Here the focus is with the program managers from all levels to arrive at different perspectives. The subsections include: Partnerships and planning; management and administration; staffing, human resources and capacity development; logistics/supplies; laboratory support; monitoring and evaluation

The third section is about the clinical service delivery and overall question’s focus is on “To what extent HIV services are integrated into SRH services and SRH services integrated into HIV services?”. The tool suggests visits to facilities to observe the nature of services for men and women. I would extend to other category and marginalised sections personally. This section aims at interviewing service providers to understand the quality of services, and scales for understanding the constraints. IT also suggest client exit interviews.

They identified the limitations of the tool:

- a. The policy section was very lengthy when used by Family Planning Association (FPA).
- b. In the services section, the options were very limited. It had limited scope for generating data for community organisations etc.

Kindly find the tool at: [http://apps.who.int/iris/bitstream/10665/69865/1/91825\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/69865/1/91825_eng.pdf)

### **TOOL FOR MONITORING OF FAMILY PLANNING SERVICES**

Sana Contractor presented a tool for monitoring the family planning services, developed by CHSJ along with Health Watch Forum, UP and Bihar. Two rounds has been implemented in 10 districts of UP and Bihar during 2013-2015. The members of these networks were involved in developing the tool. In UP, the members of *Mahila Swasth Adhikar Manch*, group of women leaders working across 10 districts (selected 5 districts) of UP collected and monitored the entire process. The *Mahila Swasth Adhikar Manch* members are also associated with various NGOs. **They are trained leaders who have experience in monitoring of maternal health services in the past. So, they had a SRH orientation and they knew how to use tools.** In Bihar, it was done by the NGOs.

The second time it was used in 2016, when Engender health approached us for a social audit of Family Planning (FP) services of CHCs. This place and area is where they were doing training of providers and improvement in quality of care. So, we selected the catchment areas and facilities where engender was working. During the tools revision from first round to second round, initially we did not look at postpartum IUDS as much in the first round. Since they were training on IUDs we created a separate tool to monitor this aspect in the second round.

In 2015, as part of the Devika Biswas v Union of India case, the court has asked the government to submit a report on the status of its camps. At that point, we had launched '*campwatch*'. We had reached to civil society to monitor these camps, and that was used to submit as an alternative information to the court. These tools has been extremely useful and the same has been now used across and implemented twice by MHRC in 2015 (28 camps) and 2016 (35 camps) across 14 districts.

These are a set of tools that involved interviewing users, FGDs with eligible men and women, facility observation and provider interviews. The domains included: identification of clients; information, choice, targets and coercion; quality of services (including availability of infrastructure, human resources etc); provider knowledge; follow up management; and documentation. Each of these domains have a separate tool. The score card is prepared at the end.

The process followed include:

- a. Training of women leaders/organizations - carried out in 2 phases - 3 days before data gathering and 2 days for scorecard and analysis, including a field demo
- b. Selection of facilities and area
- c. Data gathering: Group discussions with "eligible women and men" (newly married, one child, pregnant women) and current users; Interviews with users of PPIUD, IUD, Sterilization in the past 6 months; Interviews with service providers – ASHA, ANM, MOIC; Facility survey – observation; Pictures; Case studies

Pointers:

- In the camp watch several pictures were taken and used for media advocacy.
- Data gathering was done by team of women leaders/organization field workers
- Supervised by one expert who checked all data
- Data collated and analysed in a workshop
- Score cards prepared from the excel sheet entry as per 6 domains

Dissemination: It was disseminated as part of mobilisation and entitlement awareness at village level (primarily to make aware among those who participated about what was found), facility level, district level Jansunwai, state level Jansunwai, sharing with media especially with camp watch, mainly stories of individual camps, PIL some evidence was shared.

## **ADVOCATES GUIDE FOR SRHR INDICATORS**

Sundari Ravindran presented a set of sexual and reproductive health and rights indicators. She quickly ran through the indicators developed by ARROW some of which are identified from the DHS data as sexual and reproductive health indicators and some of which have been newly developed by ARROW. She flipped through some of the indicators:

For instance, the difference between the indicator - median age at marriage and legal minimum age at marriage. So, from these two indicators, what we get is country or regional level picture. But an indicator is developed based on this available information. Similarly, ‘grounds under which abortion is legal’ is not a typical indicator in terms of the numerator, denominator. But a score is developed based on the grounds or restricted grounds which gives a picture. For example, there are yes/no indicators developed by ARROW. Again, from best to worst options are given to gain a picture of certain rights indicators from the DHS data about the legal orientation of relationships, legislation and policies pertinent to gender identities, policies related to SRH and extent of gender based violence.

For more detailed guide refer to:

[http://arrow.org.my/wp-content/uploads/2015/04/Advocates-Guide\\_SRHR-Indicators\\_2013.pdf](http://arrow.org.my/wp-content/uploads/2015/04/Advocates-Guide_SRHR-Indicators_2013.pdf)

What ARROW essentially does is prepare report cards for countries at every ICPD +15, +20 etc. This publication was meant to make people understand how to make meaning of the available indicators and use them differently and not use them.

## **TOOLS DEVELOPMENT DISCUSSION**

Sundari Ravindran presented a summary that addressed the following questions, helpful for the tool development process.

1. What are the kinds of tools we have seen?
  2. What are the SRH domains?
  3. Who is collecting data from whom?
  4. What kind of process was adopted?
- In terms of SRH vast majority are looking at maternal health and a few tools have looked at contraception, adolescent health (within contraception) and abortion.
  - Many tools were assessing facility to know what is happening at that level. Many were community based from their perspective. These community based tools had the possibility to capture both public and private sector. While facility based so far can only be at the government facilities.
  - Data gathering has largely happened through lay persons, through community based persons, or members of WRAI who are civil society actors not necessarily research based.



- Community based data gathering possess major challenges, where we debated what kind of data is possible with lay persons, what would be the data quality, that needs to quality assured.
- With regard to the nature of data analysis, a popular way seems to be report cards or score cards that are colour distinguished for district level village cards. This give scopes for us to think within a village to represent specific populations through such score cards.
- Overall, a lot of time and energy has been spent in tool development and information collection. All of them have had some impact, irrespective of the actually imagined impact. This calls for setting our objectives very clearly – what do we want to achieve?

Two questions that needs to be reflected upon is:

1. What is being monitored?

Actually, we are so far monitoring the entitlements as promised by the government. Sundari raised the need to think thorough before we begin this process. She asked, **should we not at this moment broaden the envelope of entitlements to human rights entitlements?. Is it not ‘right to food’ instead of ‘give me food in ICDS’. Could we challenge it, instead of narrowing it down? If we are narrowing it down for substantial reason, it is fine, but is there a scope to debate over it?**

2. Why is it being monitored?

Use of the tool itself is a mobilising, awareness creating process. The ultimate objective is, some understanding among the people what their entitlements are and they have hope that they are empowered to ask questions. Some amount of local dynamics and a culture is created about challenging entitlements in order to sustain even after the monitoring process/project is over.

The other is to actually make some changes - incremental quality improvement, better coverage, better behaviour (where a two way process of empowerment is created between NGOs and providers or community (sometimes parallel, sometimes connected, or both ways)

Some of the questions could be: Do we want incremental changes? Or do we want policy changes? Or do we want to create a culture of enforcing accountability. We need to answer which is a primary objective or what could be the add on bonusses? Or do we have group strengths and expertise that could be worked on instead of all muddled together?

If we bring the context to ground, there are huge gaps in knowledge within specific population groups and specific areas of SRH. This deserves our intention. For example, if we choose to work on maternal health – could we focus on the migrants, specific vulnerable population groups, minority communities, people with disability/HIV. It means MH in a holistic way. Similarly, for other domains such as contraception, abortion etc could be thought out. The big gaps – do we know



what women do for gynaecological problems? what are the adolescent health issues? what do they do? what is promised and what is given? *Areas or dimensions of SRH that has remained invisible vs people and population groups that have remain marginalised are worthy to look at. 'We would like to give voice to the marginalised therefore we would monitor'.*

- In terms of quantitative and qualitative data - What do we get by collecting quantitative data? Is it to be able to say, it is there or not there, find gaps? While the importance of quantitative information is acknowledged, do we want to still do the same even at the community level? There are gaps explained by the large data sets. While we may not be able know everything, but there is a need to decide on new issues vs unfinished agenda such as in maternal health. What do we need to work in MH, similarly, in contraception?

### **Participant comments**

Madhumita added that the focus is always on younger or older women. There is need to expand to all “women”. Again, contraception is viewed only for married women or otherwise in terms STI and there is no discussion on sex for pleasure. Unmarried, do not feature in any of these discussions. Renu added from a previous conversation wherein if a sex worker wants to have a child, How does it bothers others? There is a need to look at old problems in new lens where unmarried adolescent, dalit women, single women can speak their experiences.

Alka raised a doubt whether in the first place make a review within the lens of rights, of the policies based on the commitments, particularly the case of abortion particularly within the human rights context. For instance contraception is a problem for adolescents under the POCSO. Sundari clarified that when she says from the perspective of Human rights, there are two things. One is human rights principles and the other is human rights entitlements. I (sundari) would be guided by principles and abortion for women, feminism is a right and non-availability is a gender-discrimination. Within the boundary set by laws and going by universal principles where are we positioning ourselves?

Sana shared her view that, monitoring could be used from a management or a rights perspective. But within the rights perspective, if we freeze the indicators we may not be able to push the frontiers further. But there is a need to distinguish what are our legal entitlements and what is provided or guaranteed by the policies and things that we aspire. From a practical perspective of talking to a District Medical Officer certain data are still required such as the unfinished agenda. Without compartmentalising we should be able to draw the necessary and required data to also be able to say what is available and not available.

Sundari pushed this further by a provoking question, are we looking ourselves as brokers, to display that there are gaps? Is it what we want to do? when their hands are tied, less and less funding coming in, they are more frustrated than we are by saying what is there and not there. What is the point of doing this in this context? One can use it for some small incremental changes. Or make the community understand this and take it forward at their priority preferences. *There is need for narratives, voices!*

Rakhal countered that, there is still scope for identifying gaps for a simple reason for why are we doing this. But if we want to mobilise at the local level, the local people should be able to see it as their problem. “I had a bad experience is to say, eight out of ten had a similar experience”. This is to raise consciousness of individual problem as a collective’s problem. The point is, if we keep doing this and keep seeing the same gaps over a period of time, therefore it should not be frozen. In order for the community to understand systemic constraints, local gaps identification is still important. Mandhakini added that, community involvement in the context of sex workers helps them to get sensitised about the issues as well such as discrimination of services, or new procedures which are realised. Only repetitive actions make them realise these, not just one-time conversations. So, gaps identification is important.

Sanjeeta addressed the issue while handling with the policy makers, implementers where there is a need to give solutions rather than always talking about gaps or problems.

Sreeparna raised a fundamental critique of whether should we call this exercise a monitoring and evaluation tool or a mobilisation tool instead? This could change the frames. She also added from her expertise of working both in the education and health sector, where she spoke about the decentralised budget schemes in the education sector that allows flexibility to cross boundaries of spending within the needy areas. Lindsay added that monitoring and evaluation from a service provider’s perspective is considered very threatening. She added that they have been monitoring their own services for a long time and the purpose is to ensure that they are not lacking anywhere and improve services. Therefore, it should be promoted as a self-monitoring and self-evaluation approach.

Nilangi invoked the shrinking spaces context yet again and the declining movements of JSA and the rights to health care initiative etc. She emphasised the clear linkages and health care issues that needs to be highlighted.

Pallavi stated that there is a need to decide who is to be monitored and evaluated? - we or the people? While public action for health is a wonderful concept, it does not come up to that level. Thus, in order to mobilise the people, to challenge the system is important.

Leila added the need to critique the development paradigms given that the ability to get one’s entitlements are impacting SRH and its determinants as well.

Renu brought out the emerging new dimensions from the discussions where one of the larger vision is alliance building where the service providers perspective are to be brought during the next day’s discussion. While she did not think there is a need to change the term

monitoring, at core the aim should be mobilising and give them a voice. Sundari added to Renu's opinion that there is lot of frustration at this time among the professional medical students in the public health area due many meaningless things being instructed. There is a possibility to bring them in for data collection support in different places and look beyond the NGO community to give scope to experience the reality. It is also possible to decide that at the bottom of knowledge we are building an alternative evidence base irrespective other action outcomes, keeping aside the feasibility issues. One could keep pushing the UPR from international to local levels, presenting alternative sources of information, and **doing it regularly** like done by the annual survey of education. **Therefore, the process becomes a mobilising tool plus an alternative evidence base. A soul-searching process, and narratives building efforts, where processes of discrimination or exclusion are captured in addition to finding the gaps as identified by the people.**

#### IN A NUTSHELL DAY 1

Participants introduced themselves following a brief welcome session by Subhasri about the purpose of this workshop and its objectives. Followed by that, Renu Khanna set the background for the meeting within the larger context and CommonHealth's work so far. The purpose of this presentation was to guide the participants through the opportunities and challenges that one may encounter in the process. Followed by that Sundari Ravindran, presented an overview of "what do we mean by Rights based monitoring?", that could be incorporated into the tool.

During the post lunch session, there were presentations through which the experiences of people who have developed the tools, used them in the field, taken it to different levels – policy, advocacy and back to the community shared their experiences. There were six such presentations that focussed on the process and content of what was monitored. Following which, through brief presentations the tools already available from different sources were presented. This offered a brief overview of the content of these tools. The process overview was limited considering that not all of them have used these tools with individual experiences.

At the end of these presentation's Sundari presented a summary of the emerging outcomes – learning and challenges and the questions that needs to be discussed for our own tool building initiative. Other participants added their opinions, concerns and ideas, that needs to be carried forward for the next two days discussions and process.

#### DAY 2

##### TOOLS DEVELOPMENT DISCUSSION CONTINUED

During the morning session, the participants began the discussions based on previous day's inputs received from others.

Nilangi began the day's process by knitting it with the previous days discussion threads. She raised two questions for a group consensus and summarised the four major why's from previous day's discussion.

Why are we monitoring?

- Mobilisation process
- Bridge the data gaps and with more emphasis on marginalised groups
- Bring out change at the policy and advocacy level
- Alternative evidence building platform

The views of the participants also brought together answers for: What are we monitoring? and who are we monitoring?

- Given the emphasis of private sector, even within the public sector based on the experience with the recent policies, it becomes imperative to monitor the private sector. Perhaps we don't want the community to go that way. But if the private sector is being promoted by the govt as more efficient/effective then let us test them.
- Process of monitoring is a process of awareness generation and consciousness building. So, the process of entitlement literacy is itself very important. So, one of our (CH) main reasons for monitoring is for: mobilising, visibilising the situation, experiences and voices of invisible groups from an equity perspective.
- Another perspective is to look and articulate at 'why would communities want to monitor?'. There is also a need to problematise the use of the word 'community'. Who are we referring to given the diversity and equity and it is not possible to represent everyone.

In response: In the Indian networks of sex workers, the sex workers themselves are talking about their experiences. What happens in the community is communicated best by the community. So 'community' is an important term to be used.

While at the policy level the extent of influence through the community monitoring may be limited but at the local level it may have sound mobilisation, and possibly empower them through this tool. This opinion was contradicted by another participant who said that, there exists a clear link of community with policy. Community is just not informed about the policy. If we don't ask the community and explain how policy is made then it may be important.

**The most important reasons there is a need to create alternative discourse not just for the government but for the students, young people, people getting trained, who are looking for answers to look at another way of thinking.** Many people such as professors in the medical schools are spellbound to see certain evidences and wonder if research could be done in different ways.

- Monitoring is important for alternative evidence building but also for change in the discourse irrespective of small or larger communities. But there is also the need for some visibility for ourselves to share these evidences with the government stakeholders, especially in a context when rights are being negated. In order to

change the discourse there is need to extend our networking and allow ourselves to be noticed with those influencing the policies and who share those invited spaces. For this there is need to have robust research methods while building an alternative evidence base.

- There is always pressure to sugar coat the reports and information evidences. There is a need to speak the language of the government officials and the mediators have a scope to couch it in the language of rights, and always there are bound to be gaps and conflict between both. However, it is more acceptable rather than from those coming from a rights perspective in the community, who are not acceptable. It is also important to remember that, not always influencing these groups may have large impacts. Research shows that the higher officials are deliberately diluting the messages despite believing in equity.
- Mobilising, building alternative evidence, policy advocacy are all not mutually exclusive. Given that, there is shrinking space where does this effort or process fit into the larger crisis and movement building in the country? If we are monitoring for evidence building or mobilising, each will have a rigour of its own and may have different methodologies. There is practical need to locate it within CH's journey so far. There is also a need to find ourselves understand the language of the CSR, who are prime allies in the decision-making at the government level. While we are broadening our monitoring framework, we are also broadening our alliances towards the larger movement that is already happening.

Some of the issues raised were parked for later discussions.

- How do we claim our legitimacy, in a situation when someone can ask us, 'Who has given us the right to monitor?'. Do we have the sustainability to engage in this process of monitoring? Should we re-strategize to reach out or to reclaim our legitimacy? We are getting funds from certain organisation and that is also attached to the credibility and legitimacy issues.

In response: I am a citizen, I have the right to do it.

- One of the participant asked: how does community mobilisation take place? How far is the community willing to go? Given their marginalised situation - how much energy do they have? Are they not fatigued? – instead of fighting they would find alternative ways.
- Are we pinning too much on monitoring? Chorus from participants: YES.  
What time frame are we looking at and accordingly can we have realistic vision and the first steps? Are we all really comfortable with the term monitoring when we are going beyond a term monitoring? Because this word will direct us as the sole purpose for further direction.

In response: Subhasri said, the community has the right to monitor and we are only the facilitators enabling that process.

In response: Monitoring could be seen as one tool for enforcing accountability. We want to do mobilising, building evidences which are all the more important and monitoring is one tool. Big part is media – coverage at the level of district media. They are waiting for evidence. There is need for constant engagement rather than just collecting information and share it with government, which is only one mode. For instance, like involving young professionals is a way beyond monitoring. There are too many tools for monitoring. We are doing something different.

**We are doing it differently.** Dead women talking proved that a reasonable robust body of knowledge can be generated. Are we willing to give extra time, which is a strength, doing for particular reasons? **Community mobilisation for me is creating a culture, like in Kerala, where communities holding people accountable without intrusion of brokers. That is what we mean by community getting empowered, community mobilisation etc. While community accountability is one thing, accountability among duty bearers and service providers is also important - sundari.**

- *What are we monitoring?*
  - 1. govt guarantees vs
  - 2. human rights based entitlements ratified treaties, (dignity, non-discrimination)
  - 3. HR principles/values including people's notions/norms.)
  - This has to be extremely context specific, depending on what will progressively help that community and to what extent the community is prioritising. We do look at the entitlements but one after the other.
  - There is need to talk beyond government guarantees but it does not go beyond “women” – what about others?
  - There is a need to move beyond the primary level of health services.
  - How do we monitor the guarantees of the government? For instance, if the government policy asks the private sector to provide services, it's an entitlement, and we may end up questioning the guarantee itself.

In response: in order to monitor the private sector, is it available, accessible, affordable framework could be used.

- How can the private sector that has not been involved with the government – how can they be accountable? – how feasible are they to be monitored?

In response: there are many things happening around us. COPASA has involved in monitoring the private sector, *Sathi* in a small way is working with the private practitioners. There is a need for us to look at may be RMPs, alternative systems etc. At the community level, it is possible to monitor the private sector, based on the use of private sector experiences of the users. But how to make them accountable is going to be challenging task.

It is worthy to note that the private sector is not homogenous. Middle level family private practitioners are opposed to the giant corporates. There are fractures emerging within the private sector and we could take advantage of this scenario to hold the private sector accountable.

### **The domains for tool development**

Based on the groups consensus the following were tabulated for group work. (the primary axis was determined)

Components	Other framework of rights	Invisible groups.
Maternal Health, Contraception, Broader Gynae services, menopausal and post-menopausal women, Adolescent and young women, sexual health	Accountability (a sub component of governance and it's operationalised), autonomy, participation, dignity could be fit in AAAQ framework. Some needs to be spelt out separately.	Social minority, religious minority, sex workers, people with disability, migrants, single women, sexual minorities, adolescent boys, men including boys, people living in institutions, tribals, HIV affected, humanitarian groups, population groups from chronic conflict areas, ASHA/AWW/women workers/unorganised sector
cross cutting - diabetes, mental health violence, sexual health, nutrition		

Some of the concerns addressed while doing this listing were:

- There is a need to do sexual health but does CH has the capacity, asked subhasri.
- Renu shared that there are experts working in specific communities. These people are capable of bringing in important aspects for specific groups. As part of CH's alliance building, through this tool it can be evolved. Therefore, one could have generic and sub-tools. Sub-tools can be good to start with.
- Observing CH as an external person, the rights (second aspect is central) and it is articulated in a doable fashion and we need to make sure that rights aspects are adapted.

- d. Subhasri said, “if the communities are the ones who are monitoring what kind of research methodology should we choose? Then we could come back to operationalising on ethics, quality etc.
- e. Qualitative and quantitative is unbridgeable. Micro narratives of 7-8 lines could be a good way to get the essence and to capture. For instance, a mobile is sufficient to capture voices etc.
- f. Quantitative numbers are essential for political representation. At the same time, many of the qualitative information does not get that easily captured in a tool.
- g. There is a need to build pressure from bottom -up. That will allow people to speak. What is important is meticulously documenting and the role of a training plays an important role. And being the generic tool, if the people going to collect data and are clear why they are collecting data and come back to us on how and why, that should answer these concerns discussed above.
- h. Rakhal said, first is there are different levels of evidence and need to ask a question, for that organisation to achieve, what is the level of evidence we need and how robust it has to be rather than the perfect method. Given that sort of perspective, what may come as one after flushing out one and two, the group can use a different methodology that suits. We can use multiple methodologies and feed back to the core.
- i. If we decide methodology at our level and expertise, will it work is depended upon who is going to collect information. Will we take them into consideration while building the tool or take their perspective?
- j. At this moment there is a need to be creative in developing our own indicators rather than sticking to specific sets of indicators such as only AAAQ etc.

Conclusion: Therefore, the research methodology can be flexible and adaptable to contexts.

#### **GROUP PRESENTATIONS OF DOMAIN SPECIFIC TOOLS**

Four groups were formed based on the comfort level of individuals to take up certain specific domains. The groups worked independently and presented. It was decided by the group that they will have the following outcomes

1. define scope of domain
2. other definitions
3. indicators
4. example of tools
5. guidelines for administering the tools and possible methodology

#### **GROUP 1: SEXUAL HEALTH, PRESENTED BY SREEPARNA**



The group consisted of Sreeparna, Rakhal, Madhumita, Sanjeeta, and Priya. The focus of this group was to delink sexual health from reproduction and chose to focus on non-normative sexualities embedded within the life-cycle approach to cater to different needs of age groups. The different domains covered was knowledge, belief systems/norms/sensitivity, service design – systems based Service delivery – provider oriented, and confidentiality. If possible two separate sections mostly for providers and some for the users could be imagined.

The indicators identified are:

knowledge indicators - Sexual health needs of different groups such as adolescent boys, basic awareness of human physiology, awareness of sexual health needs – different groups, source of information- given that mostly it is through pornographic sources, SRHR oriented curriculum in medical education & training.

Belief systems/norms indicators - Non-normative belief system (ideas about promiscuous, loose, non-monogamous men and women, heterosexuals, procreation is the only reason why people have sex, substance use, age-specific – young vs old people that restrict service delivery, disability-oriented – for eg: women in mental institutions are thrown to hysterectomy), mental health (for eg: who reports feeling with low sex drive and are there referrals.)

Service design indicators –

- Physical infrastructure – dignified, maintains privacy e.g. covered examination area, separate toilets, separate wards for transgender
- Appropriate referral systems e.g. referrals for cases of abuse
- Compliance with POCSO (\*adolescent sexual rights vis-à-vis mandatory reporting)  
Need to address and be aware of the consensual sexual relationship issues among adolescents.

Service delivery – indicators

- Non-discriminatory services
- Respectful & humane care
- Communication & interpersonal skills  
Appropriateness of treatment & care e.g. medical negligence, hygiene, outdated procedures

Confidentiality – indicators

- Data protection
- Anonymity

- Use of discretion for referrals/family/authorities  
(Ensuring interest of user is primary)

### Indicators to tools

Case examples or situations could be one way of understanding the belief systems and help us to start further conversations. Some of the broadly thought through situations are:

- A single woman visits you (provider) for an RTI.
- An adolescent boy visits you with concerns around nocturnal emissions.
- A female sex worker visits you with fertility concerns.
- An adolescent girl tells you that she is sexually attracted to women.

### Guidelines for administering tool

- Individual interviews, group interviews and observations

### **Add-on from the floor:**

- If users and providers are only the respondents, what about those who have not accessed these services at all? (need for tailoring the contexts)
- We should think about the methodology. It is more of a research than a monitoring tool. Are there interpreters available? Marriage is made a pre-condition for services. What we know could be concretely added and then the others. A research tool is done just once, but a monitoring tool is repetitively carried out.
- Belief systems and including the providers is understandable. But under the rights claims, does this fit into a accountability frame.
- Sexual health or sexuality is not part of the health system, first point. What is our entry then? When an individual enters a health system do they have a facility space to provide anything? Then if so, do they have credible knowledge, how do belief systems play a role, how is confidentiality and privilege addressed in general sickness vs sexual health, informal providers. We developed just the domain and a set of indicators for one.

### **GROUP 2: GYNAE SERVICES AND POST-MENOPAUSAL HEALTH PRESENTED BY SUBHA SRI B**

This group consisted Sundari, Subhasri, Lindsay and Nilangi. We firstly captured all the issues not generally looked within the domain of maternal health. These are: menstrual problems, RTIs, STI, prolapse, periflow, reproductive cancers, obstetric fistula, infertility, sexual health of women, hysterectomy (issues upto and post hysterectomy). The second and the other way is to look at cross cutting issues such as anaemia. We focused on women, and parked the facts that men also have needs but not adding at the moment and similarly of sexual minorities and other specific groups.

What would we monitor?

– where the scope would be as self-identified by the women based on symptoms and not look at latent problems.

### Indicators

For each of the indicators we followed a AAAQ paradigm.

- availability by curative, preventive and promotive, information
- Access by both financial and physical access
- Quality by technical and women's perspectives (need to consider differences between community perception of quality vs the technical decision) Therefore, how do we address the dilemmas of quality standards vs community perceptions)
- Accountability – availability of spaces for feedback and responsiveness and grievance redressal availability (knowledge, ability to use and the whole cycle)
- Autonomy – informed decision making and consent
- Participation – ability to participate in community based decision making (planning, budgetary allocation) and bring in SRH issues and budgetary provision
- Dignity – informed consent

### Tools

- Group interviews with specific groups of women to map out the problems, and availability for those issues, and see if issues are resolved at that provider level.
- Participatory techniques to map them and grade for access and quality
- Narratives that document the lived experience of women experiences with seeking care, unmet need unable to meet their problems. It could capture the burden of the consequences of one to another problem.
- If possible facility visits and have broad generic checklist for specific issues.
- Wherever the program is facilitating this process map things like service provision camps and where details could be gathered, and could also follow upon that.
- To increase the credibility, the involvement of PRI members, higher levels and private sectors needs to be monitored, and experiences of women sought care from private sector could be tapped rather than approaching private sector directly.

### Floor queries

- Anywhere are we looking at secondary data and also PPP interest with SRH services?

Response: as of now ppp is focussed in contraception and MH services.

- How do financing mechanisms of PPP affect services?

Response: we have not listed budget and system monitoring at all in our previous discussions

### **GROUP 3 CONTRACEPTION AND ABORTION PRESENTED BY SANA CONTRACTOR**

This group consisted of Renu, Sana, Alka, Bhuvana, Rajdev and Mandakini.

Scope of the domain: Universal access to contraceptive information and services (irrespective of age, gender, occupation, social group and marital status)

#### **Levels of Monitoring**

- Policy – Global, National, State, Facility level policies that impact contraceptive services
- Program implementation level – Government orders, state priorities, budgets, quality assurance etc
- Service provision level – Facilities, health workers, training
- Community level

#### **Indicators**

The rights domain was used.

*Availability* – at different levels of facilities as appropriate- are there any stock outs, aids and IEC material, counselling services, outreach, are services available to survivors of sexual violence, displaced populations

*Accessibility* – Information about different contraceptives (indications, contraindications), geographic, social accessibility, financial accessibility for different populations. Is comprehensive sexuality education available to all (not just school children but also other groups like sex workers)? How comprehensive is the sexuality education? Is it sex positive?

*Acceptability* – Do women get methods that are acceptable to them, does the institution provide support for women to negotiate family dynamics (partners, family members)?

*Autonomy* – Targets, informed consent and informed refusal procedures, incentives and disincentives to acceptors, motivators and providers, conditional services (get condoms only if you give blood sample, MTP only if you adopt sterilization etc), are there forced procedures in institutions?

*Quality* – infrastructure, trained personnel (technical, value clarification, quality guidelines), supplies – are guidelines followed, screening, intra-operative procedures, follow up management

*Participation* – social audits, consultations on guidelines, RKS, who are the members of these committees?

*Equity* – gender skewing – are men being reached out to? Are certain methods being targeting to certain populations? Does the policy exclude certain women – like single women? Mechanism to ensure protection that women from vulnerable communities are not

targeted (women in institutions, low income, minority women, etc)? Are services available and accessible to all populations (age, sexual orientation, caste, religion, single women, disabled)? Is disaggregated data available on this?

*Accountability* – Quality assurance mechanisms – are the committees formed, are they meeting, who are the members, follow up and registry surveillance for long-terms complications of contraceptive use, operationalisation of insurance. Are women provided documents to be able to claim redress?

*Others* - Is the policy called FP or contraception? Denial by provider, due to fears of compensation.

#### Examples of Tools

- Policy analysis (laws, govt guidelines, govt orders, state policies etc) - Coercion in policy – incentives and disincentives, targets, two-child norm – how are ELAs set, focus on fertility rates in policy documents

Does the policy exclude certain women – like single women? Mechanism to ensure protection that women from vulnerable communities are not targeted (women in institutions, low income, minority women, etc)? Is there a protocol for provision of contraception to sexual assault survivors?

Is comprehensive sex positive sexuality education available to all (not just school children but also other groups like sex workers)?

Do policies include social audit/accountability mechanisms?

- Interviews with users – of different methods, consent parameters, any coercion used including - conditionality, incentives, quality parameters (pre-op op and post op), was follow up care, post-procedure complications, documentation (did you get a certificate)
- Focus groups with different populations including men and boys - Information about different contraceptives (indications, contraindications), are women from some groups being systematically being left out/denied services? Outreach by ASHA/field workers?
- Facility observation – Availability – of different methods (stock outs), personnel, infrastructure, for quality assessment – (things that community can measure/assess with validity needs to be worked out). Need to look at needs of disabled within the
- Interviews with providers - technical knowledge, attitudes, knowledge of quality guidelines, training, pressures of targets. Availability – of different methods (stock outs), aids and IEC material, counselling services, outreach by ASHA, do they ever deny services?
- RTIs – information on functioning of quality assurance committees– are the committees formed, are they meeting, are facilities and procedures being audited, who are the members, what actions are taken?

- Case studies – failures, deaths, complications, stealth procedures

Guidelines for administering tools

Training content – needs to include technical knowledge because it means how to identify instrument, and supplies

Ethical concerns need to be spelt out and guidelines to deal with them (especially among the abortion seekers)

- protecting identity of women and service providers,
- backlash

Abortion

In this we had a lot of discussion around should we have user interviews, given the ethical dimensions and about who is going to conduct the interviews.

Given the limited time, tried our best to list the indicators

Scope: Access to safe abortion services and post-abortion care

### **Indicators**

*Availability of services* – at different levels of facilities as appropriate, availability of pills without stock outs.

*Accessibility* – information about legality of abortion services and conditions under which it is legal and to whom it is available, are women given information about different methods and their use, are services available at no cost in public sector and affordable cost in private sector? Time between seeking service and getting services? How far are services? Perception and experience of confidentiality? Experiences of denial?

*Autonomy* – services available free of conditionality, consent procedures followed, no denial of services (Provider knowledge and attitudes about this), were women informed of different methods and allowed to choose which method

*Quality of services* – pre-and post abortion counseling, providers knowledge skills and attitudes (on different methods and counseling), availability of supplies, guidelines followed (need to ascertain indicators that can be captured by community persons), what procedure was used (D&C, vacuum, medicine), post-abortion care, post-procedure complications

*Equity* – are some persons excluded systematically?

*Accountability* – quality assurance mechanisms, grievance redressal

### **Tools**

FGDs – How many women know if it is legal, where is it available, who is it available to? What is cost? What are the barriers

Pathway of seeking abortion – where do you go, can all women go there, where do other women go, what is the experience in the facility, how much money is spent, what is the behaviour of providers, what information is provided

- Facility observation – facilities identified from listing, are services actually available there?
- Case studies of marginalized/vulnerable groups – coercion, denial, conditional
- Case studies of mortality -
- Provider perspectives and knowledge (ASHA, MO, ANM)– Legality, values, technical information
- District level committee functioning
- Budget analysis –
- Key informant (counselors, peer educators, ASHAs)

Renu added that, we wanted monitor the technical quality of services, but then we decided, we first wanted to know the knowledge of abortion service knowledge and legality and pathways.

Sreeparna said that it is puzzling here- in the policy, certain things such as comprehensive gender and sexuality education is not provided by health services. Who will administer these? (policies themselves are barriers is a one-time thing that these could themselves be barriers)

In response: certain things could be a one-time thing in terms of barriers but need to be done as part of that and could be included across the groups.

Given that a trained researcher may not be involved, there is a need to look at the existing tools with pictures to get technical information. Similarly, with photos, where a medical expertise person needs to pick up what needs to be monitored but not in so much detail as we are not involved in auditing. There also need to be organisations grounded with trust in specific locations. So, we thought of other options such as key informants interview who could be proxies.

There is a need to pull together contraception and abortion rather than looking at it in a compartmentalised manner and things like contraceptive sabotage, violence, are all one stretch. There is a need to incorporate these as a continuum of episodes.

#### **GROUP 4: MATERNAL HEALTH PRESENTED BY LEILA**

The maternal health group consisted of Pallavi, Leila, Sunil, Manjula, Bharti, Rakhal and Sunanda. We chose to focus on the domain of - Services for unmarried women and adolescents.

We classified for each rights indicator the contexts, indicators and tools

Rights	Conexts and Invisible Groups	Indicators	Tools
Inclusive non-discriminative services:	How many of the unmarried girls, second third, wives Multipara women Faced difficulty or denied services or entitlements?	Community-based stats of denial, proportions utilized sent away because of barriers and active measures	Case studies, narratives Periodic surveys
	Seasonal Migrants, those women working in difficult situations such as tea gardens, construction workers, salt pan workers, places where seasonal access is denied		Study such specific groups to get stories

We took unmarried category because there are huge barriers due to both social and institutional barriers. Cultures where women do not fall into the usual nuclear families, migrants and services suggest the family definition very differently unlike found in tribal communities.

#### *Quality:*

- Medically Technically appropriate as indicated, Quality of care
- Culturally appropriate (subjective, different meanings)
- Satisfaction
- Safe
- Positive attitude of provider? (not clear)

#### *Indicators*

- Standards of clinical care available,
- Incidences considered as culturally inappropriate by the women especially childbirth

#### *Tools*

- Many tools available which should be reviewed and contextualized
- Facility assessments ( DQAC)
- Respectful maternity care prepared WRA and USAID, Mchip
- Focus group discussions to measure what women consider culturally appropriate
- Exit interviews for satisfaction

#### *Access*

What does it mean access in different situation and for urban and rural population and specific groups? Access at individual may exists but at the population level needs to be re-looked with a new thrust of good roads, time, catchment areas-

- Ensure 24 hours services at strategic points



- Geographic access to be remapped; seasonality, roads, transport
- Continuity of care to women who migrate seasonally; also working in difficult situations such as tea gardens, construction workers, salt pan workers

#### *Indicator*

- Review availability by roads distances, time,

#### *Autonomy*

Indicators: informed consent for procedures such as C-sections, episiotomy  
(need to build in the idea around this)

#### *Accountability of duty bearers*

Indicators:

- Person responsible and contact details
- Forums available for grievances, complains for quality of care, medical negligence, functionality
- Redressal mechanisms (Redressal commensurate with level of authority)
- Number of complaints received and redressed
- Is the government ensuring that all private providers and institutions are registered, regularly inspected for standards, and report performance?

#### **Suggestions from floor**

- There is 'choice' missing in terms of where to deliver, which position – both lacking at providers and women's knowledge.
- Autonomy of women starts at home environment rather than at the institutional level.
- Respectful care does not look at untouchability (caste based), language issues, needs to be incorporated
- We have gotten with women's and community perspective come in. How women's mobility - how and who does it matter, in terms of autonomy needs to be discussed. In respectful maternity care, lack of cleanliness of toilet stinking, was lack of dignity. Here contextual definitions become important.
- Videos done by woman on respectful maternity care needs to be sought. Through social media we can reach larger sections.

#### **In a nutshell day -2**

The rich discussion during the morning allowed to a great extent identify the domains, certain specific issues and population groups to be mapped, the need for balanced and mixed method approaches. The individuals based on their strengths and interest were able to form their groups and work on specific thematic domains. By the end of group presentations, the need to understand and comprehend the additions and differences in

presentation across groups was recognized by many. Presenting the summary of the groups work and planning ahead was scheduled for the next day.

### **DAY 3**

#### **EXPERTS PANEL DISCUSSION, CHAIRED BY SREEPARNA CHATOPADHYAY**

The panel consisting of Sana Contractor, Mandakini and Manjula presented their experiences and views on the tools development workshop.

*Panelist 1:* Sana in the light of previous two days discussions at the workshop, shared that, less has been spoken specifically at Muslim women's situation, and certain region-specific groups. Similarly, the role of social determinants and contextual factors has not been discussed in length. She gave an example of ghettoization in urban areas and its impact on Muslim women in Mumbai, Mumbrai and Malegaon, where water and sanitation facilities are poor and with lack of space, tuberculosis and other diseases are common. These are important to examine both on their own, but also as conditions that play a role in maternal health conditions and non-obstetric issues. It is also important to explore issues of access, despite the fact that Muslim women in Maharashtra for instance are located largely in urban areas, home births still occur. It is worth documenting such differences even in the presence of hospitals. She suggested also looking at how the intensifying coercion in family planning service provision is impacting Muslim women, because of the mindset that Muslim women produce more children. Further there is a need to focus and look at disrespect and abuse more specifically for the disadvantaged and marginalized groups. With respect to Muslim women, there is now some documentation on specific discriminatory behaviours which can be included in the tools.

*Panelist 2:* Mandakini spoke on behalf of the sex worker collective forum. There are different categories of sex workers and their issues are different is important to bear in mind. The pregnancy and childbirth related schemes of the government exist in all states, but this population mostly is both unaware and do not receive the benefits given the lack of residential proof and claim for other documents.

The decision-making for contraception use is primarily for preventing STI/HIV. There are multiple aspects of violence involved in deciding to continue a pregnancy given that a 'regular partner' of a sex worker may not want the women to continue a pregnancy but the women may want to continue. In such cases, the brothel economic situation also influences whether the women could continue a pregnancy or not. Therefore, the decision-making is not necessarily a women's in this context of abortion. These are important to understand given the rights perspective in place.

Similarly, the issues of pregnancy have to be associated to other factors such as addiction to substances, not following up ante natal care etc given their emotional and mental

disturbances, which is very sensitive and different from the general population groups. They also lack information on pregnancy or delivery related complications.

There are several unethical practices at the field level. Suppose a blood sample has to be provided to an NGO performing lab tests, they will insist on a condition to buy a Condom worth Rs.50 as part of social marketing of condoms. There are other issues such as compulsory accompaniments of persons, blood demands from relatives, refusal of contraceptives to people inserted with IUDs in other places eg Nepali women need to return to Nepal. There is still lack of awareness of contraceptive methods even after two and half years of SRH intervention at field level.

Case stories, personal interviews, will help to understand the gaps and awareness levels in specific population groups.

*Panelist 3:* Manjula shared her views from her recent field experiences on lower caste dalit women situation given CH's focus on addressing the vulnerable marginalized communities. Given that reaching the lowest caste/dalit groups, and especially certain occupation groups is a big challenge (*based on my experience working with manual scavengers*). Further it is important to think how could this tool that we are preparing be able to reach out, to be used amidst those groups?

Given that caste, class, and religion, as axis play an important role, it could be useful to use the critical race theory to identify the difference in access to services amidst say for example a Christian dalit vis-a-vis Punjabi dalit.

There are so many invisible groups that we have identified in the last two days. Do we want to focus on all these groups and is it feasible is my question?

Untouchability is still an issue and I have worked on it at the capacity of a legal expert. There is also possibility to observe (through trained video capturing techniques) and incorporate the untouchability aspects in maternal health and reproductive health aspects. More of this kind in the advocacy efforts.

There is a need to look at these within the framework of law. My work with Adivasi and dalit women shows that the law itself is very gender insensitive to the reproductive health issues of women.

Universal tools cannot be used across. For example, the survivors of violence, the mental health condition of these survivors is a great concern and there is lacunae in the health system and lack of information too. The women in conflict prone areas are highly prone to rapes and it is not possible to even register a case at times. For example, the migration is higher in Orissa and Bihar, where men migrate and women stay back. On the one hand their sexual needs and their sexual health is not understood and on the other hand when man migrates, the women become sexual victims of landlords. But this sensitive information may not emerge until someone who closely works with the communities and has created that rapport can help to identify these women. How are we going to capture

and use these personal narratives to help women or for ourselves? These are life stories of suffering women. Great confidentiality aspects have to be worked out. The need for simplification of language is very important. There is also a need to map areas and population groups. But it could be an important tool for advocacy, focus campaigns.

Pulling the common threads by the chair

- Need to focus on social determinants
- Systemic and systematic discrimination – structural factors embedded within the larger structures.
- It is going to be challenge for us to separate or pull into the tool, to identify the role of multiple factors causing not-good health and suffering from other reasons.
- Making the tool culturally sensitive to contexts, accessibility of language for the tool to capture information, mechanisms to collect data with anonymity and confidentiality of data is going to be a challenge. Given the qualitative aspects of data collection. While relying on in-depth interviews it is also important to include observation.
- When we are looking at the larger context of structural violence, the critical race theory, the tool is expected at capturing ‘what is happening to me and what is the health systems response to it?’. Primarily it could be used as an advocacy tool.

### **Additions from the participants**

Sundari added that a tool as a formative work to document the manifestations of discrimination faced by the dalit women in Tamil Nadu has happened before. They used a workbook where they made them tick to translate the experience of weekly discrimination. And user-friendly manuals with pictorials have been worked out in the past, to suggest that such kind of assessment is possible.

The modality of engagement with different stakeholder will vary with different people. It calls for intensive sort of processes with whom the community is comfortable with. The researcher should be able to take a back step when communities are not responsive at times or comes back with lots of demand. In one of such past experiences, we asked them to maintain a diary with the stone cutting experts, manual scavengers who are from the unorganized sector. But for this there is a need to be specific about what we want out of this process, how do we want to use it to zero down to other aspects of collecting information and tool building – Rakhal

There could be one generic tool, but that shall be adapted to community based needs. The community may pick up several tools from these in an ongoing way-Priya

Should we concentrate on building marginalized groups alone and their disadvantages? So we only work a framework for the marginalized communities- Bharati

The suggestion is, yes, we are trying to build more of facilitating tools on say only maternal health, contraception and abortion of the marginalized groups and generic tool that would address specific issues, say only case studies and focus on it for the next one years. For instance, sexual health has more scope for research than the other areas.

There is need to look at the health system barriers, health system functioning apart from the community based people's perception for a balanced approach – Leila

We keep saying in SDG “no one is left behind”. Identifying or mapping the left behind groups through this tool is a inclusive framework It is not necessarily about aligning with SDG framework but still would be useful to disseminate at different forums. - Nilangi

Subhasri flagged the need for discussing the ethical questions and concerns. Personal narratives is much used in maternal death and is more of a public events. It is a completely different scenario and ethical concerns needs to be built into the scenario unlike in maternal deaths personal stories. There is a need to have related guidelines in the tool. – Subasri

The session was concluded given the time constraints and a summary of the previous day's emerging points for discussion and way forward were discussed.

#### **SUMMARY OF GROUP'S TOOL BUILDING INITIATIVE BY SUNDARI RAVINDRAN**

Sundari presented one after the other, the dimensions that lead the discussions

Firstly, she put together the SRHR areas identified and among the population groups that emerged. She also incorporated whether enough has been discussed on certain aspects which are in italics here within brackets.

- a. Sexual Health: Non-normative sexualities; across life cycle; (*normative sexualities de-linked from reproduction, to include sexuality post-sterilisation ??*)
- b. Maternal Health: Institutional Deliveries, specific focus on vulnerable groups: adolescents, single women, migrant workers, tea garden workers, second and third wives, salt pan workers etc, manual scavengers, migrant workers
- c. Contraception: Information and services on all methods to all sexually active persons  
Abortion: Safe abortion services for all who seek, who need
- d. Gynaecological health needs, across the life cycle, focus on vulnerable population groups  
INTERSECTIONALITY LENS? [*Sexual violence and structural violence,*

### *Structural factors]*

In terms of the dimension of rights the following were mentioned.

- AAAQ
- Non-discrimination with special focus on vulnerable groups
- Accountability
- Participation
- Equity – going beyond non-discrimination (sundari added in her perspective - affirmative action; probing inequities in social determinants contributing to inequities in health outcomes and social and economic consequences (irrespective of non-discrimination, access, availability at service delivery level).

She framed a way one could look at for example - How are people in different social locations affected by larger social forces that lead to unequal access to social determinants and consequences?

Rakhal added that in a right based perspective it is moving progressively, but we are digressing and moving backward. For instance, there are contexts both positively and negatively influencing. Amidst the changing conservative norms, we also need to challenge these.

Thus different participants suggested the positive and sort of negative contexts listed here. Therefore, the contexts were foregrounded where rights violating legal provisions, government regulations are coming in.

The negative contexts added were: Unconstitutional and extra-legal measures. - Aadhar card as restricting rights, increased surveillance/atmosphere of fear, shrinking spaces for civil society, attempts to homogenous based on hegemonic/majoritarian norms, conservative forces/structural violence/non-scientific guidelines etc affecting sexual and reproductive rights, increasing corruption, funding diverted to conservative groups/institutions, growing intolerance, interference with education and decimation of institutions, global context – double edged SDGs double edged with private sector as a potential partner, galloping neoliberalism, control by transnational, privatization and changing modes of financing.

The context 2 are some of the positive changes:

- Growing resistance from students/ farmers/traders/private practitioners/unions/small traders (scope for forging new alliances)

- Technology and social media (potential for positive use )
- Recognition of and efforts at alliance building.
- Few progressive legislations (maternal leave, criminal law amendment against rape...)

What are the levels at which these tools could be used?

- Community
- Service provision
- Programme
- Policy
- Locating within global/ national/ state/ local contexts?

She asked at the community level could we also look at household and individual levels and could we also look at the historical context?

#### *WHO/ WHAT IS TO BE STUDIED?*

Community – users and non-users of services; specific marginalised groups; persons with specific experiences with both positive and negative; persons who are responsible for governance and decision-making

- Providers – all levels, all systems, formal and informal, public and private as relevant within the context of specific communities (understanding community and user perspectives about various providers) (there was also emphasis on understanding the provider perspectives, their concerns)
- AAAQ perspective; understanding provider issues and provider-barriers including knowledge and attitudes)
- Health facilities (at relevant levels)
- Programmes (as conceived and as implemented)
- Policies (-do- )

#### *What methods could be used?*

- Group and individual interviews; key informant interviews, observation, FGDs, Case studies, Narratives, Scales and tools for understanding attitudes, Community mapping, Participatory evolution of AAAQ criteria and assessment of service delivery points, Secondary data review/ Policy review/ Programme documents including G.Os, data from RTIs; synthesis of existing evidence and secondary Data, Previous research.

### *WHO WILL DO IT? (AS EMERGING FROM THIS SYNTHESIS)*

- Trained CBO workers, community leaders from VHNSC and PR
- Researchers from NGOs and academic institutions with the same world-view (the discussions suggest and went beyond the community)

### *WHAT NEXT?*

- Plans to develop tools: All? Some? Phased manner?
- Groups; point persons; realistic time-lines

This summarizing helped Renu to comprehensively narrate CH's efforts in the direction of this tool building workshop to plan ahead concretely.

### **ALIGNING THE TOOL BUILDING WITH COMMONHEALTH'S PRESENT EFFORTS**

*Chair: Renu*

DWT was a similar process, where the maternal deaths assessment was part of mobilizing local level advocacy and community action. At the national level, it was not that successful as envisaged. At the international level, there was some level of success. Many of our partners used this tool. Yet another tool that was prepared by SAHAJ and CommonHealth, used elaborately, was the monitoring the quality of maternal health. Given that MDRs are not frequent, we developed an assessment tool for quality. This resulted in preparing report cards and had implication at the facility level in Gujarat. These tools were used by many JSA members in Gujarat. The third tool, the abortion related tool developed by Alka and Rajdev which is being pilot tested in UP and Gujarat, aimed for advocacy.

The fourth is maternal morbidities that were captured through case studies after seven organization that were trained to do the same. The fifth is a statement on quality of care on perinatal deaths which was developed as a part of quality of maternal care assessment was documented. Then the sixth, is the rights based monitoring of contraceptive services. This was introduced in the last two meetings of CommonHealth and is being thought about for operationalizing at the field level. Now, it is time we are looking at a comprehensive tool that we could use at different levels. We and our partners want to document the varied contexts, that could be used at the local level by our partners for local level advocacy, at the district, state and national levels too. We want to strengthen community specific local level struggles through local campaigns.



Where do we take these efforts altogether? So apart from community level campaigns, how do we as agents change the discourse, to visible the struggles of marginalized/vulnerable/invisibles around SRHR?

For CommonHealth right from the beginning irrespective of the level we are working we aim to bring change at that level which may be community, systems or policy level. Some of the things which we have committed in the future are:

- a. Conducting regional level meetings where our agenda as well memberships are to be expanded. The regional level meetings are conducted with the help of our members. Memberships are of those who are actively involved and willing to work on CH agendas.
- b. As part of the Universal Periodic Review, CommonHealth was active along with other coalitions such as NAMHR and JSA and we together put up a report on sexual and reproductive health. This went into as a separate chapter in India's
- c. WE had young members from CH who have also contributed at their capacity during the talks.
- d. We also had a workshop in Pune to analyze how the SRHR indicators should be viewed at all levels. This was helpful to prepare a shadow report for the health chapter on SDG indicators for the *Wada na thodo* report along with NAMMHR and JSA.
- e. We are very consciously looking at alliances with different campaigns focusing on SRHR and social determinants. We are regularly inviting different groups at each level to expand our alliances. We are stepping one step ahead in our levels of understanding and how to integrate other campaigns within our agenda.

Sundari suggested a proposal where we look at specific groups of women shaped by spectrum of reproductive pathways on the one side. The other will be interfaces with others if any, where we combine groups, individuals through everything in the reproductive pathway and map those dalit women and their perspectives and the providers pathways. Thus, we could cohesively combine all the things we are looking at.

The policy, program and national contextual factors that affects groups from policy and structural factors needs to be incorporated.

The lenses is yet another framework where we spoke about intersectionality, structural violence and rights. While looking at the reproductive pathways one needs to be guided by these lenses while deciding variables and indicators for seeking information.

Subhasri added that we as CH want to break the silos and have a holistic framework.

Rakhal shared his concern that actually, building the lenses into the tool at this point into the tool or method now is bringing them explicit as focuses or lenses may be a little early now. If we have a tool, and then when we say, these are the four studies representing certain vulnerable groups using different methods of data collection, each of them will explicitly direct a framework. At the synthesizing phase of converting it into a body of knowledge, could emerge on its own.

Leila answered Subhasri by saying comprehensive is not silos at our level. Because when we take it at the community level certain factors will overwhelm the others. The caution is contextual factors are political irrespective of a good tool.

Sunil emphasized the need for avoiding shoddy data collection which is very common but scientifically not useful although community mobilization may happen. Initially bringing in these lenses and reviewing an existing NGO doing their work, and through our expertise involving with them could be a time saving aspect. We have reporting from which we shall flush larger frameworks.

Sundari addressed further leila's concern. This tool is for community level purpose with certain markers for data collection. A narrative approach where women are happy to share, not easy to collect but there is a possibility of community level worker who has the ability to collect it. The sexual and reproductive pathways is beyond pregnancy history and it is an open-ended narration. The sexual and reproductive health histories are different from pathways, since the histories have a methodology that evolve around events. The pathways are influencers of history. Depending on the life-stage of respondent we are capturing.

#### WHERE DO WE GO FROM HERE AND TIMELINES?

This report is intended to flush out the framework emerging. We will weave those into the elements of sexual and reproductive elements. Not discrete but an elaborate framework.

Some of the concrete steps that emerged are: A few of the people accepted to try bits and pieces of this tool at their respective areas, where an intersectionality framework could be looked at and decided to come back. Prior to coming together again with the little piece of work, a need to plan the in-between period was decided.

A decision on a conceptual framework was outlined.

1) Comprehensive reproductive pathways (rather than in silos) – Spectrum of different groups of women. (Definition required – beyond events, open ended narration, not just history of pregnancies, but also sexual history, infections, contraception etc. also influencers of the history)

2) Interfaces with the health system (women's and providers' perspectives) for different groups

3) Policy and program context that affects that group – both from the perspective of services but also structural factors

4) Global factors

### Timelines

Sr. no.	Tasks	Responsible person	Time
1	Report	Bhuvana Sunil, Priya, Sana – Comments	31 15
2	Conceptual framework (3 page)	Bharati (coordinate), Sundari, Rakhal, Subhasri,	Be
3.A	Implement the framework in different groups/communities: <ul style="list-style-type: none"> <li>- Identifying groups and issues</li> <li>- Converting framework into tools – examples of tools given in the conceptual framework</li> <li>- Data gathering</li> </ul>	Abortion-UP (Rajdev and Alka), Sex workers-Mah (Mandakini), Muslims-UP (Sana), Tribal Adolescents- Gujarat (Sahaj), Haryana – Dalits (Manjula), TN – Dalits (RUWSEC) To be done by groups who are implementing	Re En Oc
3.B	Evidence synthesis – secondary data and literature review	???	??
4.	Meeting - Consolidation and tool finalization	CH	Jan

### CONCLUDING AND THANKSGIVING

Renu thanked each and every participant and those who were unable to participate physically but had shared their inputs. It was such an exciting event full of energy and thoughts emerging. She thanked Asha Nivas for providing the space for the workshop, accommodation and food supplies for the event. The CH representatives thanked the staff from SAHAJ who helped us in many ways to organize the workshop. We acknowledged and appreciate the efforts of our travel agent Mr. Anand from Pune who helped in the entire logistics of travel bookings. She also acknowledged the efforts of our CH board - Subhasri, Nilangi, Bhuvana and others towards organizing the workshop. The end note was awaiting to meet again with concrete steps taken ahead.

### ANNEX-1

#### PARTICIPANT INFORMATION

**Alka Barua** is a pediatrician in Ahmedabad with 25 years' experience in health sector. She is a researcher and an independent consultant.

**Bharati Sharma:** Works as an Associate Professor at the Indian Institute of Public Health, Gandhinagar, Gujarat. Been working on the reproductive and child health aspects for the last several years in association with several organisations. Her doctoral thesis obtained from Karolinska University, Sweden focused on why India does not have midwives when many other countries do have the systems in place. She teaches research methodology, social determinants of health. Many of her students are engaged in researching the reproductive health issues in India.

**Bhuvaneswari Sunil:** Presently a doctoral scholar at TISS, Mumbai. The study looks at the abortion decision-making experiences of women in Tamil Nadu. A CH member for the last seven years and presently also on the steering committee of CH. My interest lies in the area of sexual and reproductive health, gender, feminist frameworks.

**Lindsay Barnes.** Working in Jharkhand for the last 20 years and founder of the organization called Jan Chetna Manch in Chandankiari, near Bokaro. They run a health centre managed by the cooperative members represented by the locals. Through the women's health centre, they provide normal delivery care 24 hours a day, 7 days a week. People come for treatment of gynecological problems, infections, infertility and contraception.

**Leila Caleb Varkey.** Based in Delhi and working at present with the Centre for Catalysing change as a senior technical advisor for RCH. Very much part of the liaison with the government at the policy level. My engagement at present is involved in the regions of Gujarat, Rajasthan, Jharkhand and west Bengal that looks at the quality of care for maternal health services and understanding the huge alliances and what their understanding of 'quality of care' means, through which the government could be made accountable. At the same time, create content specific process that could enable government to take it up seriously. One of the founding member of CH and my engagement with CH and learning the gender and right perspectives, and the fact that Maternal-neonatal and safe abortion services needs to be a package rather than individual threads, which I learnt from CommonHealth has carried me across my career. I am also a privileged, first CommonHealth fellowship holder. 51.24

**Mandakini Chudaman Desale:** Works with the NGO Saheli Karyakarta Sangh, in Pune, India, as program manager. I work mostly with the community members and involved in counselling. Since 2003 working in the HIV prevention program. Since last two years, I am working with a focus on SRH issues and integrating it with the issues of female sex workers. Through this we are involved in counselling health and legal issues and child rights.

**Manjula Pradeep:** Worked with Navsarjan Trust for about 25 years and led the organisation as Executive Director from 2004 till 2017. she has done Masters in Social

Work from MS University and Bachelors in Law from Gujarat University, Ahmedabad. She has trained thousands of grassroots activists and dozens of advocacy organizations, represented the National Campaign on Dalit Human Rights (NCDHR), served as a member of the Executive Committee for the National Center for Advocacy Studies, and International Dalit Solidarity Network. She has been addressing the issue of caste based discrimination at the United Nations and In European Parliament for past 15 years. Manjula is one of India's foremost Dalit woman leaders.

**Madhumita Das:** Recently joined CREA and involved with the community based programs and adolescence program. I am looking at incorporating monitoring and evaluation across CREA's portfolio. Earlier engaged as a senior technical specialist at the International Center for Research on Women's at different capacities involving research and evaluation. Also worked as a senior program specialist at Constella Futures, where the expertise involved in program management, operations research and communications for a project to provide reproductive and child health services in India.

**Nilangi Narendra Sardeshpande:** Independent researcher based in Pune. A CH member for the last four years and presently also on the steering committee of CH. Having obtained a bachelor's degree in Ayurveda, presently working on a research interest that looks at how Ayurveda is integrated into the public health institutions. Also involved in yet another research that looks at commissions practices and views of providers especially the doctors, radiologists and pathologists in the private sector in Pune city. Also, a member of the Community of Evaluators South Asia and feminist evaluation group. I am part of a few ethics committee within India and also involved in the training.

**Pallavi Patel.** I am representing, CHETNA (Centre for Health, Education, Training and Nutrition Awareness), Ahmedabad. The organization has different programs for women and children. Geographically we have more outreach in Gujarat, Rajasthan and Madhya Pradesh. We work towards building health awareness with a gender perspective. In MP, we are involved in empowering the SHG's in collaboration with other NGO's. With White Ribbon Alliance India (WRAI) we are involved in the advocacy efforts for Quality of Care for Maternal and Newborn Healthcare services. In Gujarat, we are engaging with the government for the provision of quality maternal health services.

**Priya John:** An independent consultant, based in Mumbai. Presently engaged at reviewing critically the past 10-15 years research on maternal health and abortion, sexuality and adolescent health in India. This is happening in collaboration with the Achuta Menon Centre for Health Sciences, Trivandrum. These are critically looked at from a gender and inequity health perspective, given that I also have a degree in gender studies. I have also had experience working on Maternal health issues in the state of Jharkhand.

**Rajdev Chaturvedi:** I am the director of the organization, Gramin Punarnirman Sansthan. We are working with women and children in the Azamgarh district of Uttar Pradesh, India. Our organization is part of Mahila Swasthaya Adhikar Manch (Women's Forum for Health

Rights). The organisation works with an approach focusing on capacity building of leaders, issue analysis, case documentation/study, dialogue with block and district level officials and continuous advocacy. We have associated with CommonHealth, Sahayog, NAMHHR on various partnership to strengthen our work at the community level.

**Renu Khanna:** Belong to an organisation called SAHAJ (Society for Health Alternatives) based in Baroda. SAHAJ works on range of social accountability issues such as adolescence, maternal health accountability and child rights. There is a strong community based programme that works with the urban poor and coordinates with other partners in the district. My own work is in the areas of gender, health and accountability. I am: a member of the Jan Swasthya Abhyan. The secretariat of People's health movement, JSA-Gujarat is at present located at SAHAJ; one of the oldest steering committee member of CH [also the founding member of CH]; part of COPASA – Community of Practitioners for Social Action on Health; part of the feminist evaluation network – Where we are having a online process for gender evaluation and also member of medico friends circle.

**Rakhal Gaitonde:** Presently engaged as a senior scientist with Centre for Technology and Policy, Indian Institute for technology (Madras). Pursuing my doctoral studies exploring the community accountability mechanisms within the National Rural Health Mission (NRHM) focusing on the implementation of policies regarding community participation in health. I have been associated with the implementation of the Community Action for Health Project under the NRHM at the capacity of Project Manager, Tamil Nadu Region. Also, been involved with the community level monitoring of the environmentally impacted areas such as around newly developing industries, pollution impacted communities, around industrial areas. Interests include: community based accountability and governance in health systems. Member of the people's health movement, Jan Swastha Abhyan and Medico Friends Circle.

**Rajalakshmi:** Possess experience working with the urban population in Chennai within the reproductive child health programme. Having completed my law degree, have also engaged in sensitizing the judges on trafficking issues, as part of multi-state study across ten states in India. I received a MacArthur fellowship through which I conducted a research study on informed consent in reproductive health services, both from the provider's and user's perspective. I engaged with RUWSEC on a project that studied on how religious fundamentalism and sexuality education in India. Presently, I am a doctoral scholar at Tata Institute of Social Sciences. The study looks at gender issues involved in the publicly funded health insurance programs, taking the case of the TN's health insurance policy for the poor. I am also recently an active member of the Tamil Nadu MNI-JSA chapter, MFC circle.

**Sundari Ravidran.** One of the founding members of CommonHealth. Currently Professor at the Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum. Teach master's graduates in Public health as well guide students enrolled for the doctoral studies in public health. Earlier, it started

with the founding of the Rural Women's Social Education Centre (RUWSEC), a grassroots women's health organization in Tamil Nadu, established in 1981. RUWSEC continues to work towards women's well-being and empowerment. Been engaged at different levels, research, community work, international level. Co-editor of the Reproductive Health Matters Journal. Current academic pre-occupation involves engagement in a health equity project through which many activities are carried out. Presently we are engaged in a literature review to fill the void of a social, gender and equity perspective research on the areas of maternal health and abortion, sexuality and adolescent health in India

**Sunil Kaul:** Founder of the organization called '*the ant*', situated in the Bodoland, Assam. A public health doctor by profession the ant works with communities to ensure basic services such as health care and local employment opportunities, and sharing knowledge and experiences with a variety of NGOs across the region through training workshops and printed publications.

**Subhasri:** Based in Chennai and gynecologist by training. I work with RUWSEC, where we provide gynecological services through the RUWSEC clinic. Been involved with CommonHealth for the last nine years and trying to carry forward the work of CH with the support of other CH board members. Since last two years, also been engaged in the state of Bihar towards strengthening the public health system. My role has been towards working in district hospitals and trying to work with the doctors for improving the obstetrics services. An amazing experience filled with challenges and learnings, with an insight to look at the system from within. Been engaged with the MFC and actively involved in building the Chennai MFC group with younger medical students. One of the new initiatives is the 'Conversations and Kaapi' where young medical professionals get an opportunity to talk with experts in the field and bring in dimension besides the medical curriculum.

**Sanjeeta:** Been engaged with women's health issues for the past 5-6 years working with various organisations. I have worked in five states namely Chhattisgarh, Jharkhand, Haryana, Maharashtra and Bhutan. I am associated with CH for the last five years. My engagement with CH has helped me a lot in understanding the issues in a great way.

**Sana Contractor:** Works as a program Manager at Centre for Health and Social Justice, based in Delhi. The organization has a research and policy focus. At present involved with the health and governance scheme project and also involved in the interventions research for CHSJ. Trained as a public health professional, works as a researcher, trainer and interventionist, in the areas of violence and health (gender based violence, armed conflict and communal violence), sexual and reproductive health rights, and social exclusion in health. Associated with CommonHealth for the last seven years. Also associated with National Alliance for Maternal Health and Human Rights, COPASA and MFC.

**Sreeparna Chattopadhyay:** A cultural anthropologist by training. My focus has been on health and gender. Presently a faculty member at School of Advanced Studies and Research, Srishti Institute of Art, Design and Technology, Bengaluru. Until recently I

joined Srishti, I was working as an assistant professor at the Azim Premji University. My interest and doctoral thesis was on domestic violence in India that looked at with a gender lens. My interest also is in understanding the Maternal Health situation in India.

**Sunanda Ganju:** Been Associated for long with SAHAJ, Baroda. Presently working at SAHAJ as a board member. Been associated with CommonHealth for the last few years. My present interest is working towards peace in the region of Kashmir by documenting a series of narratives.

**Sudha Rani:** A physiotherapist with Master's in Public Health. Presently engaged as a research associate with Centre for Technology and Policy, Indian Institute for technology (Madras). I am working currently on a project that looks at Cesarean section deliveries and the beliefs associated to the auspiciousness and childbirth decision-making. Earlier I have experience working within a project on Tamil Nadu Chief Minister's Health Insurance scheme programme.

\*\*\*\*\***END OF REPORT**\*\*\*\*\*