STRATEGIC CONSULTATION TO BUILD PARTNERSHIPS FOR REPRODUCTIVE HEALTH RIGHTS

ORGANISED BY COMMONHEALTH

2-3 December 2016

ABBREVIATIONS

ABVP	Akhil Bharatiya Vishva Hindu Parishad
AFHC	Adolescent friendly health centres
ANM	Auxilliary Nurse Midwife
ARROW	Asian-Pacific Resource and Research on Women Centre
ART	Antiretroviral Therapy
AWC	Anganwadi Centres
AYUSH	Ayurveda, Yoga, Unani, Siddha, Homeopathy
C-sections	caesarean sections
CAC	Comprehensive Abortion Care
CEHAT	Centre for Enquiry into Health and Allied Themes
CHC	Comprehensive Health Centre
CHWs	Community Health Workers
CLA	Criminal Law Amendment Act
CommonHealth	Coalition for Maternal-Newborn Health and Safe Abortion
CPD	Commission on Population and Development
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisations
CuT	Copper T
CWC	Child Welfare Committee
DH	District Hospitals
ECP	Emergency Contraceptive Pills
EWEC	Every Women Every Child
FIR	First Information Report
FOGSI	Federation of Obstetric and Gynaecological Societies of India
GSWCAH	Global Strategy for Women's, Children's and Adolescent's Health
HIV	Human Immuno Deficiency Virus
HLPF	High-level Political Forum
HRLN	Human Rights Law Network
ICDS	Integrated Child Development Services Scheme
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
IGMSY	Indira Gandhi Matritiva Sahayata Yojana
IPC	Indian Penal Code
IWHC	International Women's Health Coalition
JJ	Juvenile Justice
JSA	Jan Swasthya Abhiyan
JSSK	Janani Shishu Suraksha Karyakram
MDR	Maternal Death Review
MMC	Mumbai Mobile Creches
MoHFW	Ministry of Health and Family Welfare
MSM	Men who have sex with men
MTP	Medical Termination of Pregnancy
NAMHHR	National Alliance for Maternal Health and Human Rights
NFSA	National Food Security Act

NGO	Non-governmental organisations
NHRC	National Human Rights Commission
NREGA	National Rural Employment Guarantee Act
PCPNDT	Pre Conception Prenatal Diagnostic Test
PHC	Primary Health Centre
PIP	Programme Implementation Plan
POCSO	Protection of Children from Sexual Offenses Act
PPTCT	Prevention of Parent to Child Transmission
PPTCT	Prevention of Parent to Child Transmission
PTG	Particularly Vulnerable Tribal Groups
PWDVA	Protection of Women from Domestic Violence Act
PWN	Positive Women's Network
RSS	Rashtriya Swayamseva Sangh
RTIs	Reprodutive Tract Infections
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TB	Tubercolosis
UPR	Universal Periodic Review
WB	World Bank
WHO	World Health Organisation
WTO	World Trade Organisation

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organised by CommonHealth at FIAMC, Bio-medical ethics hall, St. Pius College, Mumbai

December 2-3, 2016

ABOUT THE CONSULTATION

Sexual and Reproductive health concerns must not be viewed from the lens of health alone. These concerns cannot be addressed without tackling social and economic inequities. Issues related to income, caste, ethnicity, religion, education, access to food and nutrition, water, hygiene, sanitation, geography, migration and displacement impact health outcomes. Dalits, adivasis, muslims, people with disability, people living with HIV are among the most excluded groups owing to their social and geographical vulnerability, poverty and biological identity. Within these socially and economically disadvantaged groups, women's and children's vulnerability is at an entirely different level because of their lower status. There is a plethora of evidence to suggest persisting trends of inequalities in the health status and healthcare access of dalit and adivasi women and children.

The neo-liberal policies adopted by every successive government have driven holes through the existing safety nets for the vulnerable in the country. Commercial and divisive designs of the old and new dispensations have further marginalised poor minorities, dalits and adivasis. Health, education, natural resources are consistently sized up as 'commodities' to be thrown into the free market for the highest bidder. Burgeoning efforts to privatise all social sectors go in tandem with the state's withdrawal from all public systems. Equity is sacrificed in the name of efficiency and productivity. Claims of improved growth rates do not see a corresponding increase in public expenditure in health, education and other social sectors.

The right to health and improved sexual and reproductive health outcomes would flow from the realisation of socio-economic, cultural and political rights. In the current policy environment with its shrinking spaces for accountability it is important to coordinate efforts and speak with one voice. There is a need for greater synergy among rights-based groups addressing various structural inequities to join hands to support each other.

In this context, a two-day strategic consultation to build partnerships for reproductive health rights was organised by CommonHealth on 2-3 December 2016 in FIAMC, Bio-medical ethics hall, St. Pius College, Mumbai with the support of the International Women's Health Coalition (IWHC) and Asia-Pacific Resource and Research Centre for Women (ARROW). There were a total of 64 participants representing different regions and organisations. There were participants from Odisha, Bihar, Gujarat, Maharashtra, Chhatisgarh, Uttar Pradesh, Haryana, Punjab, Tamil Nadu, Andhra Pradesh and Karnataka. Most of the participants were CH members. The consultation was also attended by representatives from IWHC and ARROW.

The specific objectives of the consultation were:

- To explore interlinkages between various pro-people campaigns and movements and build a collective ownership for a sustained partnership on Maternal Health Rights by:
    - Understanding and appreciating the goals and strategies of different pro people campaigns and movements
    - Exploring how Maternal Health Rights can fit into each movement/campaign's agenda
    - Developing a tentative action plan (including planning for the People's Maternal Health Convention later in December 2016)
- Identify, understand, and prioritize recent issues that affect or have potential to affect access to safe abortion.
- Identify specific contextual issues at state and regional level with respect to access to safe abortion services, sex selection and implementation of the MTP Act.
- Engage with regional and Asian level networks in addition to state and national level and bring voices from diverse constituencies to influence discourse at the national level.

The report is structured as per the sessions of the consultation. Each of the session is documented to capture the main points shared by the presenters and the subsequent discussions.

MATERNAL HEALTH RIGHTS – DECEMBER 2, 2016

WELCOME ADDRESS – DR. SUBHA SRI

The consultation commenced with a welcome address by Dr. Subha Sri, Chairperson of the Steering Committee – CommonHealth. Subha Sri shared the main objectives of the consultation as stated above and welcomed all the participants who came from different parts of the country. She shared with them the programme agenda in detail. After the welcome address the participants introduced themselves and their work.

SESSION I: INTRODUCTION TO COMMONHEALTH'S WORK

PRESENTER - DR. NILANGI SARDESHPANDE, PUNE

Dr. Nilangi Sardeshpande is a Pune-based independent consultant who works on sexual and reproductive health and rights (SRHR) issues. She is also a Steering Committee member of CommonHealth. In this first session, she introduced CommonHealth's work to the participants. Nilangi began with a reflection on CommonHealth's journey thus far. CommonHealth, a coalition of individuals and institutions working on maternal-neonatal health and safe abortion issues, currently has 27 institutional and 179 individual members. The members largely volunteer their time for the work they undertake as a part of the coalition.

On an average maternal and neonatal health indicators have improved but there are regions in the country where the conditions of maternal-neonatal health and safe abortion services remain poor. Over the years, CommonHealth has endeavoured to produce systematic evidence to expose the conditions in these marginalised regions. While the emphasis of government policies and programmes has been to increase institutional deliveries, CommonHealth advocates provisions for safe delivery whether it takes place in a formal institution or at home. To make people aware of this alternate discourse, CommonHealth has been focussing on capacity building.

CommonHealth's members recently came together to document 124 maternal deaths across India in a rich and timely report called 'Dead Women Talking'. The report specifically pointed to the absence of social determinants in the state guidelines and tools for maternal death reviews (MDR). CommonHealth believes in an integrated and holistic approach to SRHR concerns that stretches beyond the dominant biomedical paradigm. Within this, women's perception of safe delivery and quality of care must be given precedence. To this end, the coalition along with member organisations, has prepared tools to capture women's perceptions and their concerns related to reproductive health issues. In addition, CommonHealth has developed several factsheets such as 'Malaria in Pregnancy', 'Sickle Cell Anaemia' and many others and compiled state-wise data related to maternal-neonatal health and safe abortion indicators. These resources are easily available on the CommonHealth website – www.commonhealth.in. She concluded her presentation with a look at the new areas that CommonHealth hopes to explore in the coming years. These include issues around maternal morbidity, audits of near-miss cases, perinatal deaths and respectful care. She shared that this consultation is also a step towards opening up many underexplored areas.

SESSION II: NEED FOR BUILDING ALLIANCES IN THE CURRENT CONTEXT

PRESENTER - DR. T K SUNDARI RAVINDRAN, ACHUTHA MENON CENTRE FOR HEALTH SCIENCES STUDIES, THIRUVANANTHAPURAM

Dr. T K Sundari Ravidran is a Professor at the Achutha Menon Centre for Health Sciences Studies, Sri Chitra Medical College, Thiruvananthapuram. She commenced her presentation by highlighting that the main focus of the work related to maternal health thus far has been to map the provision of maternal health services. However, social determinants such as living conditions, hunger, poverty etc. that are directly linked with maternal health have received scant attention. In this context, the impact of global forces on local communities and their realities must be unpacked. The association between the factors at the community level and the global level is integral to realising SRHR. The failures we've witnessed in achieving our goals despite our enormous efforts are partly owing to these macro factors that prevent change at the micro-level.

At the macro level, the neoliberal economic policies have influenced and impacted the lives of every single person. It is important to be cognisant of their influence on maternal health while strategising community-based actions. The economic reformation that began in the 1980s liberalised markets, enhancing foreign investment and simultaneously, reducing public expenditure on health, education and other social sectors. This economic policy attempted to rein in expenditure within the national income in order to lessen the fiscal deficit. To explain how this impacted people's lives she gave the example of a poor family that tries to manage it's expenses as per the income. However, should this family not send the child to school because it cannot bear the expenses? If the child remains illiterate then the condition of the family is unlikely to improve in the future. Hence, loans to developing countries were granted to improve these conditions but the expected outcomes were not achieved due to their improper utilisation.

After the establishment of World Trade Organisation (WTO), all signatory countries were obliged to welcome foreign investments in education, health, insurance and other sectors. But has this investment made a dent on the existing inequalities in the country? Foreign investments have not gone in labour extensive areas such as agriculture and industries. Instead their mainstay has been the information technology sector requiring limited human resources. Thus, this has led to negligible increase in employment. This has, in turn, widened the urban-rural divide and the inequalities between the rich and poor. There is extreme polarisation even within districts. Women and their livelihoods have been the casualties in this socio-economic and political

environment. The reduction of subsidies in agriculture, lower profits from farm yield, displacement of marginal and small farmers for corporate farming and industries has resulted in various forms of migration giving rise to bonded labour, homelessness, sex trafficking and migrant sex workers. This affected women more as they are the shock absorbers in the family. Women work more and eat less to feed the family better.

Sundari further pointed to the impact of neoliberal policies on the health sector as a reduction in government expenditure and an increasing commercialisation of healthcare. In this context, those who wish to avail public-funded hospitals face barriers such as unavailability of facilities in their vicinity. In case there is a hospital in the area then are there proper roads and transportation facilities to reach the hospital? We also find that without any efforts to improve the availability of primary care there is an attempt to improve health outcomes. Moreover, maternal health is discussed sans sexual and reproductive health rights. Within this, the government and other agencies neglect the provision of safe abortion services. In fact there appears to be a counter-narrative at work vis-à-vis abortion, which can seriously damage the rights-based dialogues that have been initiated.

Sundari concluded her presentation with the assertion that the struggle for improved maternal health is not merely for better health services. ***The struggle for improved maternal health is a fight for social justice. The struggle is against discrimination and poverty. The fight is for better homes, livelihood, food etc. It is therefore imperative that every movement recognises that we are interlinked and indispensable to each other's struggle.***

SESSION III: VOICES FROM COALITIONS, NETWORKS, MOVEMENTS

CHAIRPERSON: DR. ARUN GADRE, SATHI-PUNE

PRESENTERS: SANDHYA GAUTAM – NATIONAL ALLIANCE FOR MATERNAL HEALTH & HUMAN RIGHTS, KAJAL – JAN SWASTHYA ABHIYAN, GANGA RAM PAIKRA – RIGHT TO FOOD CAMPAIGN

The session was the first in a series of presentations from different coalitions, networks and movements working on human rights concerns. Dr. Arun Gadre who is the Coordinator at SATHI and a member of the Jan Swasthya Abhiyan (JSA) chaired this session. At the outset, Dr. Gadre stated that campaigns and movements are working on a variety of concerns ranging from human rights to provision of health care services in different parts of the country. The work is quite challenging within each of the areas. It is even more challenging to work across issues with a common understanding. He contended that it is imperative to collaborate but building alliances can be difficult considering movements and organisations mostly work in silos. In this context, expertise tends to take precedence. However, he asserted it is now time to put these issues aside to work together and identify a common ground to take social justice concerns forward. Before commencing with the presentations, Dr. Gadre shared his recent experience in New York where he attended a meeting with participants working on human rights concerns from across the globe. The participants at the meeting were working on rights based issues from around the world including South Africa, Malaysia, Cambodia, Latin America etc. There were many participants who had come from conflict-affected areas. Although the gathering had convened to discuss solutions for context-specific problems, it was clear in the course of the meeting that the issues uppermost on all the participants' minds were global concerns. He then invited each of the

presenters to put forth their views and the work carried out by their respective alliances and movements.

I. SANDHYA GAUTAM - NAMHHR, DELHI

Sandhya Gautam is the Coordinator of NAMHHR and works with the Centre for Health and Social Justice, which is also the secretariat for NAMHHR. Sandhya Gautam commenced her presentation on NAMHHR by explaining that the alliance is dedicated to working towards improved maternal health in the country with a human rights perspective. The Alliance came into existence with the visit of the UN Special Rapporteur on the Right to Health, Paul Hunt, and the resultant discussions within the country around health concerns. The right to health discourse threw light on the abysmal state of maternal health and violations of women's rights therein. Within this the main concerns of the alliance include but are not limited to high maternal mortality rates, issues of accessibility of services, lack of dignity and respect in care etc. NAMHHR has 60 members from 18 different states. NAMHHR also has as its members networks such as the Right to Food Campaign and the Health Watch Forum. The objective of linking with other movements and networks is to work collectively with them and also, to be energised by their work.

The Alliance has focused its energies on bringing to the fore the ground realities of different regions, communities and areas. Government has launched numerous schemes and programmes, such as the Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram. So what is the reality on the ground with regard to implementation? Are communities benefiting from these schemes and programmes? NAMHHR tracks the implementation of programmes through the members. Along with maternal health services, the alliance also works on sterilisation, family planning services and abortion services. The advocacy efforts are concentrated at the national level. The attempt is to work with the government to improve the services. For instance, NAMHHR works in association with the National Human Rights Commission (NHRC). In a recent maternal death case, a NAMHHR member paid a visit to the family to identify the circumstances around the death so that the family is not held unfairly responsible for what was beyond their control. This fact-finding mission was undertaken with the support of the NHRC.

Another initiative of NAMHHR is ensuring adherence of the guidelines and the standard operating procedures during sterilisation operations as per the Supreme Court judgments in the Devika Biswas vs Union of India and Ors. W.P. (C) 81 of 2012 case and Ramakant Rai vs Union of India, W.P (C) No 209 of 2003. Despite the judgements, there is no significant change in the approach adopted in carrying out sterilisation in most parts of the country.

NAMHHR carried out a fact-finding of the sterilisation deaths that took place in Bilaspur in 2014. The alliance also conducted a study in tribal areas to unpack the nature of social exclusion in the health care sector experienced by marginalised communities in the country. The study sought to capture the attitudes of health care providers to specifically describe the prejudices harboured by them against tribal communities.

A national dialogue on maternal health of tribal women was organised by the Alliance. NAHMMR is currently thinking of the next chapter of this dialogue. Recently, community based maternal death reviews were carried out in Jharkhand, Odisha and West Bengal. The documentation of the deaths included interviews with family members and health workers. The attempt was to juxtapose the maternal death reviews with the state level or regional data related to maternal mortality ratios. ***The alliance seeks to draw attention to the woman and the loss of her life, so she ceases to be viewed merely as an indicator.***

During the dissemination of this data, the response of the government was predictable. There were claims of achievements of the government machinery instead of an acknowledgement of issues within the system.

In association with the Right to Food Campaign NAMHHR has been raising the concerns related to maternity entitlements as per the National Food Security Act 2013.

Sandhya concluded her presentation stating that our work must be directed towards the benefit of the poor and marginalised. She reiterated the need to join forces with different movements and campaigns to address maternal health concerns in the country.

II. Kajal Jain – Jan Swasthya Abhiyan, Pune

Kajal Jain works with MASUM, Pune and is a member of the JSA – Maharashtra chapter. The People's Health Movement's India chapter is the Jan Swasthya Abhiyan which has as its members individuals who work as researchers, academics, clinicians etc. Since 2000, the JSA has been working on a variety of health related concerns at different levels, especially struggling for strengthened primary health care, community mobilisation, fair drug pricing and health budgeting. The work of the Maharashtra chapter takes into account global realities of decreasing government support for not only health but all social sectors such as education, livelihoods etc. In the current context, one finds that there is widespread contractual employment, which translates to limited social security benefits for workers and job insecurity. Recently, packaged food was introduced in *anganwadis* which could result in the loss of work for women employed in the AWCs as helpers and cooks.

The JSA is devoted to working on budgeting for health and nutrition-related services along with resisting attempts at privatisation of the health system. The implementation of the Clinical Establishment Act needs to be ensured to regulate private players in the health sector. The impact of reducing health budgets at the grassroots level is documented through regular audits. Community based monitoring is carried out to capture the implementation of schemes and programmes in addition to document the state of health infrastructure and facilities in different areas.

In January 2016, a public hearing on health concerns was organised in association with the NHRC. For the public hearing, JSA was involved in recording testimonies in the field. Most of the cases that were presented at the hearing were women's health related concerns and were specifically, maternal health cases. The main concerns that emerged in the hearing included – shortfall of human resources, frequent and unjustified referrals, discrimination against women etc. Discrimination was recorded in the cases of HIV positive pregnant women who were referred from one facility to another for delivery resulting in the death of the newborn. Often, women are abused and beaten to such an extent that there are visible injury marks on their bodies. However, this particular case of abuse could not be taken up at the public hearing, as the victim was unable to appear before the panel. There was also a case of insertion of CuT without the patient's consent.

A study on the implementation of JSSK revealed that 50% of rural hospitals in 5 districts in Maharashtra had shortfall of gynaecologists, paediatricians and surgeons. Also, burqa-clad women were not allowed into the rooms and were deliberately kept waiting. Health personnel had to be persuaded or forced in some way to assist in the delivery of Muslim women. This was especially seen in urban hospitals such as Bhabha Hospital in Bandra, Mumbai.

In JSA's experience, there are gross human rights violations, incidence of violence within the health system, lack of quality of care and absence of adequate and appropriate human resources for health in Maharashtra. Also, ***in Maharashtra, despite modern advances one sees that there are large pockets of tribals and dalits who continue to use a stone or a bark to cut the umbilical cord post delivery. Most are not even aware of the public health system.*** But they do avail services from private providers. Numerous studies in the state have shown that hysterectomies, which are not medically indicated, are rampant. There are cases of prolapse in women as young as 25 years of age. Many communities continue to be excluded from the services in the public health system. Maternal health related morbidities, malnutrition, sickle cell anaemia are the other problems in the area.

Kajal concluded her presentation with some recommendations. She shared that in discussions with women self-help groups, it was identified that there is a crucial need for capacity building of Community Health Workers (CHWs) on women's health issues. Secondly, at the regional, state and district level there is a need to engage the elected representatives. Finally, thus far media has not been adequately explored for advocacy and so, greater efforts must be made to use different media for this purpose.

III. Ganga Ram Paikra - Right To Food Campaign, Raipur

Ganga Ram Paikra is with the Right to Food Campaign and works with the organisation Chaupal based in Chhatisgarh. Ganga commenced his presentation with a reference to the maternity entitlement of Rs. 6000 under the NFSA passed in 2013. The entitlement was envisioned as monetary support for poor and vulnerable women to augment their food and nutritional intake or in case of wage loss owing to pregnancy. However, there is no implementation of this regulation in the country. National Rural Employment Guarantee Act (NREGA) has been modified to state that in a year if a woman has worked for 15 days then she would receive the entitlements related to maternity. He contended that this conditionality in ensuring maternity entitlements was completely unnecessary. In Chhatisgarh, there were few women who received the maternity benefit under NREGA.

Additionally, women in Adivasi areas are burdened with work – both production and reproductive work. He argued that women are seen to work the most but eat the least in the household. Often, women eat only once the entire family has eaten. In this context, the maternity entitlement would be very useful. There should be no conditions attached to the provision of the amount. Rs. 6000 is inadequate in poor contexts, but the revision of this amount can be done at a later stage. On 22 November, there was a nation-wide demonstration regarding maternity entitlements.

In Chhatisgarh, there is a Particularly Vulnerable Tribal Group called Pahari Korwa. They reside largely in the hills and the lack of road connectivity transportation is a major concern of this community. These communities are unable to reach health services in their areas. People of the Pahari Korwa community have to climb down the hill two kilometres to reach motorable road and then they find transport.

The government is not interested in restoring the social system that existed earlier in these areas. He contended that even social movements and campaigns are not driven towards this end. Also, it is important to bear in mind that tribal areas have changed considerably over the years. ***The vegetables that were freely available in forests in the area are no longer easily available. Mushrooms and other vegetables are not available anymore. The production of nutritious millets too is negligible at present. Government funding and support encourages the***

production of rice and wheat. Similarly, the old rivers in the forests have died and with them the local communities' access to fish protein has ended too. In this context, there are many organisations working on agriculture, forest rights and food security concerns. It is important to collaborate with these organisations in the long run.

Ganga concluded his presentation by stating that better women's health means improved health of the family. He also shared that he felt that the meeting was a concrete step towards building alliances for improved women's health and for bringing together diverse voices from different parts of the state.

CONCLUDING REMARKS

The chairperson, Dr. Arun Gadre reflected on the presentations to conclude that it is imperative that the work with marginalised sections should be strengthened and sustained. He highlighted that in Maharashtra there is large-scale conversion of tribal communities to Hinduism. As a result, vegetarianism has increased among communities that were traditionally meat-eating. Nutritional intake is poor with an absence of protein and low calories in their diet. Women's health is most affected in these cases.

Government strategy is to claim public services are ineffective and we aid them in the process by highlighting all the existing lapses in the government support system. The government's aim is to eventually declare the services unviable and withdraw public funding. This is a matter of fine balance between what we'd like to see happen and how the government can manipulate it for its own end. Moreover, with the election of the current dispensation, there was a prediction of aspirational politics coming into play. In rural India one witnesses the race for development in line with this aspirational politics. The desire to use private health services as a mark of progress is an example of this. There is a need to dismantle these myths and lies. Nearly 6-11% vulnerable pregnant women in rural areas need c-sections but do not have access to the services while in Indian cities the rate of c-sections is 50-70%.

Dr. Gadre concluded the session with the thought that we need to carefully examine how our respective work will flow into the work of the national alliance. He recommended that as the government is actively bringing in privatisation in health services civil society actors must have an alternative plan to counter this move. In the wake of voting in favour of Brexit in the UK and Donald Trump's election as the US president, we need to accommodate these changes in our strategies and build our alliances accordingly.

DISCUSSION & QUESTIONS

- Traditional nutritional foods such as millets and vegetables have vanished from tribal homes. These were readily available in rural, tribal areas earlier. At present, these commodities are available for very high prices in retail shops in urban areas. So, local seed conservation must be undertaken. Also, in Maharashtra, Aami Amchi Aaroya Sathi is encouraging kitchen farming.
- Awareness generation among poor, rural and marginalised communities regarding global and national issues needs to be ensured. The communities must be aware of their entitlement and also understand policies in the larger political context.
- What can be done regarding the problem of road connectivity and transportation concerns in rural and tribal areas?
    - Ganga Paikra responded that vehicles that are provided by the government such as 108 cannot go up the hills where these communities reside. The communities contend that if roads can be constructed in the hills to facilitate the work of

corporates then why not for them. Another problem is that people are being displaced from their homes to make way for industries. However, tribal communities are actively resisting such efforts to exploit and oppress them.

- What can be done with regard to organic farming in local areas among tribal community?
    - Ganga responded that millets are very easy to grow as they can be grown is any kind of soil with or without irrigation. The farming of millets can be encouraged through the government machinery. The District Collector's office could take this forward.
- In the case of a starvation death in Bihar it was seen that government officials claimed in their report that the death was a result of lack of medicines. The real cause of death i.e. lack of food intake was undocumented.
- It was shared that there is a dire need to collect data regarding child marriages in rural and tribal areas in Odisha.
- In Maharashtra, sickle cell anaemia is a major health problem. Also, it was noted that there is a lack of coordination between Primary Health Centres (PHC) and District Hospitals (DHs). Despite positive identification of anaemia in antenatal checkups, there is no follow up with the patients.
- It is seen that mostly HIV-positive maternal and child deaths are not counted in national or state-level health statistics. The data that is available or collected is the number of children who are born HIV positive.

SESSION IV: VOICES FROM COALITIONS, NETWORKS & MOVEMENTS CONTD.

CHAIRPERSON: DR. LEELA VISARIA

PRESENTERS: MANJULA PRADEEP – NAVSARJAN, SMRITI NEVATIA – LABIA, MANDAKINI – SAHELI SANGH, KIRAN DESHMUKH – VAMP & SANGRAM, VINITA SAHASRAMAN – YP FOUNDATION

The chairperson Dr. Leela Visaria, Honorary Professor and Former Director at the Gujarat Institute of Development Research, opened the session by urging all the participants from different organisations and movements to concentrate their efforts on quality documentation of their work for advocacy purposes. She then promptly invited the first speaker, Manjula Pradeep from Gujarat to share her views.

MANJULA PRADEEP – NAVSARJAN TRUST, AHMEDABAD

Manjula Pradeep introduced herself as an activist working on Dalit rights for the past 24 years. She is currently the Executive Director of the Navsarjan Trust, a grassroots Dalit organisation based in Ahmedabad. She shared that her presentation on the sexual and reproductive health rights of Dalit women is based on her work on caste and gender-based discrimination. She highlighted that access to health is a function of the intersectionality of caste, class and gender in the case of Dalit women. She explained that social interaction with Dalits hinges on the notion of the purity of their identity. Women and their identity are negated to such an extent that they are not even seen as human beings.

Also, one finds that even among Dalits there are those who are considered 'purer' than the rest. In this graded hierarchy the lowest in the rung are those who are engaged in scavenging or are *safai karamcharis*. Women make up nearly 90-95% of scavengers. It is important to note that these

women are paid far below the government wage rates for the work they do. In villages, one has witnessed women scavengers being paid as low as Rs. 5 for the work they do, making roughly Rs. 5-600 per month. In the Valmiki community, families compel women to continue scavenging work during pregnancy. The health concerns emerging from the unclean work during pregnancy needs to be studied in detail.

She shared that there is a dearth of literature on the health concerns of *Devdasi* women. Also, Dalit and tribal women working as agricultural labourers are vulnerable to sexual violence. In Gujarat, the health needs of women and young girls living and working in the salt pans have been neglected over the years. There are government schools for the education of the children of salt pan workers. The concerns of women and young girls are not considered serious enough to warrant action. So much so, that there are no basic health facilities in the area to reach out to them.

She asserted that in the context of Dalit women, living with dignity and respect are foundational for survival. Currently, the literacy rate among Dalits is low – in fact more than 50% of Dalit girls drop out from schools. ***So the question is when one is least aware of one's rights how can one know about one's reproductive rights, know about one's body and one's right to well-being?*** Cases of sexual violence against Dalit girls abound. Better awareness among young girls about their reproductive rights would help in averting sexual violence.

There have been mass attacks on Dalits during which women were targeted. It is important to examine how vulnerable women become owing to such violence. Issues of access and security of homeless women living on the streets have to be highlighted. Often, homeless women give birth on the streets. Also, in cases of social boycott and violence, families or individuals have no access to basic amenities such as food, water, education, public or private transport. An untouchability study was conducted in 1589 villages in Gujarat and in more than half the study villages it was found that government-employed midwives discriminated against Dalit women and did not assist in childbirth. In another study in 101 villages in Gujarat with more than 3000 Dalit and non-Dalit mothers, it was seen that 46.5% Dalit women did not receive health services.

She concluded her presentation with an appeal that the health concerns of Dalit women should be brought to the forefront.

SMRITI NEVATIA – LABIA, MUMBAI

Smriti Nevatia is a part of Labia, which is a queer collective based in Mumbai. She stated at the outset that in the course of the presentation, she would be sharing insights from a study conducted by Labia to understand 'gender'. Labia, initially a queer collective for lesbian and bisexual women, gradually drew people of different gender identities as its member. Later, a study was conducted with 'persons assigned female gender at birth' to capture their lives and to unpack 'gender' through their life histories.

The study was named 'Breaking the Binaries' which aimed to dismantle gender binaries that exist within society. There were a total of 50 study respondents from across the country. Of the total 50 respondents, 22 did not identify themselves as women, 10 identified themselves as men and then some considered themselves neither men nor women.

So, who are the people that we are talking about, when we speak of non-binary genders, non-normative sexualities or non-binary sexualities? These are people who are not easily categorised within heteronormativity. A newborn is declared a girl or a boy based on the physical or biological characteristics of being male or female. Both sex and gender are binaries i.e. they are

understood as either male or female. At birth, based on the estimated sex, gender is also assigned to a person. The assigned sex and gender then confines one to the binaries. There are feminists who have addressed this issue. Through its struggles, the women's movement in India has questioned and re-engineered ways in which one understands gender. However, the question is whether we have been able to rise above and deal effectively with homophobia and transphobia? ***The imprisonment of individuals within the social confines of what is allowed and disallowed based on one's assigned gender continues unabated. This dictates the spaces she can access and who can be her sexual partner etc. This is further complicated by social norms and culture.***

But can we be certain of who is a 'man' and who is a 'woman'? What if someone is assigned a certain gender at birth but as she grows up does not feel like the assigned gender. Further, what about the sexual and reproductive health needs of such people? We need to think about groups such as intersexed or transpersons and those in polyamorous relations. Do we understand their concerns adequately?

These communities are subjected to stigma, exclusion, violence and neglect. There is considerable body shaming and moral policing of these communities.

In this context, we must ensure that sexual health is included in the framework of reproductive health. Single women are often uncomfortable while accessing health services for their sexual and reproductive health needs. Even if one is a heterosexual woman, visiting a gynaecologist for one's sexual health can be a traumatic experience.

Smriti then read an excerpt from their book 'Outlaws in the gender galaxy'. The excerpt, from the chapter called 'Self and the Body' and the subsection – 'The expert', dealt with how health care providers assumed that single women were not sexually active, the male body and heterosexuality was considered the norm and basic information/discussions regarding women's concerns were reserved for 'husbands' instead of the patient herself.

In her conclusion, Smriti Nevatia shared that the medical syllabus and education needs to be inclusive of non-normative sexuality and gender issues.

MANDAKINI – SAHELI SANGH, PUNE

Mandakini works with Saheli Sangh, which is a Pune-based female sex workers' collective. The government initiatives for female sex workers have been limited to HIV prevention. Saheli Sangh consciously moved away from HIV related work to identify initiatives that are based on the felt needs of the community. In case there is a need to work on HIV then that is taken up as well. Currently, Saheli Sangh is working on reproductive health rights. Members of the collective are encouraged to avail antenatal care in the first month of their pregnancy. Within this project, the organisation also provides information related to different contraceptives. Prior to their intervention, the assumption was that only men use contraception or protection during sexual intercourse. At present, there are a large number of women in the collective who use female condoms. Earlier, there were misconceptions regarding the use of CuT leading to infections among sex workers due to the high frequency of sexual intercourse.

Medical abortion pills are not accessible at present but, the percentage of self-medication for abortion is quite high. It must be noted that currently the sex workers or their partners are able to access medical abortion pills from unknown sources. It was also seen that with regular partners the use of condoms is quite low. In these cases, other contraception methods are shared with the women. Owing to the issue of sex selection, use of sonography has become difficult as

providers at sonography centres often ask for the married partner to be present. There are many cases of denial of health services on account of the absence of 'blood relatives' or 'husbands'. This is a potential future focus area for Saheli Sangh.

Discrimination against sex workers is witnessed in certain hospitals. Women are not informed of the complications in their pregnancy. The patients' thumb impression is taken on a sheet of paper as consent and the medical termination is promptly carried out.

Cases of sexually transmitted infections and reproductive tract infections are higher among women who do not use condoms. ***Even if the woman is treated for the infections, she is prone to contracting more infections as long as her partners remain untreated.*** Also, if condoms are not used then there would be a recurrence of infection. If the sex worker introduces the Saheli Sangh team to her partners, then the team attempts to counsel them regarding the use of condoms and treatment for RTIs and STIs. There were many instances of incomplete abortions by unqualified private practitioners. In a study with 300 sex workers, 40 women reported that they were pregnant before the age of 18 years. There was also a case of a 25 year old sex worker who had undergone six abortions. Another area of concern among female sex workers is substance abuse and other mental disorders.

As Mandakini completed her presentation of sex workers, she drew attention to their erratic working hours coupled with the lack of proper rest and nutrition. She urged in the end that advocacy efforts related to sex workers should focus on the issue of working conditions as well.

KIRAN DESHMUKH – VAMP & SANGRAM, SANGLI

Kiran Deshmukh heads the sex workers' collective VAMP and is associated with the organisation, Sangram based in Sangli, Maharashtra. Sangram works on sex workers' rights. The organisation works in 3 districts in Maharashtra and 2 in Karnataka with 5500 sex workers.

There is a growing recognition among the collective regarding the sexual and reproductive rights of sex workers. There is a realisation that sex workers are entitled to maternity rights as well. Many sex workers want to give birth and want to take care of their children. Kiran Deshmukh shared that in 2012 a four-month pregnant friend was so badly beaten by the police that she miscarried. As she was being beaten, she implored with the policeman to spare her as she was pregnant. ***He retorted that a sex worker must not have children - kya randi bhi kabhi maa ban saktii hai? This is the prevalent attitude in society towards sex workers. Yet, who are they to decide what a sex worker can or cannot do? How can they decide whether a sex worker can have a child or not? Ultimately, it is the sex worker's child, her income and her body. This is a matter of her right.***

Similarly, for admissions in schools, the father's name is essential. Before Sangram's intervention, it was a major problem faced by sex workers. Sex workers change their partners roughly every six months and so in schools, they'd add the name of their current partner. However, at present women in the collective do not add any man's name and insist on being the sole guardian of the child as per the school records. In civil hospitals one faces similar issues, when providers ask for their address and their husband's names. The authorities are usually shocked to learn that they reside in the 'red light area' and have no husbands. If the doctors resist providing services, then the sex workers collectively demand health services as their right. Health care providers are reminded that sex work is their work and they have a right to do this work.

She also shared that often in hospitals sex workers are given beds that are next to the toilets. She asserted that they wider society views them as if they are monkeys in a circus. She added that

those women who are living with HIV face even greater discrimination. Health providers are unkind and disrespectful in their treatment of HIV positive sex workers. The collective always accompanies them, as they are aware of the awful treatment meted out to them. She related the case of an HIV-positive pregnant sex worker who was beaten in a health facility by a doctor on account of the multiple partners she had had.

As Kiran concluded her presentation she stated unequivocally the need to include the issues faced by sex workers while strategising for sexual and reproductive health and rights.

VINITA SAHASRANAMAN - YP FOUNDATION, DELHI

Vinita Sahasranaman is the Director of Programme and Advocacy in the YP Foundation, Delhi. At the outset, Vinita shared that in her presentation she would talk about how YP Foundation works with young people, their focus on SRHR and the potential for building alliances to strengthen SRHR. Vinita contended that discrimination stems from social identities or signifiers such as caste, class, gender etc. However, this is further complicated in the case of young people. Age-based discrimination and human rights violations therein are difficult to assess and grasp. Violations of SRHR are perhaps the most common. A concrete example of this is the lack of information about one's own body, sexuality, reproductive rights, the need for consent etc. during adolescence. This is a national as well as a global concern and many groups and organisations are dedicated to working on these concerns.

A look at Comprehensive Sexuality Education (CSE) reveals that some issues get precedence over others. In YP Foundation's experience, there is a certain clampdown on or resistance to CSE in co-education schools and classes. Content related to menstrual hygiene, growing up, gender and puberty are permitted however, discussions on sex, consent and relationships are not appreciated. The fundamental discomfort with adolescent or young people's sexuality needs to be addressed first and foremost. Without this, there would be no headway in the realisation of the intersection of adolescents or young people and SRHR.

Firstly, there is a lack of awareness among young people. Secondly, there is an absence of youth-friendly health services. In reality, there is a hierarchy of services in which young girls are discriminated against. In Lucknow, an audit of both public and private services was conducted with the help of young persons who sought services in different health facilities. It was found that in case one is seeking abortion counseling then the services might be provided. However, if abortion service itself is sought then the young patient is humiliated. The patient is asked unrelated and unnecessary questions such as - why do you need information regarding abortion at this age, are you Christian, what marks did you get in your exams etc. They also found that young girls wearing *sindoor* have better access to oral contraceptive pills. ***There continues to be great discomfort with sexual and reproductive health outside the limits of marriage.***

Another case in point is the national iron supplementation programme for adolescent girls. The motivation behind the programme is to ensure cohorts of healthy mothers in the future. The health of the adolescent girls is not seen as an end in itself. The programme disregards the agency of girls to become mothers or not. The framing around future mothers, both by the government or non-government organisations, is problematic.

Another lapse to be addressed is how heteronormative-heavy and gender-binary conforming CSE is. For instance, sessions on safe sex with students do not talk about methods suitable for lesbians.

In this context, Vinita highlighted that many students and young people are challenging traditional views on sexuality and identity. These initiatives lie outside NGO spaces and raise important questions on security, menstrual hygiene, public spaces, sexism etc. It is imperative to engage with them and integrate these efforts into alliances such as this.

As she concluded her presentation she threw light on how right wing forces mobilise youth for their end. The Rashtriya Swayamseva Sangh (RSS) and Akhil Bharatiya Vishva Hindu Parishad (ABVP) activists are also at the forefront of resisting any progressive efforts with students in Delhi. The YP foundation is, therefore, considering strategising around student politics.

DISCUSSIONS & QUESTIONS:

- Did you take any action against the policeman who beat the pregnant sex-worker so badly that it led to her miscarriage?
    - Mandakini responded that in such cases, the national network of women sex workers is activated. At the organizational level also steps are taken. Rallies and demonstrations are launched for these cases. Documentation of such cases has also been strengthened.
    - Kiran responded that a massive demonstration was launched in support of this particular woman. The case was taken to the National Human Rights Commission. The end result was that the policeman was transferred from his position.
- With the support of PATH a project on the SRH of sex workers was undertaken in Bihar. The main problem identified was that sex workers are unable to access health services. For this purpose, a convergence of SRH and HIV-AIDS was forged. Medical colleges participated in this project. ID cards were issued to the sex workers which helped them in accessing services at the medical colleges.
- Sex workers, Men who have sex with men (MSM), youth are included only in the HIV programme with the aim to prevent HIV transmission. These groups are largely neglected in SRH programmes.
    - Smriti agreed that specific groups such as MSM or *hijra* community are targeted for HIV-AIDS.
- Has any work been done on further intersectionality within each of the groups represented? For eg. Dalit women with disability.
    - Manjula responded that there is limited work on intersectionality within the Dalit movement. It is only recently that gender has come to the fore in caste-based organisations.
    - Smriti responded that the Labia study tried to capture intersectionality to the extent possible. People with disability were included as study respondents. There were respondents who were older, rural, urban etc.
    - Vinita shared that there are various layers of identities that can be added to the youth. YP Foundation's understanding of intersectionality is very strong. However, in implementation there are only certain concerns that one has been able to work on.
- Within movements how much SRH work do you think can be prioritized or worked on? Do you see any special spaces opening up for SRH in your work?
    - Manjula agreed that there is a need to open up spaces to work on SRH within different movements.
    - Mandakini concurred that women sex workers needs includes SRH concerns and that it is important to work on this.

- Within youth or adolescent there are many layers of urban-rural divide, tribals-non tribals etc. These layers throw up many issues and concerns. Firstly, teachers in schools need to be sensitised. Secondly, examinations need to include questions on reproductive health.
- Couples who would like to undergo sterilisation as they do not desire any children are denied the service. This is owing to the dominant belief that couples must necessarily procreate.
- Sexual system is a far more overarching subject as opposed to reproductive systems. Curriculums should make this change so as to subsume reproductive system within the sexual system.
- Unfortunately, the preoccupation with HIV-AIDS has resulted in homophobia. Homosexuality is wrongly seen as linked with HIV prevalence. It would useful to advocate for the declaration of homophobia as a mental disorder much like the earlier categorisation of homosexuality as a disorder.
- Tamil Nadu has stopped the provision of Emergency Contraceptive Pills under the pretext that this would promote pre-marital sex. This is a violation of SRHR.
- There is a need for behaviour change of doctors.
- The Transgender Bill is hugely problematic even at the definitional level. Labia has registered its reservations with the Committee responsible for drafting the Bill. The Bill fails to identify the difference between intersexed persons and transgenders. There are all kinds of bodies that exist and it is important that policy takes into account this reality.
- Kiran contended that there are numerous policies on sex workers, however, there is no participation of the community in the policy-making process. She also asserted in response to a comment that she proudly claims that she is a sex worker. She shared that her daughter is currently studying MBBS and openly declares that her mother, a sex worker, is supporting her education.

CONCLUDING REMARKS

Dr. Leela Visaria concluded the session with a reiteration that there are multiple identities and innumerable issues entwined within these identities. She acknowledged the challenges involved in these endeavours and asserted that we can take small positive steps only if we organise ourselves and work together in taking this forward.

SESSION V: VOICES FROM COALITIONS, NETWORKS & MOVEMENTS CONTD.

CHAIRPERSON: DR. SUCHITRA DALVIE

PRESENTERS: VRUSHALI NAIK – MOBILE CRECHES, P. KOUSALYA – POSITIVE WOMEN'S NETWORK, NIDHI GOYAL – ACTIVIST DISABILITY RIGHTS & GENDER JUSTICE, SHUBRANSHU CHOUDHARY – CGNET-SWARA, HASINA KHAN – BEBAAK COLLECTIVE/AWAZ-E-NISWAN

VRUSHALI NAIK – MUMBAI MOBILE CRECHES

Vrushali Naik works as the Programme Coordinator in Mumbai Mobile Creches (MMC). She started her presentation with an introduction to the work carried out by the organisation. MMC has been working for several years at construction sites to establish day care centers for children, in order to address their health, nutrition, recreation and security needs. Site workers are typically young couples that have migrated to Mumbai in search of work and living in temporary

accommodation at the construction site itself. The living conditions at these construction sites are extremely poor. Thus far, we have spoken at this meeting about rural areas lacking basic infrastructure. A visit to any construction site would reveal that the living conditions are deplorable. The construction workers living at the site depend on water tankers for water supply. Water is supplied for barely half an hour a day. Women and children all get busy in collecting water from the tanker in that half hour. There are nearly no toilets. As most construction sites are in under-developed areas in the city access is a major concern.

Despite decades of advocacy to introduce ICDS at construction sites, MMC has seen no change in this. There have been some discussions related to mobile anganwadis for construction sites but there is no concrete step taken in this direction. Similarly, setting up of anganwadis cum crèches at construction sites is a thought only on paper with no sign of actual implementation on ground. Recently, MMC was able to start the provision of anganwadi services through their own day care centres.

One of the reasons for the neglect of this constituency is that they are migrants who are not residents of the city and therefore, do not have voting rights. Political parties are not interested in this group and so, are not prioritised while formulating government schemes and programmes.

As the real estate prices in Mumbai have been sky-high, the builders' mafia has considerable clout in the city. In this context, another challenge is the nexus of builders and politicians. Any form of community-based advocacy against the builders is difficult as this invariably results in being evicted from the construction site. A balance has to be struck. So, MMC approaches bodies such as the Builders' Association of India or the Maharashtra Chamber of Housing Industry in government forums to try to persuade them of certain interventions. The results depend entirely on their willingness to take steps.

Migrant children are in the city or at a certain construction site for roughly 3-6 months. This is the small window MMC has with them and it is difficult to bring about change in such a short period. Also, the transient nature of population dims the potential of community-based advocacy. Most construction sites are located in the suburbs, Navi Mumbai or Thane. The immunisation levels are fairly poor at construction sites. The health centres are willing to come for pulse polio but not for any other immunisation. The providers ask MMC to take the children to the health centres for the vaccinations. Without the provision of transport the organisation is unable to accompany the children to the centres. Additionally, for birthing most women prefer to return to their villages considering the lack of facilities at the construction sites. In case deliveries take place in the city, they are mostly institutional deliveries. If there has been a delivery at home, then the women ensure that registration and immunisation is done at the nearest health facilities.

Vrushali concluded her session stating that MMC would like to associate in the future with the forum for advocacy efforts. MMC hopes to work in solidarity with such forums to raise the concerns of construction workers.

P. Kousalya – Positive women's network, Chennai

P Kousalya is one of the founders of Positive Women's Network (PWN), which is a Chennai-based network of HIV positive women across the country. At the outset of her presentation, Kousalya stated that she would talk about women living with HIV.

With regard to women and HIV, there are as many as four prevention paths but as of now only two are available in the country. The two prevention paths are – [a] prevention of infection from

mother to child and [b] prevention of infection transmission from sex workers to their clients. These are the only two prevention programmes targeting women. The recently launched prevention programme is for prevention of infection through drug use. However, this is focussed on care through Antiretroviral Therapy alone.

The PWN plans to organise a campaign for primary prevention as women form 40% of the infected in India. In Andhra Pradesh, Maharashtra, Tamil Nadu etc. this percentage is higher. As per National AIDS Control Organisation, 86% were infected from a single partner. In this context, PWN is planning prevention campaign for women as this is not easy. Gender sensitisation is important among these women so they grasp the control that men have over their lives. They would not be able to go for an HIV test without their partner's permission. Men make all the decisions and it is often difficult to negotiate for an HIV test. In this scenario, there is a need to address gender barriers in order to discuss HIV with women. As per the government's understanding, HIV prevention among women is either expensive or difficult to implement. The assumption is that reaching high-risk women such as sex workers, drug users, pregnant women is easier. Moreover, women are not seen as 'at-risk' population.

There are an estimated 9 lakh women who are HIV positive. The total number of people including adolescents, transgenders, men and women registered at ART centres is approximately 7 lakhs. It is understood that 45-50% of women are approaching ART centres for treatment. There is a small percentage of positive children who are being treated for HIV. After a period 18 months post-delivery, if a child tests positive for HIV under the Prevention of Parent to Child Transmission (PPTCT) programme the mothers often do not understand what this means. The health authorities are unable to clearly explain the implications to women. The jargon used in these situations is difficult to understand. For example, during the floods in Chennai PWN found a family in which three generations of women tested positive for HIV and were completely unaware of their positive status. The grandmother had transmitted the infection to the daughter who in turn transmitted HIV to the granddaughter. P. Kousalya asked that if women were unaware of their HIV status then how would they possibly prevent transmission to their baby.

There is a dearth of literature related to the PPTCT programme especially regarding medicines. Previously, women were given one dosage of Nevirapine during delivery. Subsequently, the child is administered Nevirapine solution within 24 hours after delivery. However, this medication is outdated and also, some women proved to be resistant to this medicine. It is also seen that women who are given the whole course of ART, experience numerous side effects. They are not informed of the side effects in advance. They take the medication for the benefit of their child when the health authorities claim that it is beneficial for them.

Many women experience psychological trauma in the first 18 months after delivery as they wait for the HIV test results of their child.

There is a lack of research related to ART medications and its impact on women's health in the country. PWN's work has revealed that HIV positive women who are on ART medication are prone to developing fibroids in their uterus. As she concluded she shared that hospitals are reluctant to operate on HIV women for abortion. They usually provide them with abortion pills over a period of time. Also, the government is largely focussed on PMTCT. There are concerns around cancer but no tests are developed for this.

NIDHI GOYAL – DISABILITY & SEXUAL RIGHTS ACTIVIST, MUMBAI

Nidhi Goyal is a Mumbai-based Disability and Sexual Rights Activist who works with several disability-focussed and women's rights-oriented organisations in the country, one of which is Point of View based in Mumbai. In her presentation, she shared some of the main concerns of women living with disability with a special focus on their SRHR.

At the very heart of any endeavor with a community is the primary need to recognise the community, identify where they are and to visibilise them. Disabled women are so invisible that as per the 2011 Census, only 2.12% women were identified as disabled. On the other hand, around the same time, the WHO and World Bank estimates that 19.2% women are disabled in this country. Micro studies have also supported a higher estimate of the disabled women population. The invisibility of women living with disability shrouds their concerns. As in the case of Dalit women, one finds that a particular stigma attached to disabled women is that they are not seen as 'women enough'.

Disabled women are seen as either 'asexual' or 'hypersexual'. Most disabled women are deemed 'asexual' because it is easier to claim that disabled women have no sexual desires, personality, sex life etc. In this way, one's vulnerability to ignorance, abuse and violence increases. There are others who are considered 'hypersexual', particularly intellectually disabled women, due to the assumption that they are ill quipped for socially acceptable behaviour around sex and sexuality. Between these two extremes of asexuality and hypersexuality, CSE is seen as unnecessary. In addition, there are actual physical barriers to accessing, understanding, seeing and listening to CSE material. The material used often do not accommodate for the different needs and barriers faced by disabled women.

Nidhi shared that before commencing with the disability and sexuality workshops, a needs assessment was conducted with disability organisations. The organisations were asked to identify what is important within the sexuality spectrum. In the responses, parenting, abortion, adoption were given the lowest priority by organisations working with disabled persons. The dominant perception was that disabled people would not adopt or parent because they are either unmarried or unfit to be parents. There is also a widespread misconception that disability perpetuates disability i.e. a disabled person would give birth to a disabled child. This fuels the assumption that disabled women won't have children. Nidhi recounted a case of a blind girl at the Gender Resource Centre in Gujarat, supported by Shanta Memorial Rehabilitation Centre, Odisha. On her wedding day, the father of the blind girl gave her 'vitamin tablets for daily intake'. After a year, when she failed to conceive it was discovered that the father had given her contraceptive pills. This case goes to show the extent of opposition to conception by disabled women that they are administered contraception without their informed consent.

Continuing with the recounting of violations of disabled women's reproductive rights, Nidhi threw light on the rampant forced sterilisations or hysterectomy of disabled women and young girls especially those with intellectual disability. Instead of supporting their menstruation needs, institutions and families resort to sterilisation or hysterectomy to rid themselves of the responsibility altogether. ***This practice started in 1994 in mental institutions in Maharashtra after the government passed an order to carry out forceful hysterectomies for women admitted in these institutions. There were two main reasons for this order one being zero management of their menstruation and the other being prevention of pregnancy in case the woman is subjected to sexual violence in the institution.*** This was the state's solution to the epidemic of sexual violence against women patients in the institutions. The approach was to prevent the consequences of violence rather than addressing the violence itself. Often the victims are unable to articulate what they have been subjected to. If they've undergone a hysterectomy

then the assault does not result in a pregnancy. This aids in making the abuse invisible and the violence goes undetected. Similarly, doctors recommend hysterectomy or sterilisaion to parents of disabled women to prevent pregnancy.

In both rural and urban areas, due to an absence of accessible toilets girls with limited mobility face a number of issues. Often, there is no one to clean them, especially during menstruation. Nidhi related two cases to highlight the issue of lack of skills in the health infrastructure along with the insensitivity of health care providers vis-à-vis disability. A blind woman (with a blind partner) delivered a baby in a health facility. Once the providers established that the baby had no apparent disorders or disabilities, they openly discussed how the patient would be able to take care of the child considering she is blind. In another case, health care providers were unable to communicate with a hearing impaired woman who had just delivered her first baby that she needed to push again to deliver her second baby as she was pregnant with twins.

So, both health infrastructure and health professionals must be seen within the framework of reproductive rights.

In the end, Nidhi shared that there are so many lapses that any initial steps taken together would be big steps towards realising reproductive health rights. Collaborating with the existing network working for doctors' sensitisation would also lead to considerable changes. Advocacy for accessible and disabled friendly infrastructure and information needs to be undertaken. Also, reproductive health products must be redesigned to be disabled-friendly to ensure women's autonomy, privacy and agency. For example, blind women would not be able use pregnancy kits without assistance. Finally, it is important to stop thinking of disabled persons as a separate category and move towards a cross-cutting approach wherein there is integration of the issues of disabled persons within each and every group that we work with. She called for greater intersectionality within our constituencies and work.

SHUBHRANSHU CHOUDHARY – CGNET-SWARA, DELHI

Shubhranshu Choudhary is the founder of CGNet-Swara. In his presentation, he shared the ways in which the media can be used to take one's work forward.

He started with the explanation that 'media' essentially means *madhyam* or medium. He elicited responses from the participants to explain media further. He shared that between the audience and the speaker there are two mediums viz. the microphone and the air between them. He contended that the microphone is an elitist medium, which only a few people have access to or control over. Air, however, is a more democratic medium as it allows everyone to speak. He asserted that there are democratic and undemocratic media and the endeavour should be to move away from 'feudal' forms of media to a more democratic system of communication.

Communities are formed through communication. He alerted the participants of the danger of using feudal media of communication, as it doesn't result in the creation of democratic communities. He reiterated that old tools such as the printing press, television, radio etc. were more aristocratic, but new tools such as the social media are more democratic. Yet, this form of media may not be 'social' as not everyone in the country has access to the Internet.

People's voices must be amplified – sex workers, migrant workers, Dalit etc. It is imperative that those who suffer the most have a voice. The person who faces the problem is best able to discuss the problem. Although, there are numerous media and media tools it is important to identify

those which are democratic. One way of going about this is to think of a person in the most disadvantaged position and if your message can reach that person while his or her message can reach you then, it is a good communication system.

The mobile phone is a great mass communication tool as each and every one of us has a phone. He described an innovative mobile phone based communication system that he and friends are using in Chhattisgarh. The elements of this communication system include – the Interactive Voice Recording system, Bluetooth and a computer. With a phone in each hand, a computer needs to be placed in the centre. Bluetooth transfer, the most commonly used mobile application in villages, connects a phone to another phone without any extra charge. Radio programmes can be developed and shared within villages and across them. Stories from the ground can be locally prepared by a community and shared within the community. In this way, every community can have its own radio station.

HASINA KHAN – BEBAAK COLLECTIVE, MUMBAI

Hasina Khan is the Founder of Bebaak Collective comprising Muslim women's groups. She started her talk by drawing attention to the current state of affairs in the country and how difficult it is in this day and age for those who belong to religious minority groups. The population of Muslims in the country is 16-17% of the total population. Maharashtra, Bihar, West Bengal and Uttar Pradesh have significantly high Muslim populations.

Islam, like all other religions, exercises social control over women. This social control is accentuated when the religious group is under attack and the state withdraws its control or perpetuates the discrimination. At this point, the community becomes the only source of support for people.

In 2005 the Rajinder Sachar Committee was commissioned and its report dismantled many myths related to the Muslim community. The committee put forward evidence that the popular belief that Muslims do not practice family planning or are not concerned about reproductive health is baseless. At the same time, the Sachar Committee unequivocally stated that Muslim women understand their reproductive health rights and negotiate for family planning within their families. Even though, abortion and using contraception is considered un-Islamic women are speaking in favour of their reproductive right and seek services when required. Moreover, there is ghettoisation of the community alongside major discrimination against them. There are fewer PHCs in areas with significant Muslim population. Poor health infrastructure and shortfall of human resources are major concerns.

But why has there been no state accountability? This question has been raised over and over again. There is a lack of state accountability owing to a deep-rooted bias against the community. The myths perpetuated through statements released by the current government include the ever-increasing Muslim population in the country, as Muslims do not use contraception. Such baseless statements from the state machinery, results in further alienation of the community. The community is then averse to accessing the system. There are innumerable experiences of disrespectful treatment of Muslims in health facilities. At sonography centres, women are mocked for having 'too many children'. Hasina pointed out that there are no mechanisms in the country to address the grievances of community – whether it is regarding lack of access to services, lack of employment opportunities etc. Additionally, health has not been a political issue within movements, even in the women's movement.

In the case of communal violence, the state provides relief and rehabilitation after riots to some extent. However, the state fails to provide support for women's health concerns and the mental trauma experienced in the course of the violence. Although cases of sexual assault are reported in every episode of riots, the response of the state has been at best indifferent. During communal violence, the government must take immediate action to ensure relief and security for the affected communities.

The community is being targeted, is vulnerable and insecure and there is no support from the state. She concluded her talk with the assertion that the increasing influence of right wing forces sees a directly proportionate increase of control on women, their bodies and their lives. Women are compelled to constantly prove their chastity and mould themselves as per the dominant ideology. In the end, often health is examined within the religious framework, which must be replaced with a progressive feminist perspective.

Discussion & Questions:

- In Gadchiroli, Maharashtra marriages of disabled persons have been ogranised. Also, awareness generation programmes regarding their rights are organised.
- Most public places are not accessible for the disabled. For instance, there is a dearth of ramps in railway stations, banks, offices etc.
- A study in a Muslim slum in Nagpur revealed that the average family size is 3-4, the need for contraception is high, institutional deliveries are nearly 96%. A prevalent cultural norm was that the *azaan* must be heard to breastfeed the child. Some of these practices need to be addressed in the community. There is a need to build trust and to ensure the setting up more health facilities in these areas.
- In Uttar Pradesh, *hosla poshan* campaign was launched to address malnutrition however it is not clear as who is benefitting from this programme.
- What are the possible linkages between Muslim women's movements and health movements?
    - Hasina responded that Muslim women's movement like other movements has not been able to adopt a crosscutting approach to work across issues. However, this is changing. The work has been mostly concentrated around Muslim personal law and not much work outside this. There has not been much work around Muslim women's health.
    - Koushalya shared that within HIV-related movements there is little interaction with other groups. Even if there are discussions, no concrete action is taken. She shared that there is a need to work on larger issues and move out of the silos that one works in.
- What is the space within disability rights activism for the struggle of women with disability?
    - Nidhi responded that within disability movement the women with disabilities movement is slowly growing and gaining traction. This started in the mid-1990s and now there is a clear space within the movement for women with disabilities. The disability movement itself is very fragmented. Most organisations work on institutionalising efforts. At the moment there is not a very strong women with disabilities movement.

Concluding Remarks

Dr. Suchitra Dalvie concluded the session by reiterating that women's rights groups and health rights groups need to be better informed about intersectionalities. Also, they need to collaborate

with other rights-based groups. It is important to join larger, umbrella movements in the realisation of our common goals. In the next session, further strategising would be done in how we can take this forward.

SESSION VI: WAY FORWARD

FACILITATORS: RENU KHANNA AND SANA CONTRACTOR

Renu Khanna is the founder of SAHAJ, Baroda and Sana Contractor works with the Centre for Health and Social Justice and is a member of NAMHHR, Delhi.

Renu Khanna commenced the session with a summary of the proceedings of the day. Given the context at the macro level, the need for greater understanding of each other's issues and the range and diversity of issues – what are the next steps? She appreciated the quality of introspection and reflection that was evident in each of the presentations, while laying out the areas of confusion, failure and obstacles encountered along the way. She informed the participants of the Human Rights in Childbirth Conference which is to be held in February 2017 in Mumbai. She urged members to attend the conference and actively participate in order to share our point of view.

The key areas for action that emerged in the course of the discussions were as follows:

- There is a need for building solidarity across diverse groups. We must move beyond our movements and interest groups, in order to integrate as many other constituencies as possible, in our discussions and dialogues.
- There are new potential partners and allies such as organic farmers, anti-GMO activists, forest rights activists, land rights activists, trade unions etc. There are also campaigns on social media such as the Pink Chaddi Campaign, which were launched by interest groups outside the NGO community. There are several students' initiatives as well. We must reach out and work with these groups as well.
- Local level capacity building on specific issues must be undertaken, especially among affected communities, to strengthen their voices.
- Disaggregated data must be collected. For example, data related to deaths among HIV positive women, Dalit women's access to care, variations within Dalits etc.
- There is a dire need for rigorous and quality documentation of realities. Different forms of media such as photovoice, video documentaries etc. can be explored for this purpose. Proper planning for specific audiences must be undertaken so we clearly identify who we are disseminating to, what would be appropriate for that specific group and also, which innovative means would be used to reach out and influence social as well as policy discourse.
- Food security concerns must be examined in the light of health concerns. The heavy emphasis on the cultivation of cash crops, paddy and wheat must be unpacked to understand how this affects health or leads to non-communicable diseases like diabetes. In this context, is it possible to demand the provision of healthy foods in government university canteens etc.?
- Sensitisation of health professionals and influence medical syllabi/curriculum is crucial to bring about change.
- There is a demand to visibilise the SRHR needs of disabled women, HIV positive women, sex workers, Dalit women and other groups. Within this, there is a need to

dismantle the heteronormativity-conforming reproductive health framework directed largely towards eligible, married couples and high-risk populations.

- The concrete steps that can be taken immediately across movements:
    - Join the campaign for maternity entitlements under Indira Gandhi Matritiva Sahayata Yojana (IGMSY)
    - Transgender Bill – understand the critique and support groups in voicing their critique
    - Build an understanding of the HIV Bill – support the critique
    - Join the campaign on young women's access to information about HIV – primary prevention
    - Understand the critique of the Surrogacy Act and join voices with groups working on the issue
- It is important to recognise women beggars, migrants, women with tuberculosis, women working in the unorganised workforce, single women as important vulnerable categories.
- Generating awareness at the grassroots level on bodily integrity and rights is crucial.
- There is a need to reflect on how to mobilise and collectivise different groups. Differential strategies must be adopted for different groups.
- We must also re-examine our strategy to understand whether it is time to shift from trying to influence political discourse to influencing social discourse. We must use international forums to raise questions of state accountability. Also, building relationships with regional alliances along with harnessing on-campus energies and activism should be our endeavour. People are protesting against so many concerns on university campuses. In this political environment we need to come together with these groups.
- We must reach out to academic institutions for collaboration.
- CommonHealth does not have a collective position at present on many concerns. We will have to arrive at these positions collectively. It should be our aim to evolve these collective positions.
- We need a strategy to document more rigorously - deliberating on how to do studies and disseminating in strategic places.

Sana Contractor then shared details of the People's Convention on Maternal Health to be held in Delhi on 16-17 December. She apprised the participants of NAMHHR's effort to organise policy dialogues over the last few years. State representatives have consistently been present at these dialogues and theirs has been a mixed response. The space for negotiating at the policy level has been shrinking more so in the past two years. So, in this context how should we take this forward? Both CommonHealth and NAMHHR together decided that it is important to reach out to diverse constituencies outside of the maternal health groups. So the two questions we want answered are [a] are we talking about *all* women? and [b] are there certain concerns that we need to gain insights and understanding about? Also, another question is how do we get involved in each other's struggles?

This meeting and the People's Convention on Maternal Health were envisaged to invite people from diverse groups and understand their concerns. In addition we need to draw out our position on these matters. The convention will serve as a platform for us to listen to each other, gather whether we're on the same page and whether our understanding is adequately nuanced. The national convention will be at a larger scale to delve deep into how women's social location informs their lived experience. The main objective of the convention is to openly discuss

whether maternal health concerns can be included in other movements and how this can be done.

The convention would be organised over 1.5 days. On day 1 there would be panel discussions from different states and constituencies such as Dalits, Muslims, unorganised workers etc. Cross learning will be intensified.

Day 2 is for planning and agenda setting. Homogenous groups would work in small groups to identify their SRHR concerns and report to the rest of the participants. A draft call to action can be an output of this meeting to be shared during the convention for endorsements. We need to determine who is the call to action for - is it for the state, for communities, for movements, for organisations or for society? Also, the call to action may need to have certain non-negotiables. These aspects need to be thought through carefully.

Before concluding the day's session, Sundari shared details of the website www.healthinequity.com and Sana shared details of the reprohealth listserve. These are potential platforms where groups and organisations can share their studies – published or unpublished with a larger audience.

Sundari urged the participants to think out of the box for innovative ways of pressurising, influencing and reaching out to the government. Renu then thanked the participants to draw the day's meeting to a close.

ACCESS TO SAFE ABORTION – DECEMBER 3, 2016

Subha Sri welcomed all the participants back to the meeting on day two. She then initiated the proceedings with a look at the programme agenda for the day and then handing over the session to Dr. Suchitra Dalvie.

KEYNOTE ADDRESS: WHY ARE WOMEN STILL DYING OF UNSAFE ABORTIONS IN INDIA?

PRESENTER: DR. SUCHITRA DALVIE, STEERING COMMITTEE MEMBER - COMMONHEALTH & COORDINATOR - ASIA SAFE ABORTION PARTNERSHIP, MUMBAI

Dr. Suchitra Dalvie started her presentation with a note on the Indian Penal Code (IPC) sections 312-316 which criminalises abortion except in the case of a threat to the life of the pregnant woman. So, despite the Medical Termination of Pregnancy Act, abortion is not a matter of a right for women in this country considering the IPC views abortions as illegal.

The preamble of the MTP Act categorically states that notwithstanding the sections in the IPC, if abortion is carried out as per the legislation then it would not be considered illegal. Clearly, the MTP Act was laid down more for the protection of the practitioner than with the view to safeguard women's right to abortion. At the same time, it is important to remember that the Act was passed in the year 1971 and for its time, the legislation is fairly liberal allowing for the condition of failure of contraception, albeit in the case of married couples. Amar Jesani and Aditi Iyer, several years ago, drew attention to how this legislation can be interpreted either liberally or conservatively, depending entirely on the inclination and attitude of the health care provider.

Medical abortion pills are available in the country since 2002. The MTP Act was amended in 2003 to include the provision of medical abortion pills. Those registered under the Act are permitted to provide the pills to patients. The need to register the facility for provision of pills was removed in the Act as long as the provider is registered. With this, there was more choice available to women regarding whether they would prefer surgical or medical termination of pregnancy.

In spite of these changes, women are dying of unsafe deliveries across the country. This is a violation of women's right to safe abortion services. The old estimate of 6 lakh abortions in the country must be re-examined. Sales related data reveals that 100 lakh Mifepristone tablets were sold in India in 2014. Of this, 20-25% is possibly smuggled to Pakistan. In light of this data, there is a gross underestimation of the number of abortions in India.

With the implementation of the Pre-conception Prenatal Diagnostic Tests (PCPNDT) Act, authorities have taken to reviewing MTP registers although this is not permitted under the MTP act to maintain confidentiality of the patients. Owing to this, many doctors in Maharashtra do not provide abortion services to pregnant women who are in their second trimester. In addition, state-level Programme Implementation Plans (PIPs) do not budget for abortion services. So, public hospitals are not equipped to provide medical abortion pills.

At the global level, India and the African continent are comparable in the high rate of maternal mortality owing to unsafe abortions. Unlike causes of maternal deaths such as eclampsia, deaths due to unsafe abortions are easily preventable with appropriate care. Contraception access in India is comparatively lower than in other countries. Yet, the WHO estimates that nearly 27 billion unwanted pregnancies occur despite the use of contraception. So, although there is a heavy emphasis on post-abortion contraception there is no push for post-contraception abortion, which seems to be the need of the hour considering the WHO estimate. There are also cases where abortion is being used as a family planning method.

Suchitra went on to share specific cases of women who had undergone unsafe abortion and suffered from resultant morbidities. A study showed that medical doctors were responsible for unsafe abortion in 28% of the cases. One also finds that media reports tend to lack balance and sensationalise cases of unsafe abortions and teenage pregnancies.

In a patriarchal society that glorifies motherhood, the demand for abortion can lead to severe backlash. Within this, the push to 'Save the Girl Child' needs to be put in perspective to understand the motivation behind these campaigns.

There are only 22,000 gynaecologists in this country of 1.2 billion people. Of this small number of registered gynaecologists, many do not provide abortion services as in-vitro fertilisation and laproscopies are seen to be far more lucrative. Moreover, providers are insensitive to gender and rights issues making access even more difficult. ***A study among medical interns showed that 25% considered abortion as morally reprehensible, 20% were opposed to provision of services to unmarried women and 25% claimed that husband's consent is required for abortion.*** AYUSH doctors and nurses are not being included as potential providers of services. The number of registered facilities for abortion services is abysmally low in different states.

It is important to talk about sex-determination as it overshadows abortion rights***. Targeting abortion rights in the name of addressing son preference in the society is misguided.*** Suchitra shared examples of government (and non government) IEC materials to highlight that

the state's approach to sex determination in many ways restores and strengthens sexist notions of women's roles and social obligations within patriarchy.

Putting limitations on rights based language is the problem. One can argue that gender is a disability and the woman may decide to not have a girl child to not be burdened, in the same way that foetal anomalies are seen as an appropriate condition for abortion. Also, currently most people prefer smaller families. In this context, a study conducted in Maharashtra revealed that 85% of women want at least one son. Extreme familial pressure to have a son also lends a hand in this preference. So, Suchitra flagged whether it is at all possible to regulate individuals to such an extent.

Sex ratio is an indicator that is used very loosely in the current environment. The pertinent questions include - how is the sex ratio understood and analysed and is the endeavor to improve the sex ratio or to deal with the *cause* of the skewed sex ratio? The preoccupation with improving sex ratio reinstates the problematic targeted approach within public policy.

With regard to the PCPNDT Act, there are tests available in Australia that can detect the sex of the foetus using the pregnant woman's blood. She shared information of other such technologies, which show that the regulation or banning of technologies may not prove to be useful in the long run. The entire social system needs an overhaul to ensure gender justice.

In conclusion, she recommended that abortion rights should be discussed in diverse groups and fora. Medical abortion pills are not available in the public sector as of now. Maternal death reviews must take into account the possibility of maternal deaths due to unsafe abortions. Finally, sex determination should be punished without impinging on women's right to abortion.

Discussion & Questions

- Doctors often inform HIV positive women that they are not eligible for abortion services because they are infected.
    - HIV positive women and those accompanying them are forced to clean after an abortion is carried out.
- Particular brand of abortion kit is demanded by practitioners and they deny services if the brand is not purchased.
- It is important to remember in advocacy efforts and awareness generation programmes related to sex determination that within the definition of 'emotional violence' under the Protection of Women from Domestic Violence Act (PWDVA), pressurising women to give birth to sons, is included.
- In rural areas, among lower and middle-income households most women do not worry about quality of services, as their main concern is to get the service as quickly as possible. This could be owing to the stigma attached to availing abortion.
- With the use of medical abortion pills the fear is whether the termination is completed or not.

Session I: Safe Abortion Services – Current Challenges

Chairperson: Renu Khanna, SAHAJ

Presenters: Vinita Sahasranaman – YP Foundation, Anubha Rastogi – Lawyer, Aarthi Chandrashekhar – CEHAT

Vinita Sahasranaman – The YP Foundation, Delhi

The session started with Vinita's talk on the current challenges related to safe abortion services. She referred to her presentation on day one related to CSE and the challenges related to discussing topics such as sexuality, sexual relationships etc. The YP Foundation advocates a rights-based approach in matters of sexual and reproductive health, however, in the field we have encountered resistance to this. Also, the mainstream approach in these matters has been more controlling and limiting.

Many young people who have attended the Foundation's workshops have been in abusive relationships. ***There is a complete lack of understanding and awareness regarding one's rights in this constituency. There are numerous cases of coercive relationships and the resultant adverse mental health outcomes. These outcomes stem from the decisions young people make around their bodies and relationships. Work on this intersection of mental health and young people's issues is missing.***

Sessions on increasing knowledge and understanding on abortion and contraceptives within CSE is challenging. This is because it is assumed that young people are not sexually active. The information provided during these sessions is only to be put to use at a much later stage i.e. when they are married.

With regard to MTP, minors often need the services or related information. As per the legislation, this is difficult as the guardian is expected to be present or to give consent. Young persons in institutional homes with no family or guardians are further marginalised. In such institutions, introduction of CSE is quite difficult as they have a fairly paternalistic approach to their wards. Information regarding the legislation is missing even in metropolitan cities such as Delhi.

There is a dearth of information around the process of taking decisions related to abortion. The ways in which they mediate their reproductive health decisions needs to be examined. In an audit carried out in Lucknow, the YP Foundation found that there are two Adolescent Friendly Health Clinics (AFHCs) – one is for adolescent boys and another for girls. The counsellors in the clinics claimed that unmarried major girls need the permission of their guardians to avail abortion services. The bias of the service provider needs to be challenged and done away with through consistent engagement.

The need of the hour is to take conversations around contraception and medical abortion to campuses. For example, the Shudh Desi Romance campaign comprising largely young students responded to the Hindu Mahasabha's threat to marry off couples seen together on Valentine's Day by claiming that not two but four or fifty of them were together and must therefore be married to each other. Such campaigns are premised on progressive and important messages of women's control over their bodies and the need to question marriage, restrictions on women's/girls' mobility and violence against women.

ANUBHA RASTOGI – LAWYER, MUMBAI

Anubha Rastogi is a lawyer at the Bombay High Court. In her presentation she spoke of the legislations affecting access to safe abortion services. In the last decade or do, there is considerable discussion around PCPNDT and MTP Acts. The contents of both these Acts are entirely different and we need to ensure that these separate domains are not blurred in any way.

Within the PCPNDT Act, the main and the sole offender is the radiologist who has divulged the sex of the foetus. If a woman gets an abortion as per the MPT Act, even if it is after knowing the sex of the foetus, she cannot be considered an offender. Yet the implementation of the

PCPNDT Act has been such that there has been considerable backlash owing to the numerous forms and registers that have to be maintained. The attention then has been deftly moved to the woman and her choices. ***These problematic positions are held even within the court by judges. Not much sensitisation has been done with judges. Initially, there were funded judicial colloquiums with limited discussions on PCPNDT but literally none on the MTP Act.*** In Patna High Court, HRLN had filed a petition regarding poor access to maternal health services and this included a prayer on safe and legal abortion. The judge in the case demanded responses from the Advocate General claiming that 'giving birth is god's gift to a woman'.

In this context, although there are legislations in place, it is the interpretation of the legislation that is problematic. In the Niketa Mehta case, the Union of India's consistent response was that in India as the sex ratio is skewed against girls, one cannot permit increasing abortion rates.

With the introduction of mandatory reporting within the Criminal Law Amendment (CLA) Act and Protection of Children from Sexual Offences Act (POCSO) a range of new issues have emerged in the area of SRHR. The demand for the presence or consent of the guardian has increased. Under POCSO, minors – often assaulted by their family members - need the consent of their guardians to file a case. There are also instances where if a First Information Report (FIR) has been lodged or a legal case is underway, then there is insistence on getting the permission of the Trial court to avail MTP services as the pregnancy itself is considered evidence.

The Child Welfare Committee (CWC) under the Juvenile Justice (JJ) Act established for children in need of protection, is authorised to decide whether a child can avail of an abortion or not. As per law, if an emergency procedure needs to be done then the service provider cannot deny services e.g. provision of emergency contraception in the case of rape. Often in cases where emergency contraception is sought, service providers claim that this is not an urgent matter as the patient has time to decide whether she'd like to abort or not.

Anubha concluded her session stating that the POSCO is above all legislations and if there is any sexual act where one of the persons is below 18 then it is an offence under the Act.

AARTHI CHANDRASHEKHAR – CENTRE FOR ENQUIRY INTO HEALTH AND ALLIED THEMES, MUMBAI

Aarthi Chandrashekhar is working with CEHAT as a Research Officer. At the outset, Aarthi stated that the presentation is based on the evidence collected in the course of CEHAT's intervention with survivors of sexual and domestic violence, screening of pregnant women for violence in antenatal departments in public hospitals and a project on integrating gender in medical education in Maharashtra.

According to the law, authorised hospitals or registered facilities can provide abortion services. However, in practice there are delays at both public and private hospitals. This in turn pushes some to avail unsafe abortion services. The law also asks for the consent only of the major pregnant woman yet, health care providers insist on consent from a blood relative for an unmarried woman. Additionally, all abortion cases of unmarried women are recorded as medico-legal cases even if parents are willing to give consent in the case of adolescents who have had consensual sex, the providers insist on filing a medico-legal case. There are also reported cases of insistence on the signature of the husband in the case of married women.

One of the conditions that allows for MTP as per law is the failure of contraception. Women who face domestic violence may not be permitted to use contraception. In these cases the condition for provision should be grave injury to her mental health. Providers' attitudes make

women wary and they often leave without availing the services. This includes – [a] discouraging primi gravida women by claiming risk of secondary infertility, [b] refusing services to women who have girl children by alleging son preference even when failure of contraception is reported, [c] insistence on sterilisation or insertion of Copper T as a condition for MTP, [d] insistence on husband's signature on the consent form or when confronted, [e] demand for written declaration that the procedure is without the husband's knowledge and finally [f] divorced women are asked for the court order of divorce.

Individual barriers in accessing abortion can range from fear of disclosure owing to threats by the abuser in the case of sexual violence to lack of awareness that pregnancy can be a consequence of sexual violence. In case there is delay in admission of the survivor into the hospital there are chances of her opting out of accessing treatment. At the procedural level, in case the survivor is a minor, she is forced to lodge a police complaint for investigation. ***As per the Guidelines on Response of the Health System for Sexual Assault of the Ministry of Health and Family Welfare (MoHFW), a major or minor survivor is entitled to 'informed refusal' i.e. she can refuse to file an FIR after she has been given all the information regarding the legal procedures etc. This is, however, not respected at the facility level.*** Mandatory reporting under POCSO actually jeopardises access to healthcare in such cases. There are delays owing to multiple referrals, private practitioners charge heavily even in sexual violence cases and MTP pills are provided without proper guidance resulting in incomplete abortions.

Aarthi also shared certain judicial interpretations of section 3 & 5 of the MTP Act where MTP was allowed or disallowed by the court in cases of pregnancy beyond 20 weeks.

- Bhavikaben vs. State of Gujarat (2016) - The High Court of Gujarat permitted the abortion of an 18-year old rape survivor at 24 weeks of pregnancy who had attempted suicide by consuming acid. The Court's interpretation of Section 3 based on the opinion of an expert panel of doctors was that her mental trauma would increase if pregnancy continues. The court ruled – 'This continuance of pregnancy since involves grave injury to her mental health as her pregnancy being the result of rape, the anguish caused also is to be constituted as a grave injury to the mental health of the victim, and therefore also, termination of pregnancy is permitted.'

- Ashaben vs. State of Gujarat (2015) – A 23 year old survivor who was gang raped approached the court for MTP at 24 weeks. The judgement made several references to the right of the foetus. For e.g. 'The State is to effectively fulfil its duty to protect the developing life' and also that the law does not permit MTP beyond 20 weeks. The court ruled – '…applicant will have to bravely go ahead with the pregnancy and when time comes, she should deliver the child… howsoever harsh one may find the law, yet it remains the law and one has to respect it.' The District Collector was directed to ensure proper delivery and future of the child after birth.

- Madhuben vs. State of Gujarat (2016) – A 14-year old survivor at 22 weeks was granted permission to abort through interpretation of Section 3 and 5 of the MTP act. The court ruled in favour as the request was made by the petitioner herself with the consent of the parents, bearing in mind, her very young age and incident of rape with pregnancy, grave injury to her mental health is to be presumed

- The case of a 23 year old at 23 weeks with Anencephaly and Omphalocele (Miss X - 2016) - A medical board of 7 doctors was constituted under the direction of the Supreme Court. The report of the Medical Board stated that the foetus was incompatible with extra-uterine life and there is risk to the health of the woman in continuing pregnancy. The court ruled – ***'In view of the findings recorded in para 6 (referring to radiological diagnosis of congenital defects) of the report, coupled with the recommendation and advice tendered by the Medical Board, we are satisfied that it is permissible to allow the petitioner to terminate her pregnancy in terms of Section 5 of the Medical Termination of Pregnancy Act 1971.*** In view of the above, we grant liberty to the petitioner, if she is so advised, to terminate her pregnancy.'

Aarthi concluded her presentation with a reiteration of the need for interpreting the MTP Act to include the right to live with dignity and health, need to offer services beyond 20 weeks especially in the case of survivors of sexual violence, implications of mandatory reporting and need to bring 'informed refusal' in the legal framework.

Discussions & Questions

- The setting up of a panel of doctors each time there is a case requesting for MTP beyond the stipulated 20 weeks is difficult, time consuming and unreasonable. It is proposed that a compilation of all such cases be done in order to advocate for allowing MTP without a panel of doctors.
- The choice of contraception for adolescent married couples is made by the service providers. The options are not openly provided to them. Also, adolescent boys are reluctant to go to the local ASHA or ANM for contraceptives as they are either relatives or neighbours from the same or nearby villages.
    - Vinita responded that sexual health of men is already a big problem. There is no privacy or confidentiality related to their SRH concerns. But at the same time, there is an anxiety that men's concerns might hijack the spaces being created for women and their concerns. Work on masculinities is dividing up the resources available for women's rights work.
- In the field one finds that women do not have any guilty feeling regarding abortion. There is a dearth of literature in our country regarding the cultural understanding of the viability of foetus and the personhood of foetus etc.
    - Aarthi responded that there is a need to address the social conditioning, which assigns personhood to foetus. This can be done through counseling. Every survivor of domestic violence must be offered abortion services, as there can easily be unwanted pregnancies in such cases.
- POCSO, CLA, MTP legislations have created a lot of dilemma. There is a lack of clarity. There is a matter of law and then there is ethics. Within this, we need to remember what the policy guidelines say about 'informed refusal'. Should we produce a position paper on behalf of CommonHealth or others regarding the MTP and POCSO Acts?
    - Renu responded that having a position paper is imperative at this juncture
- In the case of a 16 year old who was sexually assaulted and required MTP - the health care providers insisted with the parents who did not want to file a legal case that if the police are not informed then MTP will not be provided.
    - Doctors should not insist on filing of medico legal case to provide MTP services.
    - Also, within criminal law the state pursues a matter against a person or an entity. So, no matter who the original complainant and/or informant is, once a case is filed then it is the state's responsibility to take it forward.
- One of the main concerns in access is the economics of availing services. Young people and college going students are unable to access expensive abortion services. Example of a young professional who had to pay Rs. 80,000 for an abortion was shared.

- Most young women get information through informal channels. Often a friend informs them of the name of a medical abortion pill which they could take. There is also confusion about the ECP and medical abortion pills.
    - Vinita responded that payment is the biggest problem not only with regard to abortion but also other SRHR services.

SESSION II: ACCESS TO SAFE ABORTION – ISSUES FROM STATES

CHAIRPERSON & DISCUSSANT: T K SUNDARI RAVINDRAN

PRESENTERS: ANAND PAWAR – SAMYAK, PAWAN SHEOKHAND – VOLUNTARY HEALTH ASSOCIATION OF PUNJAB & ISRD, RAJDEV CHATURVEDI - GRAMIN PUNARNIRMAN SANSTHAN, SANGEETA MECWAN - SAHAJ

ANAND PAWAR - SAMYAK, PUNE

Anand Pawar is the Executive Director of SAMYAK based in Pune, Maharashtra. Anand started his presentation by tracing back the initiation of the discussion around abortion nearly a decade ago. Samyak has carried out several studies on the issue of safe abortion rights. One was a study with private medical practitioners, another among women who were denied the services and a third study with PCPNDT authorities in Maharashtra. Based on these studies, since 2014 advocacy efforts are underway in 10 districts in Maharashtra. A regional advocacy group has been set up comprising organisations that work on SRHR, women's rights or social justice issues. There are also government bodies associated with this work. The aim is to bring together actors such as private medical practitioners, NGOs and the government. On the ground one finds that each of these stakeholders is resistant to dialogue and cooperation.

The anti-abortion language and position is deep-set within society and all the stakeholders are responsible for this. It is now time to change this reality. Advocacy efforts are underway with nearly 400 private practitioners. Nearly 70 public sector providers, 10 Civil Surgeons and 80 organisations in Maharashtra are associated with the process in some way or the other. Media groups have taken up this theme seriously. There is also an abortion related telephone helpline that has been launched. With these initiatives there is now better understanding of how to take abortion related work forward.

Nearly 100 *gram panchayats* have passed a resolution that no woman would be deprived of safe abortion services in their area. These resolutions have in turn been taken to the Regional Commissioners and District Commissioners.

There is a lack of trained human resources to provide safe abortion services in the state. State level information on budget or spending on training for MTP services is not available. ***A complete list or database of registered MTP centres is also not available for the state. Municipal authorities claim that there is no such list so that unregistered centres can continue their operations undetected. Many private providers have given up their MTP licenses so it is difficult to ascertain the number of providers in an area.***

In some districts in Maharashtra, there is huge clampdown on the provision of MTP. In case failure of contraceptive has been cited as the reason for abortion, then the torn condom must be produced as proof. These kinds of extra legal procedure have to be documented. Demands such as a permission letter from the head of the private medical doctors' association for the provision of abortion have also been reported in the field.

Even within civil society organisations, there are questions of whether MTP is legal or not. There's also confusion related to the parameters of abortion and sex-determination legislations. Similarly, adequate attention is not given to these issues in the media. Anand concluded his presentation citing data from their study that of 1500 young people, 80% believe abortion is illegal in the country.

PAWAN SHEOKHAND – VOLUNTARY HEALTH ASSOCIATION OF PUNJAB & ISRD, CHANDIGARH

Pawan Sheokhand works with Voluntary Health Association of Punjab and ISRD based in Chandigarh. Pawan shared at the outset that there are few organisations in Haryana and Punjab that work on women's health concerns. Most organisations are anti-abortion. The task force on *Beti Bachao, Beti Padhao* (he represents VHAP on this task force) has a clear mandate to prevent all abortions. Since the new government has come to power, there are nearly no safe abortions in the state. The number of unsafe abortions has increased manifold. In Haryana, in financial years 2014-15 and 2015-16 there was no budgeting for safe abortion services. In Punjab the budget for the RCH programme in the year 2014-15 was Rs. 2.5 crores. Of this Rs. 23 lakhs was earmarked for safe abortion services under the MTP Act. The actual expenditure for abortion services in the state is a mere Rs. 70,000.

In both Punjab and Haryana, there are 12-1400 registered ultrasound centres. In Haryana, numerous centres have applied for deregistration. There have been nearly 16,000 raids at USG centres in a year. Punjab health authorities are more open to discussions regarding abortion rights than the authorities in Haryana.

In Haryana government officials and health authorities openly speak of needing more women for the purpose of marriage. In this context, it is understood that there is no need for abortion services. The position of the state machinery is that abortion services should be curtailed in order to improve sex ratio. Medical abortion pills are being sold at Rs. 2000.

Currently, the organisation is carrying out advocacy efforts with 20-25 NGOs as part of the CommonHealth and CREA project.

RAJDEV CHATURVEDI - GRAMIN PUNARNIRMAN SANSTHAN, AZAMGARH

Rajdev Chaturvedi heads the Gramin Punarnirman Sansthan based in Azamgarh district in Uttar Pradesh. Rajdev Chaturvedi pointed out that all of the indicators in UP are high considering the massive population in the state. The Maternal Mortality Ratio is higher than the country average. There are as many as 15-18,000 maternal deaths in the state every year. Of these 1800-2000 maternal deaths are due to unsafe abortions. There are also long term morbidities owing to unsafe abortion. Azamgarh district with a population of 50 lakhs is the second most populous district in the state. Abortion services in the district are available only in the district hospital. There are a total of 7 registered private clinics, of which 6 are based in the district headquarters.

Unqualified local practitioners provide abortion services in the district. In one case of maternal death in the area, the family had to mortgage the woman's and her brother's land to pay for the services. ***For the SRH of women, their male partners make no contribution whatsoever. Even if there is a case of contraception failure, abortion services are difficult to avail.***

There is regular reporting of MTP services in the state as every hospital is expected to do this by the state. Medical abortion pills are sold over the counter in chemist shops. The cost of the pills varies depending on the level of desperation of the woman. For example, the charges for abortion pills increases if the woman is divorced. Even in civil society organisations, abortion is

not seen as a priority. Advocacy efforts around abortion rights have commenced with different CSOs in the state.

SANGEETA MECWAN – SAHAJ, BARODA

Sangeeta Mecwan works with SAHAJ Baroda on SRH issues. In her presentation Sangeeta pointed out that ***abortion services are often not considered a part of Maternal Health concerns by CSOs in Gujarat. It is also commonly understood to be illegal in the country.*** Two workshops were organised with NGOs to sensitise them to abortion rights as a gender issue. At the workshops, discussions were woven around abortion as a woman's right, MTP Act, barriers in access, PCPNDT Act and Comprehensive Abortion Care (CAC) guidelines.

There was a shocking case of a young single woman who approached an ANM in her area for MTP. The ANM was disapproving but agreed to provide her the service. The woman was later gangraped by several men at the behest of the ANM who claimed that the rape was a way of terminating the pregnancy.

District level data was collected by different NGOs on the functioning of district level committees and the availability of drugs in the district. It was seen that most district nodal officers were not aware of the CAC guidelines. Also, there are no civil society representatives in the district level committees formed under the MTP Act. Meetings were not held regularly and the minutes of the meetings were not available in the public domain.

Sangeeta also shared that currently a list of private registered facilities does not exist. Manual vacuum aspiration equipment and medical abortion pills are available only in two facilities in the area.

T K SUNDARI RAVINDRAN

After listening to the deliberations over two days, the discussant, Sundari Ravindran proposed the following:

- There were so many new ideas that were proposed for action by CH members. Roles and responsibilities for different themes can be divided strategically among the CommonHealth members.
- Different constituencies and their SRHR needs should be mapped.
- Public awareness on the legality of abortion must be ensured.
- Need for out-of-the-box ideas to pressurise authorities and bring about change – e.g. the 'Kodaikanal won't' rap song against mercury pollution in Kodaikanal from a thermometer factory owned by Unilever.
- Engagement with young people on campuses and across classes.
- Changing medical curriculum and training to do away with misconceptions. Capacity building workshops for medical personnel in the public sector.
- Need to work with Federation of Obstetric and Gynaecological Societies of India (FOGSI)
- Legal advocacy to remove IPC that criminalises abortion
- Working with MTP and PCPNDT committees
- Working with the media
- Synthesis of different studies that so many members have been talking about over the last two days.

- Create spaces in international and regional levels

Discussion & Questions

- In Bihar there is very limited information regarding contraception. Also, pregnancy tests are not easily available.
- Availability of medicines to ensure the birth of a son is one of the many myths that need to be busted.
- In Jharkhand, medical abortion pills are available in medical stores in rural and tribal areas but they are expensive. The most common method of abortion is the use of herbs in rural areas. Untrained ANMs are carrying out MTPs in PHCs and CHCs for Rs. 2000. The pill is inserted followed by evacuation in the morning.
- During the JSA-NHRC public hearing held in Maharashtra this year, the NHRC sided with the doctor in the case of a foetal death. No grievance redressal mechanisms are available. Drugs are often asked to be purchased from outside.
- To spread awareness regarding the MTP Act, celebrities can be roped in for short public interest messages.
- In district health societies, abortion issues are not prioritised.
- ASHAs' knowledge on contraception and abortion services is fairly low.
- In tribal areas in Chhattisgarh, abortion is considered taboo. The awareness regarding medical abortion pills and vasectomy is low. Traditional medicines are used for contraception and abortion. After the Bilaspur sterilisation deaths, women are not willing to go for sterilisation.
- Engagement with positive women should be maintained around SRH issues.
- In case we file a petition against the IPC, would this jeopardise the MTP Act itself?

Session III: Regional issues in access to safe abortion, spaces and strategies for advocacy

Presenter: Sai Jyothir Mai Racherla – ARROW, Malaysia

Sai Jyothir Mai Rasherla works with the Asian Pacific Resource & Research Centre for Women (ARROW) as Programme Manager for Monitoring and Research for Evidence-based Advocacy. Sai shared that ARROW works on Sexual and Reproductive Health Rights at the regional level in the Asia Pacific region. The goal of the organisation is to ensure that all SRH policies in the region are progressive. She referred to the statements that Kiran Deshmukh made the previous day regarding her right over her body and her right as a sex worker to have children. The International Conference on Population and Development (ICPD) held in 1994 in Cairo placed human rights at the centre of population and development policies. The conference categorically stated 'that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so'. The Indian government was a part of this conference and ratified the Programme of Action.

At the regional and international level, the women's movement and SRHR advocates have identified key advocacy avenues to bring about the adoption of progressive SRHR policies at the national level. At the regional level, the advocacy fora include the Asia Pacific Population Conference and the Asia-Pacific Forum on Sustainable Development and at the international level include the Commission on Population and Development, Human Rights Council, Treaty monitoring bodies and the Universal Periodic Review. With regard to the 2030 Agenda for

Sustainable Development, the forums are the High-level Political Forum (HLPF) and the Global Strategy for Women's, Children's and Adolescent's Health (GSWCAH). These forums are situated in New York, Geneva and in the Asia-Pacific region.

The Commission on Population and Development (CPD) based in New York monitors the implementation of the ICPD Programme of Action. The CPD is held every year around March and is attended by memeber states. One annual resolution is passed but sometimes if member states do not come to a consensus then no resolution is passed. In 2012, a resolution was passed in favour of adolescents' SRHR. This resolution can be used for advocacy purpose with the national governments.

The 17 SDGs have a total of 169 targets and some of them address SRHR concerns. The SDGs form an important avenue for advocacy as the national governments are committed to working on achieving these SDGs. It is important that at the regional and national level progressive SRHR indicators are developed for implementation of the SDGs. All the heads of states and UN member states have committed to 'ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes' by 2030 as per target 3.7 of goal 3 of the SDGs. Also under goal 5, target 5.6 is to 'ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences'.

The HLPF is the global follow up and review mechanism for the SDGs. The HLPF processes are not binding on the member states but they are expected to report progress annually. The HLPF also initiates and guides the voluntary national reviews. The voluntary national review would be a great avenue to assess the state of SRHR in the country. The GSWCAH, also known as Every Women Every Child (EWEC), looks at enhancing financing, strengthening policy and improving services for the most vulnerable women and children. EWEC is strongly committed to SRHR concerns. The Government of India has a commitment letter in support of the global strategy.

Additionally, there are processes of the Human Rights Council in Geneva that should be tapped into to promote the SRHR agenda. The UPR process is undertaken every 4.5 years in all member states. At the moment, the third cycle of the UPR is underway. Each member state presents the status of human rights in the country before a panel of reviewers comprising 3 other member states. The reviewers give recommendations to the state that is under review. The third cycle of the UPR is commencing in February 2017. India will submit the national report in February, 2017. The review of the 27th Session will take place in April-May 2017. The reviews submitted by civil society are seen as stakeholder reporting. The National Human Rights Commission of India is a coordinating body for this process. Lobbying with the reviewer states can be potentially useful in pushing the SRHR agenda.

Treaty bodies are mandated to monitor the member states on their commitment towards international human rights treaties and covenants. This is done through regular reviews at the national and international level. The Asia Pacific Population Conference is held every 5 years and the last conference held in Bangkok in 2013 spoke of commitment to 'access to full range of comprehensive package of sexual and reproductive health information and other services that includes adequate counselling, information and education, access to a full range of acceptable, affordable, safe, effective and high-quality modern contraceptives of choice, comprehensive

maternity care, including pre- and postnatal care, access to safe abortion under the criteria permitted by law, post-abortion care, safe delivery services, prevention and treatment of infertility, prevention and treatment of sexually transmitted infections, HIV and reproductive cancers and other communicable and non-communicable diseases, employing a rights-based approach, paying particular attention to women, newborns, adolescents, youth, and hard-to-reach and underserved group'.

In her conclusion, Sai highlighted ***the need to engage in every possible space, whether at the regional or international level, with the support of strong evidence. Governments must be held accountable for their international commitments in these different forums.***

Discussion & Questions

- A civil society report has been submitted on women's health and SRHR concerns as part of the UPR process in India. The report has been finalised and CH members had contributed in the process.
- The NHRC organised a stakeholder consultation earlier this year but the level of participation across civil society groups is questionable.
- Is it possible to have access to documents and presentations, which are a part of the UPR process before they are submitted?
    - It is possible to identify the reviewing member states and ensure that pertinent questions related to implementation are asked so that the country can take action or be held accountable. Lobbying with those countries at the embassy level can be helpful.
- Consistent engagement at the grassroots level often does not allow for working committedly at the regional and international levels. However, it is important to take our voices to these forums.
- International law processes can appear to be ineffective as they are guidelines rather than mandates for member states or national governments. However, engagement with the UPR process has shown that these mechanisms can be effective in holding member states accountable. In UPR, the recommendations made by reviewers have to be taken up formally – it could be in the form of a response or an action. Although, India has so far not acted on the recommendations received. The entire process can be highly politicised. It is important to reach out to the reviewer country embassies to elicit a response or to push for implementation.

Session IV: Identification of Issues and Emerging Strategies

In the final session, from the concluding discussions the following issues and strategies emerged:

Strategic Actions	
Strategic linkage with movements and groups	Maintaining communication between groups – eg. invitations for trainings/participate in trainings across constituencies for capacity building and cross-learning, sharing on listservs – reprohealth, CH listservs and CH whatsapp group
	Representation at events/conventions of other movements
	Including more groups/points of view and realities (eg. Sangram's non-sex-worker constituency)
	Not duplicating other efforts but supporting, Supporting issues of other movements and actively addressing them

	Meaningful preparation and engagement of constituencies
	Engaging with pop culture. Engaging young people to mainstream rights issues
	Dialogue with those doing legal interventions (e.g. HRLN) to facilitate sharing of court orders and contribute to evidence especially at state level
Advocacy efforts	Advocacy efforts targeting parliamentarians and Parliamentary Standing Committees
	Media advocacy using social media (twitter handle using different events/days/hashtags), Whatsapp, other democratic media. To explore other creative ways to reach out to women and girl including training/sensitisation of media persons regarding lack of clarity on issues such as MTP and PCPNDT acts
	Timely advocacy – state level planning processes
	Advocacy for district level monitoring body on SRHR
	Advocacy on clarity of referral for abortion services/maternal health services
	Discussion on how we intend to engage with or resist the current government
	Working with PCPNDT advocacy groups to ensure that PCPNDT bodies don't interfere with MTP access
Sensitisation	Sensitisation of service providers/government officials; bringing about changes in the medical curriculum
	Community level clarity on MTP and PCPNDT Acts
Grievance redressal	NHRC public hearing follow up on SRHR cases. Taking this to women's commission/SC/ST commission/Minority commission
Planning future activities	Sub-groups to be formed to work on different issues and report back to general body

Specific outputs to be developed:

- POCSO, MTP Act, CLA – addressing the contradictions and preparing a position paper through a consultative process
- State-wise CSO report card on SRHR issues to guide strategic plan – eg. Girls Count
- Evidence generation on Maternal health and co-morbidities (e.g. HIV, TB)
- Rigorous documentation of stories of maternal health rights violations. Consolidating documentation on two definite areas
    - Maternal health: Documentation of grassroots stories of denials and violations
    - Abortion: MTP court cases, PIP analysis, documenting stories of denials
- The ban on emergency contraceptive pills in Tamil Nadu should be examined and an appropriate response should be prepared as part of advocacy
- There is a need to carry out studies on topical issues such as impact of demonetisation on health

The proceedings of the day were drawn to a close with a special thanks to all the participants and a promise to meet at the People's Convention with a draft call for action based on the discussions held in this two day consultation.

PROGRAMME AGENDA

December 2nd-3rd, 2016 **Venue: FIAMC Bio-medical Ethics Centre, St. Pius College, Goregaon East, Mumbai** **Strategic Planning Workshop to build Partnerships for Reproductive Health Rights** **(Organized by CommonHealth)**		
Day 1 (2nd Dec 2016): Maternal Health Rights		
Time	**Session**	**Speakers**
9:00- 9:30 am	Welcome & Objectives of the Workshop Introductions	Subha Sri
	Introduction to CommonHealth	Nilangi Sardeshpande
9:30 -10:00 am	Need for building Alliances in the current context	Sundari Ravindran
10:00-11:30 am	Presentations from different coalitions/networks/movements • NAMHHR • JSA • Right to Food • Land/Forest Rights	• Sandhya Gautam - NAMHHR • Kajal Jain – JSA • Ganga Bhai – RTF • Seema Kulkarni – MAKAAM
11.30-11.45 am	Tea Break	
11:45–1:15 pm	Presentations continued • Issues of dalits • Issues of sexuality minorities • Issues of sex workers • Issues of youth	• Manjula Pradeep – Navsarjan Trust • Smriti Nevatia – LABIA • Mandakini - Saheli Sangh, Kiran Deshmukh – VAMP & SANGRAM • Vinita Sahasranaman – YPF
1:15-1:45 pm	Lunch	
1:45-3:30 pm	Presentations continued	

	• Legal advocacy • Issues of migrant workers • Issues of PLHIV • Issues of disabled women • Media • Issues of Muslim women	• Vrushali Naik - Mobile Creches • P Kausalya - Positive Women's Network • Nidhi Goyal – Activist: Disability rights and Gender Justice • Shubhranshu Choudhary – CGNET-Swara • Hasina Khan – Bebaak Collective/Awaz-e-Niswan
3:30-3:45 pm	Tea break	
3:45–5:00 pm	Way Forward – including PEOPLE'S CONVENTION ON MATERNAL HEALTH (Identifying common ground and spaces and opportunities for alliance building)	Renu Khanna & Sana Contractor

Day 2 (3rd Dec 2016): Access to Safe Abortion		
Time	**Topic**	**Speakers**
9.00-10.00 am	Why are women still dying of unsafe abortions in India ?	Keynote address by Suchitra Dalvie followed by discussion
10.00-10.15 am	Tea-Break	
10.15-12.00 pm	Safe Abortion Services: Current Challenges (A series of talks followed by discussion)	
	Challenges in advocacy on access to safe abortion	Sundari Ravindran
	Lack of sex education/ contraceptives/ awareness of MTP Act among young women	Vinita Sahasranaman – YP Foundation
	Issues with MTP Act, its implementation and what can be done with it?	Aarthi Chandrashekhar – CEHAT
	Laws / Acts and their implications for access to abortion services	Anubha Rastogi
	Draft petition by HRLN	Sarita Barpanda
12.00-1.00 pm	Access to safe abortion: issues from the states - panel discussion Representatives from different regions including CH members involved in the CREA SAAF project	• Maharashtra - SAMYAK • Punjab/Haryana - Pawan Sheokhand • J&K: Rahi Riyaz Ahmed • UP: Rajdev Chaturvedi • Gujarat- Sangeeta Macwan
1.00-2.00 pm	Lunch Break	

2.00-2.30 pm	Regional issues in access to safe abortion, spaces and strategies for advocacy	Sai Jyothir Mai Racherla – ARROW
2.30-3.00 pm	Identification of issues and strategies emerging	Alka Barua