Vision and mission and important discussions from previous GBM/SC meetings

Vision and Mission

CommonHealth's vision is to create "*A society that ensures maternal-neonatal health care and safe abortion for all women, especially from the marginalized communities of India".* Its mission is to "*raise visibility of the unacceptably high mortality and morbidity among mothers and newborns and the lack of access to safe abortion, especially among the disadvantaged".*

Strategy

Common Health (CH) is positioned as a multi- state coalition of organizations and individuals that can bring voices from diverse constituencies to influence discourse at the national level. These constituencies are diverse not only geographically but also in terms of different areas of expertise and focus such as health care providers, public health researchers, non-governmental advocacy, research and service delivery organizations, human rights lawyers, grassroots activists, public sector programme managers etc. The Coalition is steered by a Steering Committee of individuals with considerable expertise in one or more of the three thematic areas: maternal health, safe abortion and neonatal health.

In order to further its mission, CommonHealth has followed a two-pronged strategy. At the national level, CommonHealth has, mainly through its Steering Committee members, sought to play an 'agenda-shaping' or 'discourse-influencing' role through presence and interventions/presentations in key agenda-setting meetings and conferences; organizing dialogues and meetings; and most importantly, through research and fact-finding reports and concept papers on key issues. Capacity-building workshops for state-level advocates have also contributed to the agenda-shaping role. CommonHealth has also engaged with the media through training and advocacy workshops.

The second strategy has been to engage at the state-level to mobilize and enhance capacity of a new generation of advocates for maternal-neonatal health and safe abortion. Advocates

(and potential advocates) from different sectors at the state and local levels have, through their membership and association with CommonHealth, moved out of their isolated areas of functioning and created synergies that strengthen advocacy within and across states. General members' meetings, regional workshops in different regions of India, capacity-building workshops for members and potential members, and information dissemination through our website, listserv and publications have been the means through which we have done this.

First GBM meeting – Jan 2006, Udaipur

- Vision, mission, strategies, structure and funding of the coalition - A small group of persons had worked on the original vision and mission of the coalition -- in the first session, there was a presentation of this. This was followed by discussion and feedback in the plenary. Participants expressed their views and suggested modifications, and these were incorporated. This was later finalized by the steering committee.
- The structure and membership of the Coalition were discussed. It was decided that the Coalition would have both individual and institutional members.

Second GBM meeting – September 2007, Mumbai

Sundari asked about how we balance the need to respond rapidly with the time required for democratic consultations? How will we balance reactive responses with proactive activities. The Coalition will gain visibility through its Steering Committee, the membership, participation and hosting meetings, rapid response. How will we manage the expectations others may have of us? Leila added that perceptions about the Coalition by outsiders might be different from the perception of its members. For instance, outsiders have noted that it is a group of researchers, not those involved in advocacy.

Sharad was concerned about the perception that the Coalition is not talking enough. Leila countered that visibility was not the reason why she joined the Coalition. The opportunity to link with others was more important. Sunil asked whether we aimed to form a coalition that was moving collectively towards a goal or wanted to build a network for peer support? Does the mission become the vision? Or are we held together by pure optimism? Subhasree felt that the two functions need not be mutually exclusive. Shruti added that one's work will speak for itself, which will take its own time to develop.

Leila agreed that a common activity will galvanise interest and active membership, as people will feel good at being part of something. Sandhya agreed that we need common issues to take things forward. Lindsay suggested that when we make our position clear on certain issues that will attract or detract people.

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

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

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

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

Renu asked that if this is our vision, then how do we expand membership? Asha suggested that RCH officers may be an important group. Sharad agreed that they may in fact be better advocates than us, if the issues appeals to them. At the primary health care level in Rajasthan they found that women were being discharged soon after delivery and enduring uptp 20-30 pelvic examinations. This is not good practice. Subha Sri mentioned that positive women's groups are concerned about health care, our issues might appeal to them. Sundari suggested that the Coalition will grow gradually from all these different groups.
Sharad stressed that the ability to communicate in English over email is important along with the ability to see the relevance of state and national level work. Lindsay stressed that perhaps email is not good enough. Sundari suggested setting up a system that x person calls

up y number of people. Shruti stressed that communication cannot be one way. Members need to reach out to each other. Leila asked about the different possible structures that could facilitate more communication. Renu and Sundari suggested that this might mean resources to support visits to one another.

3rd GBM – April 2009, Mumbai

- Expanding membership:
    - Membership Fee: The members ratified the idea that membership fee should be collected. The annual fee for individual members was decided to be Rs. 200/-. Individuals could become members for 5 years by paying Rs. 800/-. For Institutional membership the fee was fixed at Rs. 3000/-.
- Listserve:
    - There are many things that have not been informed on listserve like secretariat being hosted at CHSJ and joining of the new coordinator.
    - Sharad stated that the listserve has international information. He expressed the need to differentiate between news and ideas.
    - Listserve is currently used for sharing resources but not as information bank or activity information thus the subject of the mail should be very clear.
    - Invitations need to send by post.
- Collaborations:
    - It was suggested by Sharad that members could organise activities in collaboration with the Coalition. Any individual member who is not a part of any organization should start using the name of the Coalition. The members can exchange their expertise and time. For example, the ant in Assam organized a workshop for DPMs jointly in partnership with the Coalition thus giving the Coalition a platform in the North East of India.
- Creating/ operationalising thematic groups: Taking stock of the advancement of the agenda through the three sub groups on maternal health, neonatal health and safe abortion, Sundari shared that there is a need to revive the three sub groups as well as call for better functioning. The minutes of the last General members meeting held in 2007 were referred to (on page 21) to find out the names of the thematic groups and their leaders. Sundari states that as a rule, the three thematic leaders should be ex-officio members of the SC. Sharad seconded the idea.

- Possible strategies to enhance visibility of the Coalition: Sunil mentioned that much more needs to be done to make the Coalition visible and encourage membership. This would also need us to specify more clearly the advantages of becoming a member. Renu mentioned that SAHAJ had organized a press conference in Baroda and Coalition was mentioned as a co-facilitator. She asked if it was fine to use the name of the Coalition without following a process of consultation.

Suggestions:

- Sabala: the process can be followed as long as any action does not contradict the vision of the Coalition.
- Shilpa: there can be a wider consultation at the local level with the local groups and then shared with the Steering Committee for the final decision.
- Subhasri: The information can be shared in the Listserve and members can respond.
- Billy: There must be an agreed time period within which the members can respond to a particular agenda.
- Sharad: A process of larger consultation through an e-mail can be followed involving the members and not only the Steering Committee members.

Member's expectations from the Coalition	***What can members contribute to the Coalition***
• Increased involvement in Coalition activities	• Formation of smaller groups
• Need to continue local level advocacy	• Initiate work in Maharashtra
• Have clear direction and position on advocacy	• Develop a journal in peer review on safe abortion
• Research and evidence building	• Increasing visibility in various ways
• Greater sharing of information and resources	• Sharing information – contributing to capacity building
• Clarity on what is the right based approach around abortion	• Developing position papers
	• Funding

Steering Committee:

▪ SC members are elected from the membership of the Coalition. Membership to the SC is based on elections at the Coalition's membership meeting. Eligibility requires two years membership, except for constituting the first full Steering Committee.
▪ The SC will have 9 members in total, including the Coordinator and ARTH's representative both of whom will be ex-officio members.
▪ A quorum of at least 5 SC members is needed to convene a SC meeting.
▪ Two Office-bearers will be elected from among the SC members as Chairperson and Financial Advisor.
▪ SC members cannot remain in position for longer than six years. Two SC members will rotate off every two years starting from the 4th year of the constitution of the SC.
▪ Two SC meetings will be held every year. SC members who miss two consecutive meetings and are not actively involved in discharging SC responsibilities may be requested to resign to make way for more active SC members.
▪ The SC is collectively responsible for planning, implementing, monitoring and financial review of all Coalition activities in line with rules and procedures established by it. Each SC member will additionally take up responsibility for specific Coalition activities.
▪ The SC is responsible for adherence to existing laws and regulations such as the Rajasthan Societies Registration Act, Income Tax Act, and FCRA that apply to ARTH.
▪ The SC is responsible for raising funds for the Coalition's activities.
▪ The SC will establish financial and administrative procedures and ensuring that accounting is carried out as required for audit.
▪ The SC will carry out activities for strengthening the Coalition and identify emerging substantive issues in which the Coalition would be engaged.

▪ The SC will appoint a coordinator who will be remunerated for services rendered.
▪ The SC will elect a chairperson and a financial advisor from among its membership.

4th GBM – Sep 2010, Mumbai

Dr. Suchitra presented the highlights of the Second Steering Committee meeting of 2009 which was held in Sept, at Trivandrum. The results of the SWOT analysis conducted during the meeting were shared.

The strengths as a Coalition are

- Diversity of membership
- A Steering Committee deeply committed to promoting maternal-neonatal health and safe abortion
- Members' capacity for mentoring
- Credibility of members

And the weaknesses are

- Organizational structure not appropriate to realize the mission of the Coalition
- Lack of adequate human resources making it difficult to translate commitment to action
- Communication between Steering Committee and members happens face to face only once a year (only some members attend)
- Relatively low ownership by general membership

Strategic decisions taken in the SC meeting were:

- CH will channel the diverse resources and mentoring capacity available to effectively mentor a new generation of advocates, and especially community-based groups to use the policy spaces currently available (through NRHM's mechanisms for participation) to advocate for maternal-neonatal health and safe abortion issues at the state-level
- Engage in discourse-building and agenda setting on the three themes at the national level
- Will establish state-level organizational structure to promote and support membership to become effective advocates for maternal-neonatal health and safe abortion.
- Will invest time and energy on expanding membership and building a robust organizational structure that will make it more effective in its mission.
- Will consider the feasibility of becoming a registered organization in the near future, with an adequately staffed secretariat capable of implementing the mission of CH
- We will aim to create a secretariat which will be led by a senior person and have at least three programme officers, one for each theme, and adequate support staff.
- In the next two years, we will explore the possibility of creating State-level working groups

- The Steering Committee will have only governance and “steering” functions.
- The three “theme leaders” will provide strategic and technical guidance in the thematic areas, and will help the Secretariat develop action-plans and implement these.

Organizational structure:

It was shared that the mechanism at the local level for the interactions was very low and the resources to translate actions were low.

One of the members expressed the need to discuss two things

1. Whether to look at common health as an organization or as a network.
2. Expansion of membership – how to do that and what should we do.

One of the members participating for the first time requested the organization structure to be shared.

It was discussed that if CH had to work at state level, then a state level structure was required to be established. State level discussion would come into strategic plan; reference was made to the feedback plan to consolidate member’s activities.

Orissa, Assam and Jharkhand are the focus states in view of the earlier work/ advocacy projects implemented there.

Setting state level structures would have funding implications and resource mobilization was necessary.

A member from Bihar expressed the concern as to why Bihar was not considered as a focused state by CH as some work had been done in Bihar in the previous years. In response, it was mentioned that CH was a network which had its own limitations but the issues were still open to be taken up and discussed and accordingly further decisions could be taken.

It was clarified that the feedback of the members was being sought on the issues which were pointed out by external evaluators.

Member’s Expectations:

Members were requested to share their thoughts on which things needed to be clarified and what were their expectations about the meeting. Following were the responses.

- To get clarification on the terms of organization and network
- Discussion need on the thematic group strengthening, functioning of thematic groups
- No queries as being a new member it was more of a learning opportunity
- More information on the thematic function

- Clarification on State specific structure and a member's responsibility to contribute to the growth of the network
- As member what was a member's role and responsibilities and more clarification on Coalition's identity as a network
- How could a member contribute as an individual member in CH work and also in Thematic areas
- To know about how CH would support the work in Bihar, as it being a sensitive state and issues that were prevalent in Bihar were also core of CommonHealth issues
- As already the member's organization was involved with other networks and hence could contribute by sharing the experiences learnt with those networks. To look at the scope of collaborating as resource persons in the maternal health related work and trainings.
- There was increase in understanding CH. Wanted to know how to get involved in thematic areas and contribute in it.
- To understand how an individual can contribute in the work that CH was doing
- Interest was more on learning as the current work in their organization was around maternal health.
- Even though CH was trying a lot since last few years but the messages were not reaching to grassroots level. There was a need to work on HIV/AIDS issues.
- CH should continue to work with Bihar as the state needed work around HIV/AIDS, RH and maternal health.
- Common Health was acting somewhat as a resource agency that was the reason why members thought that that they would get something. CH is struggling hard to collect money and do work within the limited resource
- CH is a network and the work of members was the work of CH. If there were three to four people working in a state then it shows that CH was working in that state.
- Need to discuss as to how to increase members' contribution.CH was not one person or few persons resource agency. Need to think as to how to make CH a vibrant organization.
- Who was a GBM? What was the accountability of a member?
- CH members have hope that SC will provide direction. SC should not be considered a resource agency for guiding the work. CH does organize training from time to time and hence there was need to create a platform for motivating members to get involved, that would be based on equality. CH needs to influence the change and hence there was a need to create change at the local level in orderto build pressure at the local level. There should be demand for CH to get involved from the members working at local level and CH would join in to work at local level.
- How could one contribute as an individual?

Expectations/thoughts of people were summarized under following broad points

1) What a member could contribute in CH work and roles & responsibilities
2) What were the thematic groups, how they worked
3) State specific structure
4) CH structure whether CH was a network or an organization
5) Exchange of information

Theme leaders:

After presenting the TOR of theme leaders, it was acknowledged that it was very ambitious. Since the theme leaders were already working in their respective organizations it was difficult for them to fulfill all the expectations in the TORs.

One of the theme leaders shared that during the last year certain set of activities were undertaken which included some work at grass root level but not much was done at conceptual level. Ownership by the common health members on thematic areas was lacking and it was suggested that instead of one person there could be group of people to provide the support and take a lead in the thematic areas.

As the Neonatal group was very small nothing much had moved under that thematic area. Group level initiatives were limited. The execution of activities should be role of secretariat.

A question was asked that whether there was any budgetary allocation as per thematic areas.
It was shared that there was a difference in the working of a network and an organization. Ultimate goal was not to build three groups and work. There was need to contemplate upon how and what could one do as an individual, immaterial wherever the members were located. Thematic groups were peer groups with a purpose to inspire rest of the members to take particular stand on a particular issue. It was a thought leadership to provoke thought provoking issues for discussion.
Query was raised on whether these thematic areas of work were required? There was need to discuss whether the work on maternal health could be done without working on Safe abortion and neonatal health. Has to deliberate upon how integration was going to happen and how could it be done. The themes should not be separated but there should be integration of the themes

- Some of the discussions on Accountability were
    - Accountability of being member of CH and need to think it through as to how members were accountable as being CH members.
    - It reflects that whatever work of CH was taken up as being a partner and in collaboration with other agency, then members need to feel accountable to finish the work and also take it to logical conclusion.
    - Accountability goes beyond the physical work/project that members were doing for CH. It becomes accountability for the mission of CH.
    - Need to be little realistic about the timeline.
    - One of the members expressed that accountability could be in three ways:
        1) Individual journey
        2) Organizational goal
        3) Coalition - personal and professional

As a member one should be accountable, as an individual member, to the goal of CH.

- It was discussed that even though CH's identity is its members, and yet at the same time CH also has its own individual identity while interacting with the external world. The function of SC was concerned with governing while secretariat had executive functions. CH and General Members has accountability towards each other.

5th GBM – March 2013, Vadodara

On registering CH:
CH is an unregistered body. On the question of registering CH, several opinions were aired, its pros and cons discussed. Dr. Visaria said that she was a member of Health Watch which had undergone a similar problem. Its members had decided to register it. However, a proper secretariat was not created and after 1994, the organization became completely dormant. She suggested that registration would be a positive step if CH had a concrete vision of what it wanted to accomplish in the next 10-15 years. Supporting a secretariat involves establishing an office and hiring staff. Sarita Barpanda said that everybody must commit themselves to nurturing the organization. Gayatri Giri said that registration would detract attention from substantive issues towards administrative ones. Some of the members also argued that funding, an important reason behind registering the organization, was inevitably constraining, and came with its own baggage. Medha Gandhi argued that the current structure of the CH was flexible and open, this gave it strength in terms of numbers, and hence, it did not matter if it was unregistered. Renu Khanna was also against registering the coalition; she added that a lot had been achieved in the last seven years. The discussion was consequently closed without any conclusive decisions. It was decided that the Steering Committee should consider the General Body's views and take a decision.

SC meeting, Pune, Sep 2013

Registration of CommonHealth had been discussed in detail during Vadodara meeting. Few of SC member feel that we should explore possibility of /merits of registering CH. Suchitra agreed to take responsibility for exploring process/feasibility of registering CommonHealth.

Sundari and Renu shared that for the registration there is requirements to have organizational office address, bank account and yearly audited accounts.

SC meeting, Hyderabad, April, 2014

Registering CH:

Suchitra agreed to take responsibility for exploring process/feasibility of registering CommonHealth. She reported back that this can be done as a trust or society but we need 3-5 people who are willing to step up and be a part of the registering process. Suchitra clarified that she cannot be the sole person taking it on and starting the bank account in absence of others who can also be signatory. She had spoken to others including Sharad and Subha Sri since Sept but she cannot be the main point person.

Gayatri and Subha Sri raised reservations again but recognized that the last GBM has taken the decision to go ahead.

We need to decide if society or trust and then go ahead. We need to decide who is going to agree to do this. Look at finances issues for CH at present. We need a non- profit legal entity for CH to survive, which as of now we are depending on others to do this. If we need to set up a trust then we need trustees and some people volunteered: Sundari, Subhasri, Nilangi.

There is a suggestion to bring in people from the GBM if they are willing to lead this process. Then they can be an invitee into the SC and make a proposal to take this forward.

SC meeting, Sep 2017, skype

- Thematic sub groups
  - As discussed in the last SC meeting, a rotation of theme leaders was proposed. It was also suggested that thematic sub groups be set up so as to increase ownership and reduce pressure on a single person.
  - Names of Priya (maternal health) and Bhuvana (safe abortion) were suggested as theme leaders as they had expressed willingness to take this on.
  - Renu expressed a need to constitute the thematic sub groups urgently as some of the work, she felt, was happening in a fragmented way. It was suggested that a mail be again sent out to SC members asking for specific volunteers for the sub groups, especially those who are already working on specific activities/projects related to specific themes.
  - It was also noted that sub group members must be able to commit some time to respond to emails, issues as and when they arise.
  - Priya raised the need for not working in silos in the thematic subgroups, but rather engage with the interconnectedness between them. It was felt that the SC as an implementing body should be congnizant of these intersections and interconnectedness. The subgroups in specific themes will only be for practical facilitation of working.

Discussions on context from Chennai tool development meeting, July 2017

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

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

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

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

Since post 2014, there is a closure of all spaces. We are seeing a situation in stark contrast to pre NRHM and NRHM period, post 2014 – the forums being dissolved and progressive civil society like us not having our space. Power is being wielded by larger consultant organizations like Ernst and Young, JHPIEGO, in the technical space John Snow, Inc and many others. These were the original spaces that were available for civil society but that which is shrunk now. Thus, within the shrinking spaces who wields the power to provide technical inputs is important to recognise.

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

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

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

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

Role of civil society at the policy and program level – There are interesting kinds of galvanizing happening with the use of technology and mobilisation – For instance through

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

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

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

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

FLOOR DISCUSSION CHAIRED BY SUNIL KAUL AND LINDSAY BARNES
Multiple perspectives emerged from the floor and brought the gravity of contextual changes happening in the recent years across the country.

- At the Financing for Development Process, there is a consensus among member states that in order for them to achieve the Sustainable Development Goals without the private sector is not possible. Even at the SDG process the sequence of presentation was first the member states followed by the private sector, then the NGOs. This indicated who gets to speak first. For instance, at the Monitoring and Evaluation Conclave, there were many people who introduced themselves as

representing such and such companies from the private sector. There was a sizeable portion of people who recognize the profit motive involved in these initiatives too. Yet again, there are several 'companies' who help in advocacy and to design how to strategize the advocacies for various health programs. There is lot of financial inflow in these newly emerging sectors, where it is perceived that the efficiency is high in corporate modes of working rather than involving the NGO sector. Need to think more seriously about private sector involvement– changing scenarios, new actors, for profit companies who are present in all/most meetings. Clarification from the floor that: 'companies' – not all of them connote as for profit, since many erstwhile NGO's are registering themselves as companies under Section 8]

- Therefore, the issue of funding for rights based, community based work is drying up. Example: Recent move by Tata's to fund their own programmes themselves, rather than involving NGOs.
- The funding support for social science research is being curtailed to a great extent across many universities. Further at present, there are multiple tiers of funding cut for higher educational institutions with layers of stipulated norms and conditions within the government funding provisions. The social science courses are directed towards moving to management oriented courses that inculcates 'feasible skills' tailored to the market changes. The future workforce is being tailored to market needs of neo-liberalism and the knowledge space for evolving social scientists is curtailed. This is a real concern.
- Need to study Niti Aayog documents and many newly emerging documents in details – many of these documents suggest privatization is 'the' solution to all problems especially health and nutrition. While it's not just within the domain of health, there are other domains such as labour laws, the wage code, the social security law that's all-in place. Most of these documents were put up on public domain for two weeks seeking comments. While these are huge documents and requires detailed scrutiny, two weeks is insufficient for feedback. But it's not about dealing with those domains in silos. For instance, the new labour code is looking at radically overhauling labour laws which will be disastrous for informal labourers, most of whom are women. The role of unions is becoming nil and has no place for table discussions. There is more and more centralization happening across sectors including education. There is a need to be vigilant and learn to address it in totality unlike the piecemeal approach that is presently the case. The government is driving it and we are having almost no role for setting the tone or the direction. Where is the space to talk, and there is no audience to listen at the higher levels, unlike the lower levels to drive policy.
- In the development sector, there is lot of work happening concerning adolescent health. 'Sexual health' – with what perspective is it being spoken about? Sexual health and adolescent health programs in many development sector contexts only

looks at menstruation and body change. They do not move beyond these lines of thought. There is a need to look at this with concern.

- The legality gaps in POCSO versus the issues concerning marital rape, adolescent marriages etc is another area of concern– India has almost 2.7 million married girls below the age of 18 according to surveys. While legal gaps exist, how do we address these issues?
- Need to look at some of the positive models as well – such as *mohalla* clinics

CONCLUDING THE SESSION: There is a need to focus on having multiple strategies to address at different levels. We clearly recognise that there is a SRHR onslaught, particularly of 'women' which is not just one group but from different groups. At CH when we wanted to strategize ourselves a few years ago, we came to a conclusion that national advocacy is not our focus and decided to gather force at the ground level and organize them. This effort is to build accountability by building tools that can be used by people, shared amidst people. This should also influence at the national and global level. There is need to build accountability within the people's perspective. People need to realize that they have rights and entitlements. Thus, the need to focus our energies on communities and build rights literacy is more important rather than focussing at the moment only on policy advocacy.