CommonHealth Planning Meeting

Supported by ARROW

5-7th July 2019, Vadodara

Venue: Everest Dignity [Senior Citizen Homes]
TP 5 Opp. Banco, Bhayli, Vadodara, Gujarat 390010
Contact: 076989 50055

Names of the participants:

1. Dr. Alka Barua
2. Dr. Subhasri
3. Ms. Sanjeeta Gawri
4. Ms. Bijaylaxmi Rautaray
5. Dr. Nilangi Sardeshpande
6. Dr. Sunil Kaul
7. Dr. Lindsay Barnes
8. Dr. Suchitra Dalvie
9. Ms. Renu Khanna
10. Dr. Sharad Iyengar
11. Dr. Satish Gogulwar
12. Mr. Rahi Riyaz
13. Mr. Rajdev Chaturvedi
14. Dr. Souvik Pyne
15. Ms. Swati Shinde

The CH planning meeting was attended by 10 CommonHealth Steering committee members and 4 former CH founding and SC members. The meeting was organised in Vadodara at Everest dignity [Senior citizen homes] with the support from SAHAJ team. The purpose of this meeting was to have strategic discussion for all the three CH themes and planning for CH work for the next five years with monitoring and evaluation framework.

The broad objectives of the meeting were:

Objectives of the meeting-

1. To deliberate upon the overall strategies of CommonHealth's work for next five years, in the context of the revision in vision and mission of CH
2. To finalise the broader advocacy goals for the three themes, viz., Safe abortion, maternal health and reproductive health
3. To map out the existing alliances of CH and draw up a plan to build linkages with the groups working with the marginalised communities
4. To develop monitoring and evaluation framework for CH work
5. To discuss and finalise the advocacy plan for the project, "Claiming the Right to Safe Abortion: Strategic Partnership in Asia, supported by RFSU including locating it in the broader context of CH's work, especially on the abortion subtheme.
6. To revisit the organisational structure of CH, composition of leadership, discuss the issues of representation of marginalised groups in the leadership and find ways for improving communication/ interface with the members (needs assessment of members, plan to address these needs)

The expected outcomes of the meeting were:

1) Roadmap for CH work for next five years, for all the three themes

2) and advocacy plan for RFSU supported project

3) Strategies for inclusion of marginalised groups in CH SC and for better involvement of CH members in CH activities

The meeting began with a brief round of introduction of participants. Dr.Nilangi gave an opening note on the purpose and importance of using this 3 days' gathering for building CH vision and strategic activities under each theme for the coming years with a clear measurable outcomes. She informed the meeting is supported by ARROW project and hence one of the key focuses of this CH planning meet is to work on the and advocacy plan for RFSU project for the period of next four years.

Day 1: The first day was dedicated to discussions on all the 3 CH themes namely Maternal Health, Reproductive health and Safe abortion

Session 1: Strategic discussion about Maternal health subtheme

Presenter –Dr. Subhasri
Discussant- Dr. Lindsay Barnes
Chairperson- Dr. Alka Barua
s
In the beginning, Dr Subhasri presented recap of the work done under MH theme by CommonHealth and a quick review of current government initiatives around maternal health such as quality improvement in Labour rooms, midwifery program, and such- implications of these initiatives for CH work.

Key points from presentation:

- Work accomplishments in the last few years, reflection, learning and challenges.
  - Need to devise strategy for MH in view of the current discussion and reflection on CH's strategies.
  - MH services should be available, accessible , acceptable and good quality
  - CH focus is making deliveries safer than emphasising institutional deliveries [as government's mandate]
  - CH focus has been on technical quality and women's needs to monitor quality of care
  - Promote accountability for MH
  - Capacity building of grass root organisation with respect to MH accountability
  - Integrate MH within RH continuum
  - Focus on Abortion

- What has CH done so far?

Dead Women Talking: CH studied Maternal deaths in the community with a collaborative civil society initiative from the community based and rights perspective. In ten states maternal death documentation was conducted. CH tried to understand the social determinants

of maternal deaths, who does it affect more, whether it affects the marginal group more?. It initiated the process of social autopsy of maternal deaths for broad advocacy. Social autopsy was done by identifying gender and social issues also, understanding health system factors.

It was found that less maternal deaths were reported and less reviewed by government led MDSR. The focus was more on the bio medical factors and other background factors were ignored.CH involved community representatives in Maternal death reviews in different stages hence democratising the process. CH used SSR framework across 4 domains: technical, health system, social and human rights.

Action: In terms of action taking, CH did analysis of feedback to community and Health system at different levels, conducted interactions in the informal spaces for, gramsabha, community action , public hearings . At the health system level, CH looked at the issues in Health system from women's perspective, intersectional issues such as migration, livelihood, road, transport etc. Additionally it brought the Human rights perspective in MH and healthcare as fundamental human rights and framed the issues from angle of accountability. It set up the Community level process for monitoring of MH care in the in tribal districts of Gujarat. Additionally, CH carried out priority and ranking exercise with women, on aspects of safe delivery through group discussions with them.

Tool development: The MH tools were developed based on the exercise to assess quality of care. The team had met pregnant women 3 times during the course of the pregnancy/delivery to document their experiences. The report cards were shared at block level with health system and at community level

Capacity building beyond CH: The team developed training modules for accountability of MH and advocacy of MH as gender and rights issue, built alliances with other organisations [NAMHHR, Oxfam]. Regional meetings were also conducted to build the capacity of partners. There is need to further follow up on their work.

Reach of work: WHO took the DWT case studies as examples and CH also contributed chapter on social determinant of health for a book. So though CH has have been able to build knowledge and it is going forward but on ground in terms of action it need to check how it is been useful. While CH has been are able to generate content it haven't got visibility.

Learnings and challenges: what did CH do?

- CH was able to provide inputs at the community level pedagogical innovations and brought this into the right's framework. CH was able to engage and mobilize the community. With several consultations with partners, CH was able to develop contextually relevant methodology and tool that fed into RH histories project
- Interface with health system: There have been no formal spaces to interact and engage with the health system and access to information in health system is an issue. There is questioning from them over legitimacy and often backlash as a result lower level staff was found to be penalised. There are issues of power hierarchies between health staff and community.
- What is the Macro situation: Though there is decline in MMR [SRS 130 for India], government is celebrating , MDG 5 target [109] is far away.
- Focus has now been on quality of care- LaQSHYA

- But there are larger systemic barriers –infrastructural , HR, Governance
- Right's discourse is found to be absent in health provisioning
- Some welcome initiatives through midwifery for respectful maternity care .there are midwifery led units where 1st batch of18months training is been given, how that will be taken forward is something to check.
- Larger scenario –more privatization and insurance based financing
  Globally and nationally, there is renewed focus on 'selfcare' and emphasis to empower women, make them aware of the issues in MH

What are the challenges today?

- Placing MH within the larger paradigm of SRH and establishing linkages
- Focusing on public health system
- Regulation of private sector
- Focus should be on social determinants
- Promoting right's discourse women's agency

Following were the questions for deliberations:

a. How do CH set the advocacy goals in this context? How do CH engage with these?
b. How do CH link with the broader accountability initiatives? Where should CH see itself?
c. How do CH take forward the advocacy for MH theme on the basis of DWT report?
d. Possible ways of engaging the participants of various MDR workshops that CH has done in the past

Strategic discussions on Maternal Health

- Dr Alka pointed out that PPIUCD is another important challenge. Women are forced to go to private sector because in public sector they are required to use contraception post-delivery. There was also a discussion about how institutional births are going down in Gujarat. Some cases in Tamil Nadu were reported where women are choosing to deliver at home using you tube videos.

- Subsequently, Dr Lindsay Barnes shared her thoughts as a discussant for this theme. She raised important issues regarding the cash incentives being paid for institutional deliveries. Around 18000 rupees are being paid as incentive for institutional deliveries in Jharkhand to cases of 'good behaviour' which means the woman follows all the instructions given by healthcare staff including those of immunization of the infant. In UP, around Rs 5000 are paid in 3 instalments for institutional delivery and care.

- She flagged the issue of quality of care during the births, informing it is like bribing a family with the money and dulling people's voices so that no one asks questions or raises complaints. This automatically prevents people from raising voices against the

health system. So there is money but no basic facilities are available. In UP, traditional dais, ANMs, ASHAs have opened centres for delivery and there are instances of maternal deaths there.

The entire discussion then posed a question as to whether women need cash incentives? And why can't that money be instead used to improve the service provisioning? She further informed that there were touts and ASHAs/ANMs also are going in for commission through referral as they don't get their salaries on time and the whole mindset is 'how one can benefit' than mother's safe delivery.

Bijaylaxmi informed about a case in Orissa where the newborn died and the community had demanded to suspend ASHA but no action was taken. Dr Sharad spoke that politically giving incentive is right and is also supported by civil societies. He informed how accreditation of ARTH for JSY was removed. They have agency which provides services. There was contempt from healthcare providers for giving of incentives from the same agency that also provides the services, people are looked down.

There is reduction in maternal deaths and the focus is now shifted to still birth. Awareness on maternal deaths can't be raised on the basis of maternal deaths. Maternal death review group is now changed to maternal perinatal death review group. WHO respectful maternity care agenda is okay with everyone even civil societies run after this agenda. Respectful maternal care doesn't talk about maternal health as it includes safe abortion. The post- delivery deaths are not counted? There is need to bring the right's perspective/argument in the respectful maternity care.

He talked that Midwifery training has suddenly become an elitist agenda as they plan to train few people . The entry criterion is GNM, ANM is left out. The other agenda is encapsulated. More people are needed, CH can introspect this aspect. He highlighted that there were hierarchical issues within the system. The female nurses are over worked and senior nurses just do clerical work, Although the midwifery model is good but the agenda needs to be taken out what does this mean?.

He also flagged the issue of involving men in maternity care. Men in the family are kept out of the system, they aren't entertained and allowed inside the facility. There is no place for relative to stay, no toilets. Women do not have the necessary support system. No space for engaging sensitive men to women's pregnancy and delivery, there is a need to develop evidence on this aspect.

There is a need to start looking at perinatal deaths. Mobile phones can be used to track mortality in 90% cases. Government is not using these simple monitoring methods.

Dr Lindsay talked about respectful maternity care and told that many women are not respected and treated bad because of issues of gender, class, caste and community. How will one achieve this when there is no respect for that person. So it's abnormal to be respectful inside health system when you are not outside, it is a larger societal issue.

She suggested that there is a need to revisit 'what is safe?'. C sections are especially extremely unsafe. More deliveries are done through C section and it is 10 times more dangerous than normal deliveries.

Dr Subhasri pointed that we are looking at all the aspects of maternal health care and not just binary – technical and social. We should question biomedical aspects of the delivery such as episiotomy or giving fundal pressure.

There is a need to conduct audit of the facilities, if there more than 35% of C section deliveries in any facility. Dr Alka pointed out that no doctor writes indicators of LSCS[lower segment caesarean section].

Dr. Lindsay informed about the group discussion with women on Safe delivery. She said if they do the same exercise with women now- it would be different. Woman want normal deliveries and they also want doctors, there is contradiction. One has to do audit of Caesarean . If one is looking at caesarean, also look at the outcomes of it and important is to study the context in which C section are conducted. There are now a days large scale caesarean referrals to private hospitals and that's a racket as it all commission based.

There is also an underlying myths related to C sections such as the babies are intelligent as compared to the babies who have to go through stress in normal delivery.

Further there was discussion on health scheme such as Ayushman Bharat –what it means for Maternal Health as it does not cover normal deliveries. Many a times at the level of the health system therefore there are efforts to show complications and put the baby in NICU and the baby has to stay away for few days from mother post birth. So there is need to challenge this insurance business. ANM/ASHA take women to private sector for caesarean. Women are referred to private doctors through the government set ups giving excuses such as they do not have the facility for C section or blood availability.

Dr Sharad suggested that if we can get a case study on this, we can use this as advocacy. He told that big hospitals are not going for Ayushman Bharat as there is delay in getting money. At government health facilities the rates of C sections are low, so they do not call the anaesthetist, but manage internally

According to guidelines C sections would cost 50000 in government sector. But he emphasized on the need to look at the perinatal outcomes and not just percentage of LSCS. So one of areas for CH could be to look at the outcome monitoring. How can we strengthen public facilities so that need for referrals go down.

The Niti Ayog does monitoring of PMJAY, there is an IP dashboard in PMO [prime ministers office]. There is need to look at how central and state led schemes affect Maternal health?

Alka talked about the issue of obstretician being beaten up in case of adverse outcome of delivery could be one of the reasons behind unnecessary surgeries. There are several such cases reported in Bihar reportedly and for that reason the delivery rooms also have backdoors. The doctors when they sense any kind of trouble from patient's kin, they use it to exit the facility.

Talking about early neo natal mortality Dr Sharad said, the MMR has fallen , it will be difficult to reduce it further. In Rajasthan he said the discharge card doesn't mention anything about baby. In context of child marriages and early marriages , Dr Suchitra highlighted the issue of unwanted pregnancies among adolescent girls /women. This is a vulnerable group.

So there is also need to disaggregate MH data. She also said that due to the mandatory reporting clause of POCSO, families do not report correct age of the girl in case of early pregnancy.

Mr Rahi talked about issue of unavailability of blood banks even at the district level in Kashmir. All MH cases are referred to Kashmir, no deliveries at PHC. There is no data and not much private sector also in Kashmir . The society is medicalized and claims there is no maternal mortality. Currently there are no projects on MH. There is a need to find ways to address these issues.

Dr Alka summarised the issues and key decisions discussed in the session at the end briefly:

- **Maternity care is limited now and should ideally be extended to perinatal care.**
- **About incentives, there is need to look at whether women benefit from incentives?**
- **Midwifery model she said is an elite model and should be made a janata model.**
- **Issues of companion during delivery in the health systems need to be addressed**
- **Respectful maternity care: no respect because of issues of caste, class, community outside, how respectful care would be provided in the health setups**
- **Ayushman Bharat : Implications of not covering normal delivery**
- **Disaggregation of MH data by age/vulnerable adolescent**
- **No availability of blood bank: implications of MH**

Dr Subhasri raised the question that currently CH doesn't have any project under Maternal Health theme. How does CH take these strategies ahead ? Should CH be doing this under MH ? or otherwise?

Ms. Renu suggested that CH should begin with having some formal enquires or review with some institutions to understand how there has been any change in terms of sustainability. CH should carry out a realistic evaluation where there were capacity building done with regional partners.

TRAINING MANUALS: CH already has training manuals, those should be designed well and could be circulated widely for use. It should be reader friendly and translated in Hindi. There is a need volunteers for this translation of manuals.

MONITORING: There is LaQshya checklist, CH members can use their checklist to monitor work in our areas. Some of CH's local partner organisations have good rapport and collaborations with the government health in their areas, it can get permissions from them and could do this exercise there.

POSITION PAPERS: CH need to come up with position papers wrt Safe delivery, harmful practices, respectful maternal care , gender in medical education, lecture on don'ts in labour room and add to discourse building

GENDER IN MEDICAL EDUCATION: Gender in Medical education is another aspect to focus on.

Session 2: Strategic discussion about Reproductive health subtheme

Presenter: Dr Nilangi Sardeshpande
Discussant- Dr. Sharad Iyengar
Chairperson- Dr Subhasri

Dr Nilangi made a presentation on the work done under RH theme in the CommonHealth till date.

Broad points from the presentation:

- CH has in the past conducted a short course on 'Advocacy for Sexual and Reproductive Health Rights in 2006, The report can be uploaded on the website. This led to the subsequent causes i.e media advocacy for Safe abortion.
- Meeting on NRHM through the gender and rights lens in Delhi was organised in collaboration with Sama and NAMHHR
- CH organised a 2 day consultation on 2012 on 'ICPD+20-Beyond 2014'in Mumbai
- CH in collaboration with RUWSEC, SAHAJ and CREA, organised a two day consultation on strengthening alliances for Sexual and Reproductive Health and Rights In 2014 in Delhi.
- CH produced "Advocates' guide for rights based contraceptive services". PFI had approached CH. The guide was shortened and 300 copies were printed.
- CH produced an advocacy brief , 'call for action to integrate sexual and reproductive health and rights into the Post-2015 Sustainable Development Agenda', available on the website
- Organized a national consultation on 'Integrating SRHR Indicators within Sustainable Development Goals framework and Advocacy Strategies for monitoring the implementation of SDGs in India' (Pune, January 22, 23 2016)
- Planning Meeting for Dead Women Talking Process Forward and Right based monitoring of Contraceptives JP Naik Centre, Pune (9-12 March, 2016)
- Conducted Regional consultations on RH issues
- Have incorporated the learnings and methodology into the present RH histories research- first tool development meeting in Chennai in July 2017

Following were the questions for deliberations:

- Broader policy context of RH- what's happening nationally or globally (FP 2020, SDGs)
- Discuss about possible advocacy on the basis of evidence generated through RH history research

  Dr. Souvik made a short presentation on the RH histories research that is on going with 7 marginal groups in different states .He informed about the methodology of the research and SAHAJ IEC clearance process done for the study and the partners involved.

- Dr Sharad being discussant for this session shared his views and asked questions on the adolescent as a marginal groups in the RH history research and the bias that may come up. He also talked about the quantity of data that will be generated through this research and opined that it is too wide and too much data.
- Dr Suchitra suggested that while there may not be need to collect data on all that aspects of the life cycle, it may be useful to collect data with focus on RH aspects and document pertaining to marginalized groups.
- Dr Sharad further suggested that the study may /will bring out issues of family planning and sexual dynamics and may not have implications for health systems. Questions on sensitive aspects such as Domestic violence etc. may have implications for the respondents and hence dealt with cautiously.
- Different organisations perceive SRH differently for some it is MH and some it is STIs.
- He talked about issues of consent taking for family planning, he suggested that involving men in the process of PPIUCD is important.
- **IUD:** IUD removals documentation is needed. How women pushed into FP and consents are manipulated. The consent was taken by ASHA verbally and no records is maintained.
- He also talked about the technical quality of care after family planning camps highlighting that IUCD insertions are not done with well sterilized instruments
- He highlighted how IUCD has become core of RH and incentives are a problem in MPV
- The programmes unfortunately are based on government needs and not on the people's needs. More than meeting the unmet need the focus is to complete the task as a national duty.
- Sex education is important for adolescents and family planning.
- **MONITORING AND EVALUATION:** Supreme court judgement on Devika Biswas case on sterilization could be used by CH for advocacy . CH can work on this area of monitoring and education.
- Mr. Dr Souvik suggested using HIV infections as a means for talking about Comprehensive sexuality education .He suggested using SDG /SRHR framework used for advocacy for CSE, using international definition of young people.
- Ms. Ms. Renu informed that CSE is not acceptable and instead suggested working around body literacy. She also highlighted how many adolescent women do not get much love/attention and are discriminated at home and they tend to run away; issues of honour killing are also happening. This also leads to early and forced marriages.
- Dr. Alka opined that how schemes promote marriage instead of development. She mentioned about RKSK, family planning and safe abortion are part of it. RKSK master trainers are being featured in.

- **UNNECESSARY HYSTERECTOMY**: Dr. Nilangi talked about the issue of unnecessary hysterectomies and that there should be audits for the same. She also flagged the issue of women not getting services they need and hence leading to such instances.
- Ms. Renu said that women's autonomy should be seen in context

  Dr Subhasri being the chairperson for this session summarised the entire discussion briefly at the end of the session.

Session 3: Strategic discussion on Safe Abortion theme

Presenter-Dr. Alka Barua
Discussant –Ms. Suchitra Dalvie
Chairperson- Dr Souvik Pyne

Dr Alka made a presentation on the recap of work done on Safe Abortion in CommonHealth.

Key points from the presentation:

- Claiming the right to safe abortion is a part of 5 country project of ARROW, the aim of the project is to carry out advocacy to promote access to safe abortion through evidence generation, advocacy, dismantling barriers and accountability strategies
- The rationale of the study is that there is lack of information on availability of safe abortion services, barriers with regard to service provisions from service providers, also lack of knowledge on the prevailing attitudes towards abortion as a right for women
- A baseline study was conducted: Rapid assessment was conducted in Nawada-Bihar and Kancheepuram-Tamilnadu using primary and secondary data

Salient findings of the baseline assessment

Programme and policy level issues

- Services are legal but are conditional and not completely decriminalised
- There are conflicting laws, programmes [POCSO, RKSK]
- Programme focus is on MH and family planning
- Poor availability of data with regard to abortion
- Under performing state initiatives like Yukti yojana and CAP

Prevailing environment

- Growing antiabortion sentiments, Pro-life movement
- Anti Sex selective abortion campaigns by CSO/CBOs
- Growing number of court cases – language of foetal rights

Need amongst women

- CPR: Bihar- 23.3%, TN- 52.6% (NFHS4)
- Unintended pregnancies: >=43% & >=55% end in abortion
- Abortions (2015): Bihar-12.5 lakhs, TN - 7.07 lakhs (Guttmacher)

Infrastructure [services availability]

- Less than 1/3rd provide services
- Unequal distribution: Geographical (<30% rural), Sectors (>78% in Private)

Services availed

- >90% in first trimester
- >63% outside facilities by MMA & 5% by other methods
- Facility based: Bihar- 16%, TN- 32%; >80% in private
- Private: Bihar- Unqualified, TN- Ob/Gy (BLS)
- Practice: >31% D & C, 43% MVA
- Government: for married and Dalit only 1st trimester
- Private sector as high as 50% depending on age and legality

Provider's attitude

- Unawareness, insistence on spousal consent
- Tend to deny services leading to delays, humiliation
- Advice to continue pregnancy and use FP
- In favour of termination only when foetal abnormality & risk to mother's health

Community attitudes [conducted FGDs with women SHGs]

- There was lot of Stigma with respect to abortion and is considered a crime
- Support only in case of foetal abnormality & risk to mother's health

Women's attitude

- Stigma around abortion , reluctance to talk
- Unawarenss about services and legality
- Hence opt for private facilities for confidentiality though costly

for advocacy

Advocacy goal: to create environment where women of all ages can access non discriminatory, non coercive safe abortion services without any stigma

Problems identified : unawareness and stigma among women and communities, reluctance to support , providers unawareness , attitudes and practices , systemic issues of unavailability , infrastructure and cost, programme lacks focus and data, policy conflation, incoherence and criminalisation , environment : antiabortion sentiments , legal interventions

Given these issues to deal with following are the short, mid and long term objectives, the possible strategies and the target audience:

Objectives	Strategies	Audience for advocacy
Short Term Objectives To create awareness about legality, women's right to safe abortion services To improve availability of data for programmatic decision making	Evidence building related to problems Develop/adapt IEC material / kit / videos Meetings with SHGs, CBOs/CSOs, Media Develop knowledge products/briefs	Women Family members Community members / leaders SHGs, Youth groups CBOs / CSOs / Local NGOs CH members / partners State / national / International NGOs (?) Government service providers Private service providers Government programme managers Policy makers & key stakeholders Professional bodies SRHR advocates / Lawyers Media Other networks / technical agencies
Mid Term Objectives To advocate for improved infrastructure and awareness about quality services (SOPs) To advocate for focus on safe abortion services as a right - in programmes	State level meetings with medical students, providers, programme managers Identify & mentor champions amongst providers, youth Local level alliances & CG meetings– youth, NGOs	
Long Term Objectives To bring about changes in attitudes of stakeholders To advocate for coherence in Acts, laws, policies and programmes To advocate for decriminalisation of abortion To combat anti-abortion campaigns	Alliances with NGOs, SRHR advocates, **lawyers**, professional bodies National level meeting with policy makers, key stakeholders Media articles, opinion pieces	

The entry points to begin advocacy work could be:

- Creating think tank
- Building of evidence
- Use of media to build strong narrative
- Create network of abortion support agencies 'common ground'

Measurable outputs and outcomes

- Documentation of life histories and evidence
- Short videos on safe abortion services
- Advocacy plan
- Tool kit on safe abortion
- CSO / CBO network / engagement in activities
- Stakeholder engagement in campaign

- o Articles, opinion pieces and critiques in media
- o Conduct end term State and national level dissemination meetings and facilitate critique using national and international accountability to advance safe abortion
- o Increased awareness about abortion legality, services, rights and entitlements amongst women including the marginalised women
- o Increased awareness and change in attitudes among health service providers about legality and women's rights to safe services
- o Alliance formation for Decriminalisation of abortion

Assumptions

- o **Some women** are **more vulnerable** than others
- o **Robust evidence is missing** & women's lived realities are not taken into account
- o **Government does not prioritise abortion** and campaigns and advocacy would bring the focus back on women's rights and entitlements
- o It sees abortion in the context of saving a mother's life or alternative to FP failure & **women's choice, agency, autonomy and bodily integrity is ignored**.
- o Abortion is **considered as a need & right by activists** & partners
- o All **stakeholders are equally sensitive and invested** in abortion related issues and will hold sustained interest
- o **Environment of conservatism, patriarchal values,** restrictions on women's autonomy are the key deterrents for abortion service access
- o **United voices for campaigning** and advocacy have **not been raised** till date

- ➢ Discussion on assumptions: Is it possible to measure the change in behaviour? Dr Satish felt CH can record change claimed by participants etc

- ➢ Ms. Ms. Renu said it should be measured against some state control

- ➢ The group felt many of these statements needs to be rephrased

Dr. Alka then presented the Advocacy plan [PPT can be referred] for the 4 years listing the strategies, activities and timelines planned.

Following were the initial steps listed

- Two pagers based on research including women's experiences with abortion services in Bihar and Tamil Nadu - dissemination
- Creation of information material for women and service providers
- Part of Solidarity Alliance: 6 CSOs. Advocate for SA as a human right
- Form a coalition with those working on decriminalization of abortion
- Local level campaigns on 28th September with the help of alumni of CREA-CH joint initiative
- Plan a campaign for decriminalization of abortion – 28th September
- *Make a video on women's experiences, negative consequences of criminalization, denial*
- *Engagement with media for publication of opinion piece/s on 28th September – leveraging CH member organization / media interaction*

Post the presentation, the points put forth for discussion were

- Gaps / missing points
- Additional strategies
- Feasibility within available timeline, budget
- Possible challenges

Strategic discussions on Safe Abortion

In context of the assumption statement '**Some women** are **more vulnerable** than others', Dr. Souvik suggested using 'persons' instead of women to include trans experience. Dr Sharad suggested to keep it open, difficult to explain how persons can get pregnant. Ms. Renu suggested that a footnote can be given to include LGBTQ instead of changing 'women' to 'person'. Dr Souvik said LGBTQ may not find that inclusive. Dr Suchitra said will need SSA [sex selective abortion] frame work, disability movement against MTP act .

Dr Subhasri: word 'non-coercive' in the advocacy goal may need change. Form F of PCPNT one copy to ANM so that she must follow up for abortion. Dr Nilangi asked what is the flexibility to change since the proposal is already been submitted. Dr. Alka replied that the strategies and activities could be changed and there is no issue with that. Ms. Renu suggested that there is need to work on SA and disability rights.

- Dr Suchitra talked about the global environment and landscape for Abortion. She talked about law IPC sections 312 and 316 consider abortion as criminal acts. It was a British law made in 1860 and it was adopted by India as it is. But as per the MTP act abortion is not criminal if there were conditions like:
    - pregnancy is a risk to the life of a pregnant woman,
    - When there is substantial risk that the child, if born, would be seriously handicapped due to physical or mental abnormalities;
    - When pregnancy is caused due to rape,
    - When pregnancy is caused due to failure of contraceptives used by a married woman or her husband

MTP is exclusion to IPC so that doctor working in licenced place is free of IPC. Guttmacher study saw 60% of abortion due to medical abortion of which 90% are self-administered, hence 'criminal'- all these women lawyers want to file an PIL. Many groups have different positions on many issues related to abortion in Delhi. Pratigya /FOGSI/GPS: Sec 312 and section 316 want only women to be decriminalised, rest to remain as it is. There have been advocacy on MTP amendment and FOGSI is supportive and ready to back MTP until 24 weeks of gestation as some abnormality in the foetus may be found later.

MTP must allow AYUSH with training but needs to be approved by IMA/FOGSI members. She posed question 'If there is no law on cardiac surgery, why for abortion?

Abortion laws need to be changed to save women's rights instead of doctor's right.

There are campaigns by various lawyers in Mumbai high court to put more and more cases /PIL on abortion There have been different cases and PIL filed , around 120, 100 in Mumbai alone. There have been different judgements, hence there is chaos !! so many judgements !!

One of the positive H C judgements was that women have the right to continue or discontinue a pregnancy. What to do as HC case applicable to that state only? Another judgment also saw women has a right to her pregnancy to terminate or not.

Delhi groups have different perspectives on abortion rights. What is the CommonHealth's stand with respect to Abortion?

Dr Suchitra informed of a sting operation that was carried out under 'Mukhbir scheme'after which it was decided to add IPC to PCPNDT to increase punishment'. Lawyers are scared and hence there are so many cases. People are using IPC to reduce the freedom on MTP. "No ethical guidance for abortion > 20 weeks child with disability but born alive". Judge never realised that foetus can be born alive – now it has led to audit of all MTPs. Who will take charge of such life born after MTP? State?

So, the challenge in front of CH is to look at 'how to change the environment with respect to abortion?'

Dr Subhasri said the counter argument could be so many women going for abortion. She raised the question as to 'where should one go -to legislations or judiciary?

Dr Suchitra informed that the 2nd trimester MTP has reduced as private doctors are scared that they may be labelled for Sex selective abortion.

So, the advocacy opportunity is to be part of alliance working on Abortion. CH should think about:

- How to be invited to such meetings by Pratigya etc, how can CH be part of such legal consultations?
- How to bring CH credibility?
- CH need to create visibility so they get us there and take inputs
- CH and CREA partnership can be leveraged as they have presence in Delhi

Dr Alka: CH may bring out the contradictions in the landscape through not leading the advocacy. CH need to prioritise as Dr. Suchitra suggestion of .

Dr Sharad had the following views and suggestions:

- Pratigya phase 1 was not very good, foreign drivers? Pratigya phase 2 : for phase 2 CREA and Marie stopes have been called.
- CH may be seen as competitor.
- There is need of some legal professionals, may be Ms. Anubha who is a member.
- CH needs a voice in Delhi. Is there possibility to have a state example that is positive ?
- No one as of yet has contradicted Guttmacher study except government because people in the field are finding that the findings of the study are correct.

- Health ministry has upheld the MTP amendment, opposition only where the law ministry put them up on the website

- What is CH's stand take on -self use or not?

- Data not available for FLW. Is it possible for CH to create a channel of information that ASHAs can take to community? Can CH produce booklets that FLW can buy like ASHA/ANMs, price of the booklet can be kept low. The information can be technical, ethical, social and behavioural. There is no need to depend on funder /government for information.

- Dr Sharad put forth the question - What does CH want to focus on - decriminalisation or destigmatization? He opined that Decriminalization is a legal and a long process and it is not possible to go changing the law as it takes a long time.

- Dr Subhasri raised the concern- saying whether CH has the capacity or the will to do national advocacy for Abortion? CH has it is our own strengths."

- Dr Alka had the opinion that CH should not take the leadership but work towards creating the environment.

- Dr Sharad said CH need Delhi people to counter the effect of those who visit field realities rather than live or work on field realities".

Day 2- Session 1: Evidence generation and development of knowledge products and messages

Presenter- Dr. Alka Barua
Chairperson- Dr. Suchitra Dalvie

The purpose of this discussion was to have specific inputs for RFSU Abortion advocacy project. Dr Alka made a presentation about the 'knowledge product' and how that would be used for advocacy.

Dr. Nilangi invited the chair , Dr. Suchitra to start the session. Dr. Suchitra said this session would help catalyze the direction of the RFSU project

Key points from the presentation were:

- Dr Alka said knowledge production is an important part as the overall focus is advocacy. She explained 'what is knowledge' and 'what is information' and how knowledge is different than the information.
- Information seeks to know what whereas, knowledge is about how? Information is interesting and to inform whereas knowledge is useful and enables action /create value.
- IEC is information. It is in the grey zone
- She showcased quite a few examples –stories and case studies –on lived in experience , experiential knowledge

- Information is presentation of lessons learnt
- Knowledge product are tailored to the audience , link from evidence and used for advocacy
- Eg: Educational material / briefs / two pagers
- Media products – articles, opinion pieces, videos
- Social media: Blogs, FAQs
- Strategic plan to address gaps / barriers / improve quality

She informed that there are certain prerequisite for Knowledge product but 'demand' is not always one, often one need to create the demand. CH should be able to identify a user group with need and the KP should be potentially replicable

Further, she shared what were the proposed products for Abortion advocacy under the RFSU project:

- IEC material
- Two pagers on available evidence
- Case histories
- Video / You tube
- Media / social media – articles, blogs
- FAQs

Post the presentation, Dr Alka asked if the group wants to suggest any other knowledge products and opened up the discussion.

- Dr Suchitra asked how the discussion should flow-whether looking at RFSU project timelines or generally on the KP creation?
- Based on Ms. Renu and Dr Subhasri's suggestion, it was said that the Theory of Change of CH should be done earlier and then in the subgroups discuss the KPIs within that.
- Ms. Renu said that based on the vision and mission of CH, she had worked out a tentative framework including strategies, activities , outputs , outcomes and then took everyone through the framework.

Session 2: framework for Advocacy

Ms. Renu made the presentation on the framework for advocacy . She narrated the following strategies for CH:

1. Perspective building among members
2. Field level enquiries and participatory research studies
3. Development of position papers and knowledge products
4. Outreach through website, list serve and social media
5. Collaborations being present with movements, campaigns and common grounds workshop, etc
6. Strengthening the functioning of steering committee

The above strategies will lead to the following outputs

- Increased membership of CH
- Knowledge products and position papers
- Vibrant exchanges and collaborative actions among members
- Collective functioning by steering committee

These outputs will lead to following outcomes:

- Contribution to development of new SRHR policies and programs
- Monitoring implementation of SRHR policies and programs

The two outcomes listed would make following impact:

- Access to RSH services including safe abortion that are gender sensitive, rights based and culturally appropriate.
- Access to comprehensive sexuality education and information and SRH services for young people
- Destigmatisation of Safe Abortion and recognition of SA as a right of women
- Elimination of stigma and discrimination on grounds of gender, sexual orientation, HIV status and work (sex work)
- Recognition of women's morbidities across the life cycle and their interactions with social determinants

And, this impact would help us achieve the CH vision: **"A society that ensures the right to the highest attainable standards of reproductive and sexual health for all, especially for women and marginalized communities in India."**

Questions and Discussions:

- Dr Subhasri said that the vision and mission statement was discussed earlier and consciously mission was kept smaller/narrower
- There is need to have measurable indicators.
- How vibrant exchange and elimination of stigma are outcomes?
- There is no clear link between activities and strategies, need to think through
- Dr Suchitra suggested Theory of Change is not easy to develop for an organization, it can't be done in a meeting like this. A facilitated longer meeting with more members needs to be present. Many strategies are like activities or vice versa. Many things need to be spelt out clearly. SC functioning with membership needed to develop strategies, no fine-tuning is needed. There is no clear outline of youth role in strategic planning. How to develop Theory of Change for next five years strategies. There is no visibility of disability or domestic violence. Need consultant to guide the discussion , there is a need for robust TOC.
- Dr. Sunil agreed with Dr. Suchitra on this. Dr. Nilangi too agreed and suggested there is need of more inputs from members. He said that vision statement should be shorter and qualifiers should be added to mission statement.
- Dr Suchitra suggested to bring in more people from stakeholder group in the process
- Dr. Nilangi suggested working on the draft and taking Theory of Change to members and getting their inputs

- Ms. Renu suggested brainstorming to review Theory of Change. She suggested taking this format and work towards building it
- Dr. Suchitra put on board the broad elements: advocacy and knowledge management. These broad elements can encompasses functioning of coalition like us and can move this way too
- Knowledge creation: stakeholder need to be involved in and also in creation of strategies
- Dr. Souvik said it can be thought from other way around starting from priority issues
- The three broad strategies could be : Capacity building, Awareness and Alliance building
- The group needs to break into thematic groups and think about the priority issues and strategies
- Dr. Sunil suggested try not to fit in old and new visions. He asked 'how does community level advocacy fit in?
- Dr Alka said that Vision is non-negotiable. Certain prerequisite needed which is the policy level and which is advocacy level strategies, need to put levels first. There is need to work on our activities and strategies independent of vision and mission and then see how it can be weaved together.
- Dr. Alka said the group needs to be cognizant that it should not mix up with project focus.
- What is 'all'- to explicitly spelt out in vision statements
- Who is the 'audience' for whom the vision is made asked Dr Suchitra.
- Vision is aspirational, includes all and mission is restricted.
- With respect to CH mission, Dr Souvik asked- why it is women and girls and not people? He opined only women and girls won't do justice
- It was done with the feminist perspective –It was decided in the past vision mission building meeting that women will go into mission statement.
- There is need to sharpen the definitions
- Dr. Subhasri raised her concern saying 'how to move forward for next five years of the Theory of Change is not finalised? Dr. Nilangi answered saying, if one step is finalised the remaining two will follow.
- Ms. Renu suggested to look at impact and others flow from this, Dr. Alka suggested to club outcomes and impact
- Common understanding should be finalised before the theme development
- Recognition of women's morbidities –who's recognition- women's ?policymakers?
- Dr. Subhasri suggested going back to tomorrow's discussion, and prioritizing 2-3 areas for work, going and seeing the outcomes and not get stuck in Theory of Change.
- Dr Alka told that Theory of Change of project is different than the Theory of Change of organization
- Ms. Renu opined there can be different ways of presenting the Theory of Change. She suggested to suspend discussion of Theory of Change as of now until thematic group wise strategic planning is done. It can be looked at later how to present it visually and what strategic plan is made?

Post this discussion, three thematic groups were formed to work on the priority areas and planning for 5 years.

Session 3: Five- year plan for CommonHealth

Chairperson- Dr. Sunil Kaul
Facilitator- Dr Nilangi

The session aimed at looking at each theme more critically in terms of what should be CH goals and vision for the next five years, where CH is and where should it be going ahead.

The following groups were formed to work on respective themes:

Maternal health: Dr Sunil , Dr Satish, Dr Subhasri, Dr Lindsay
Safe abortion: Dr Souvik, Ms.Sanjeeta, Mr. Rahi, Dr. Alka, Mr. Rajdev
Reproductive Health: Dr Nilangi, Ms. Renu, Ms. Bijaylaxmi, Ms. Swati

Groups were supposed to work on:

1. **Identify the areas/issues that CH aims to work on for next five years [2-3 areas not more than that]**
2. **Look at what is current evidence and gaps in that area/issue**
3. **Advocacy : what are goals, objectives, audience, messages, strategies and opportunities**
4. **Monitoring and evaluation framework**
5. **Risks and mitigation**

Groups should also think about the possible ways of monitoring and evaluating the work in that particular theme. All this keeping in mind that it should be worked out in the next five years

Groups worked on their respective themes for one and half hour each and made a presentation on their plans.

Group 1: Reproductive Health Theme

The identified following 3 issues to work on:

1. Contraception
2. Comprehensive sexuality education
3. Unnecessary hysterectomy

I: Contraception:

Following gaps were identified:

- o Lack of awareness about contraception ,
- o Availability with ASHAs - Implementation of RKSK compromises young people’s access
- o Lack of counselling and consent procedures –coercive contraception PPIUCD
- o Incentive –position paper CH on conditional cash transfer for contraception
- o Budget analysis needs to be done

Evidence building: Current RH histories research would bring in evidence

- Generate evidence using advocates guide
- Other evidence –some info form partners using mobile technology to identify gaps in member locations
- Checklist on gaps through mobile
- Identify member states who have capacity to do this, who takes responsibility – appoint link person there

Advocacy goal: Increase awareness about contraceptives and services [availability]

There is already ready content on this-RH pamphlets

Audience: community

Strategies: existing CH pamphlets could be used, member organisations can use it in their communities , at community level programs, Translation required in local language by members in each state

Opportunities: Follow up with partners – state level, national level JSA- CH can use evidence

M and E: Increase in awareness using pre and post-test survey

II. Comprehensive sex education

Improvement and implementation of RKSK: A situational analysis [district, block and PHC level] in the states where it is working can be done by the members, this will form evidence. Secondary data can also be used to check info on adolescent health. Additionally RH histories research project can inform on this issue.

Audience: people with youth led organisation, youth clubs, adolescent groups/VSC? Nehru Yuvak Kendra, front line health workers –ASHA, ANMs, MPW, FHW, Service providers and facility

RKSK at different levels- what are the GRs?

Message: Implement RKSK, ensure budget is spent

Strategy: Increasing dialogue at various levels, mobilise youth groups, create platforms and mobile youth leaders to generate demand-Community based monitoring

Use already existing resources to reach out youth consortium, use them and forge alliance with them

M and E:

- Increased awareness of RKSK in different CH member areas,
- Increase awareness among service providers , RKSK functionary –action
- Increase awareness of healthcare providers
- Improved responsiveness of health system within RKSK
- More self-reported actions by frontline workers
- Perception of youth – conduct FGDs and document

Strategies: Contribute to alliances, align with RKSK with national level, contribute to position paper on adolescent RKSK , CSE and POCSO

III. Unnecessary Hysterectomy

Increasing awareness among hysterectomy

Audience: Community

- Producing information pamphlets on hysterectomy giving information on medical methods : Vaginal and abdominal
- Producing awareness videos and posters
- Policy advocacy for prevention of unnecessary hysterectomy through audits
- Media advocacy : scroll/wire articles
- Advocacy based on findings of RH histories research at state and district level
- Discourse building
- Other alliance among CH members

Group 2: Maternal Health Theme

Issues of safe child birth can be looked at, child's progress and mothers perspective

1. Issue: C section delivery – both low and high

Audience: Can be community-Women [who gets who don't get] and HCPs

Evidence: Prepare factsheet on C-section deliveries that gives information and knowledge on what is C section? why it is needed?, when needed , the myths surrounding it etc.

Ask women, why they want C-section, Keep written document of it. It has future implication for child bearing.

Unnecessary C-section: What could CH ask the policy makers?

Message: Give clear message so that women can act on, Ask provider to write on discharge slip , the reason of C section

Policymaker – advocacy at state and national level

All facilities should report C-section and some system should be set up as to:

- Why it was done?
- Economical/ cost?
- Voluntary or otherwise?
- Audit mechanism needed

This way evidence can be created and taken to advocacy at the policy level

Allies: FOGSI is an important ally to get on board, for rational practice =JSA and other health movement , consumer groups –ADEH, patient right's , association of doctors for healthcare

Midwifery policy guidelines – there was a discussion that it is elitist guidelines , CH need to build critique of it.

2. **Issue : Perinatal Health**

Initial plan is to build evidence [not as a proper issue] for maternal mortality and monitoring of births [both for mother and child]

- Simple tool to monitor –Outcome of births
- C section - low rate – need to link it with outcome
- Dr Barnes suggested for a population of 1 lakh- outcome monitoring can be done for a year. The survey tool should be filled at the time of the birth, 7 days and 30 days. For a period of one year this should be done to know what are the outcomes of monitoring? Then it would make sense of outcomes where delivery is C section and no C section. NSRCC looks at MDR [maternal death review], Her organization has have applied for the grant.
- Evidence : Existing work of maternal health
- Manual , DWT evaluation study, state capacity building
- Opportunities : Grant of LSHTM to do MDR
- SDG Equal measure project: looks at functioning of MDR committee, synergies being created between SDG project , NHSRC-LSHTM

Group 3: Safe Abortion Theme

Issues have been chosen as per familiarity and capacity to work it out.

1. Lack of awareness of Abortion – with CBOs and professional organisations
2. Confusion between PCPNDT and MTP
3. Availability and access issues of abortion services

Gaps: Mapping of services – what exist / where services are not available?

Advocacy goal: Ensure all women able to access full range of services [Medical abortion, surgical abortion, 2nd trimester abortion]

Primary audience: state, district and CSOs level service providers

Message: Abortion is legal, what is the difference between sex determination and safe abortion

Strategies: evidence building , producing IEC material and using existing one
- Knowledge product where there is lack of coherence [conflation of Act , Budget allocation]
- Capacity building of CSOs
- Alliance building

M and E- indicators for strategies [capacity building of partners – pre and post-test]

- Opportunities : Check availability of CH members at district and state level to take this forward
- Social media use to increasing awareness /advocacy
- Explore states where MMR is less, check safe abortion services there
- Align SA agenda with MH and PPIUCD
- CAC centers in Assam: 1st trimester abortion - quality control, upgrading abortion centers , focus on abortion and contraception in that facility

Risks: 3 major

Community based organisation –GAG rules, growing anti- abortion sentiments
2021 census: if the ratio of girls is low –sex ratio, possibility of backlash

Mitigation: delinking strategies: sex selective abortion is gender issue and safe abortion is women's right issue , National funds needed

Critique: how calculation of sex ratio in 2 years, need credible data to challenge, data sources not credible, inconsistencies in data can be highlighted-economic survey data /CRS

Post presentation discussion

- Maternal Health –there is a need of strong funding to track perinatal outcomes , sustainability in long run
- Dr Subhasri suggested that there is need to build synergies within the alliance .She further summarised : there is need to look at all the three themes. While there are newer opportunities , there is need to build on existing work
- What is realistically possible given the membership, funds, fund holding organisation should be taken into account. There is need to practically step back and reflect on these.
- There was a discussion on CH strengths and weakness and the administrative arrangements.
- There is a need to build synergy and structure between three groups
- Is there are need to reach out to NAMMHR, WRAI? And work out collaborations?
- Need also to discuss broad strategies for CH organisation tomorrow
- Dr Kaul suggested that activities among the three groups should not be done in silos and suggested that the position papers should go through all three groups for review.
- The three groups should be linked to the THEORY OF CHANGE
- CommonHealth can create universal discourse for existing issues , coherent discourse- strength of CH is CommonHealth's common ground approach

- Abortion: decriminalising statements for members and other groups
- THEORY OF CHANGE should be overarching vision , mission and strategies - should include marginalised and vulnerable , intersectional populations, Feminist principles, protecting spaces for young people, disability
- Biomedical issues: hysterectomies, C sections, what about anaemia, blood availability – member issues?
- Do CH members speak out on layer societal trends? Hysterectomy and C section within public health system, meta level discourse?

Commonalities across three groups: Dr. Souvik to work on a matrix for three groups

Session 4: Monitoring and evaluation of CommonHealth's work (across 3 themes)

Facilitator- Dr. Ms. Renu Khanna
Chairperson- Rahi Riyaz

The objective of this session was to work on the developing M and E framework for the CH work for next five years. The discussion was focused on the expected outcomes and measurable indicators for local, state, national level .

After 5 years ie. 2025, work of CH is evaluated on following points:

Ms. Renu made a presentation as follows:

1. Activities done
2. Strategy suitable or not?
3. Knowledge products

She talked about DAC evaluation [OECD framework] could be used. This has following components – relevance, effectiveness, efficiency and sustainability.

- What is the relevance of CH work?
- How is CH changing the situation?
- What is the mission statement , key ideas , values
- How inclusive is CH with respect to marginalised and vulnerable groups , gender justice
- How strong are our alliances?
- What are the process indicators for monitoring?
- How strong is our membership – qualitative and quantitative data
- How strong and effect is our coalition ?
- Steering committee strength- is it representative of communities ?
- How active and diverse is our membership?
- How responsibilities are shared among SC?
- What about communication within SC?

Achievement of our mandate

- To what extent CH is moving towards our vision and mission?
- What have we as CH members been able to influence in the field of SRHR?

Strategic indicators

- Advocacy: Is that based on Theory of Change?
- Increase in CH membership
- Outputs – addressing member needs
- Citation of papers and knowledge products in each thematic area, peer reviews
- Strategy ad principles
- Only members are not enough , there is a need contribution for the activities
- Number and type of activities for perspective building
- Process of evaluation of activities
- Number of SC meetings
- M and E framework – somebody needs to work

Discussions and suggestions

- Dr Kaul: Monitoring number of meeting would be good
- Dr Alka: May not be a proper indication but effectiveness of a meeting /decision taken is an indictor
- Dr. Ms. Renu: It is difficult to assess the impact of advocacy , through membership assess the impact of coalition
- Dr. Nilangi: In each SC meeting how can it be analysed? Indicators must be measurable .
- How would communication indicators be measured?
- What is CH doing to measure diversity?
- There should be a balance between volunteerism , accountability and reflectiveness
- Swati: annual reports of CH activities at the end of the year can be prepared . It is good way of tracking CH activities yearwise. Who will do this?
- Ms. Renu: How can the advocacy be evaluated? What method?
- Self- reflection: knowledge product –what is the quality?
- There was a discussion that there could be measurable indictors in project based activities, but in coalition how does one have measurable indicators ?
- Dr Nilangi: Strategies are fixed to some indicators , inter check after every activity of project. Ms. Renu: To see impact – what is contribution of CH to any change in policy or advocacy
- Dr. Nilangi suggested a small group should work on assessing this, annual report, post activity reflection [feedback forms]
- Ms.Sanjeeta: Loose coalition but some criteria should be there – phone surveys, survey monkeys, whats app survey with members
- Dr Barnes: Membership should be evaluated , presence of membership in General member meeting
- There is a need of resources /active engagement –negotiable and non-negotiable things, website is Non negotiable

  FRAMEWORK FOR EVALUATION :Dr Kaul : Will prepare a framework for evaluation of CH based on the discussions. He would submit it to the group around 10th of August.

  IMPLEMENTATION PLAN: By 22nd August :Dr. Nilangi, Ms. Renu, Ms.Sanjeeta, Dr. Souvik should finalise the framework for monitoring and evaluation and send to

general body for comments. By the end of August come up with the implementation plan.

Session 5: Increasing visibility of CH work

The session deliberated on questions like

- How much is CH visible in alliance /impactful visibility? Where does CH want to be visible?
- Use of social media, publications , website
- How should CH members present themselves when they go to meetings? Card? Brochure?
- Ms.Sanjeeta: What kind of visibility? How does we as CH representatives want to be seen? What Brand value?
- Dr. Satish : Visibility required for members also eg. SC meetings, Vision and mission statements to be sent out
- Dr. Nilangi: there could be different objective of different visibility. Website can have more technical material on gender + rights perspective whereas social media can have funders credibility, positions- perspective to unconverted public. Need dedicated time for this.
- Regional meetings: People write to CH, how do we respond these emails? There was a suggestion that it should be brought to the notice of SC group/theme leaders if there is an email enquiry.
- Ms. Renu: Why visibility needed: if CH doesn't have visibility then it won't be invited for other meetings and alliances
- Dr Subhasri put forth the question 'Why do we want to increase the visibility? On which areas we need visibility?'
- Dr Kaul: CH should take up issues at regional level and conduct meetings and press conferences
- Ms.Sanjeeta: For social media visibility , there is a need of a dedicated team for that who does look after it full time. Some of the CH SC members should take this tasks voluntarily.
- Dr. Nilangi: Website is non negotiable and we need to update it as it gives information about CH. we have to reorganise the content and resources available on the website thematically and chronologically. In order to take CH's work and approaches to different communities , we need to update the CH website regularly

- CH also need to update NFHS 4 data on its website. For this Bhuvana can be approached if she would like to take this assignment.

- There is need of some good photographs from field and regional meetings for website. Need to take guidelines from IDX Sussex on posting pictures on website. That doesn't need consent for posting pictures.

- The website should be user friendly and mobile friendly and can be android compatible .

- Dr. Alka: Our work on abortion doesn't get predominantly reflected well on our website.

- Bijaylaxmi: Website should also be able to keep a tab on the no of hits and likes . Institutional membership of CH should be displayed on the website [after their consent].

- It would be good to put a link on RHS [rural health system] data on the website.

- SC members should take shared responsibility of reviewing the available content on website and giving suggestions for reorganising after which Swati and Dr.Nilangi can work on it with the web designer.

- Maternal health content /resources online would be reviewed by Satish and Dr Subhasri, Abortion theme content by Alka, RH content by Ms. Renu and Bijaylaxmi.

Session 6: Increasing membership and Alliance Building/ Energising membership/Responding to membership needs

Facilitator- Ms.Sanjeeta
Chairperson- Rajdev

The deliberation was done on involvement of CH in Health issues beyond its core areas (such as representing CH in other movements/alliances/campaigns, issuing statements on various health system related matters)

Following issues were discussed:

- Renewing membership
- Who can become a member?
    - Safe abortion perspective
    - Overseas-Indian and non indian

- Surge in membership during meetings but now slump
- Alliances : with JSA, need to reach out to other alliances
- What happened after December 2016 meeting?
- Alliances with academics , journalist and lawyers

Communication and interface

Dr Nilangi shared her concern over connecting to the CH members and building interface with them which is not currently happening. She raised question, 'how does CH engage it's members'?

She said that people join in meetings for a year but no further communication happens with them, there is need to remind them. Communication with members is weak , we have not been able to keep them engaged.

She shared that in JSA they don't have much funds and hardly support travel but at CH travel is supported and even though people come they don't contribute much. There is need to plan program to involve members . There is no sense of connection 'Judav'with CH unlike JSA. A need for 'Energising movement' periodically for felt.

SC members can play an important role in their respective states/regions by engaging with the CH members there. They can be an important link between General members and SC.

As part of JSA membership , state level collaboration can be thought of.

Question on who can become a CH member was addressed. There were some request by people abroad to become CH members. Dr. Subhasri informed CH already has an overseas membership.Non Indians , non residents have been members. But it was decided not to have overseas membership as it will have issues with the membership money as FCRA will be applicable. Also there may be issue of anti- abortion sentiments .

Inclusiveness: Rigid standards of membership to be avoided, To be member but not SC

Other principles and values: Feminist, anti sexist , power hierarchies-necessary to subscribe to these

Inclusion needs to have sharp criteria , also rules of removal of membership.

Format for membership: Hold regional meetings in every region once a year and conduct workshop and take their inputs. For example if its Kashmir's blood bank unavailability issue-have a blood donation camp, put CH name to be represented.

Exclusion : 1] explicit controversial position , only after due process
2] divisive politics , hate speech

All these can be criteria for exclusion. CH needs a disciplinary committee and a process to regulate these issues.

CH representation : There should be guidelines for representation of CH and for joint program with CommonHealth.

Ms.Sanjeeta: Geography is not a criteria for membership but money in INR is a problem, she suggested not taking membership fee in that case. There could be honorary membership for overseas people.

What are criteria for membership- Dr Souvik suggested to draft key words

Involving and engaging members: Dr Kaul: make members work and contribute such as easy simple tools, compilation, reports etc

World Abortion day : Dr Alka: 28th Sep2019 is World Abortion day and CH can have a campaign. Ms.Sanjeeta asked many organizations are doing what will be specific that CH can do? Love matters /hidden pockets have online presence.

CREA had approached CH to collaborate on 28th Sep , engage with alumni of institutes.

Why are members dormant? And what is the communication gap?

Bijaylaxmi suggested to find out why old members have dropped out, she suggested calling them and thank them, making some constant communication and rapport.

Rahi talked that CH has membership in different states and there is possibility of making a cadre of volunteers as regional coordinators for that particular state. All the 3 thematic areas – those particular days [abortion day, RH or MH day] should be celebrated with some programs/campaigns on that day in states.

Alliances : CH should invite his alliances to take membership

Institutional membership :

Talking about the institutional membership, Dr Subhasri raised her concern over engaging with the institutional members and how that could be done? There is need to build synergies with the regional meetings? There is need of a separate strategy for institutional membership.

Statements

Dr Alka: CH usually endorses statements by other groups. That's easy way out. CH should also take lead and put out statements for increasing it's visibility.

Dr Subhasri- CH should take leadership on the issues and thematic areas relevant to its focus. For putting out statements, time is the issue. Statements need to be done on time, before others take the lead. Also important to keep record of issues endorsed

More fact findings should be done like Badwani/Bilaspur. One senior and one junior can team up to do this.

Dr Souvik suggested there is need to put out posts on social media like twitter and even repost , comments on social media on special days [abortion day for eg] . Active social media presence is needed.

Dr Subhasri: Maternal health legal collaborations on instances like blood availability, Oxytocin etc

Remembering and incident and commemorate

Day 3: The discussions were focused on resolving admin matters and ensuring smooth processes of functioning

Day 3 began with the review of deliberation and decisions taken for RFSU for past two days.

- The team felt that there was need to hire someone fulltime for this project.
- Ms. Renu asked the team if this amount of discussions and planning is okay with the team to move forward.
- Alka expressed her that 'she is okay with this for now'. But expressed need to do some fine tuning to have greater clarity. She believed that the current set of planning sounds more practical and doable given the resources.
- Broadly the project has remained same but the number of activities that would be taken up are lesser than earlier decided- where there were whole range of activities listed.
- Dr Souvik: suggested that if other CH members want to take up the activities in their areas the reach will be more. This needs to be explored with the members
- Dr Nilangi opened this suggestion for all the members and insisted them to think and those interested may join with commitment.
- There was an opinion that those who have done some work in the area of abortion, they can be selected and approached
- As SC members , there is need to have a one day concrete meeting to see who wants to join and how they can take the project together
- It was decided that those who wish to do it, may be given some consultancy support
- Alka suggested CREA, Samyak with whom CH already has existing alliance , there support can be leveraged
- Focus of the advocacy has now become narrow, few but focused activities so reach will be more

Session 1: CommonHealth Organisational matters

Facilitator – Ms.Sanjeeta
Chairperson – Alka

The following points were put forth for discussion :

i. Organizational structure [Size of Steering Committee]
ii. 2. Roles and responsibilities of SC members, CH office bearers and CH Coordinator
iii. 3. Composition of leadership of CH- representation of marginalised communities in CH-SC

There are total of 11 SC and 3 special invitees in the present steering committee. It has been noticed that only few people take responsibility and take the work forward while others take the role of just agreeing to what is been done. There are few who are actively involved. CH has been inviting all SC members and providing them with travel support. Cost wise, it has huge implications as people do come but they do not contribute much. What is active contribution? How this can be addressed? There is a need to look at the individual contribution of SC members for it to become a dynamic committee.

There was a discussion on whether the present number of SC members is okay or is it large. Though there is a value in having a larger SC, there is a need for efficient committee members. Just because somebody is a SC member, CH will not support any and every meeting travel and other logistic arrangements.

SC is an executive body and along with office bearers has carry out the administrative responsibilities. They have to put extra effort to take care of executive functioning. So SC has to take on executive role.

As SC member 2-3 people take the lead and take the agenda forward. But in context of cost, 1- 1.5 lakh INR are spend on travel alone. Keeping in mind the kind of resources CH has, there is a need to take a call and ensure only those who need to be present and have a role in the meeting should attend the meeting. Not everyone is required for every meeting.

The theme leaders should be present in the meetings and should go back and take the discussion to their team to take work forward.

Ms Bijaylaxmi, Mr Gogulwar , Mr Chaturvedi all have presence in your area and doing great work. As SC their contribution to CH is not as much as to their own organisation. They expressed that CH should involve them in activities that they are good at, look at the possible ways of engagements.

As previously discussed, there could be state coordinators who could be appointed and they can work with the core committee. Core committee should be 2 office bearers and 3 members.

Ms. Sanjeeta talked about the discussion in the past about the feasibility of time given by SC members. There are substantive issues, few take the lead and make strategies or plans and rest all agrees to it. There is no dynamism, no challenges , questioning or discussion rather no views are expressed. It should be changed , everyone should be able to put forth their opinions.

Dr Alka gave a message to the group ‘We are all equal here. Even if the founder is saying something , we should be able to challenge or say something.’

Dr. Subhasri expressed that it was an important issue that has come up and needs to be addressed. She hinted not to go to specifics as it is not good for organization.

Ms.Sanjeeta raised concern over thought leadership. She expressed that not all members in SC are getting opportunity to take the lead and responsibility of thought leadership. There are silent agreements as she discussed this earlier also and urged the group to think through this.

Ms. Renu spoke about the representation in CH. She said, 'state representation is there but constituency representation also has to be thought of'. Pointing to SC committee she said, 'It is unwieldy'.

Further she opined that if states take up CH membership, then it has greater advantage as CH becomes rooted but how do they contribute to CH is also important.

General body meeting: One of the important feature of GBM is members should be able to keep the issues forward.

Mr. Rahi: Can people from the government become CH member? The group has reservations and could not decide on this.

With regard to giving time for CH, Dr Satish suggested there should be some planning done beforehand. He talked with regard to involving CH partner in CH advocacy. He expressed his will to take up the project on C section. He said there is lack of communication from CH to partners, that kind of communication and activity is needed.

Ms.Sanjeeta talking on the issue of representative with SC said: What marginalized communities is CH representative of ? Does CH need to identify people by their caste identities as dalits? How does CH involve young people?

Mr Rajdev: Expressed his inability to understand and communicate in English over emails. He said he had agreed for 2 days of engagement for CH work. He said they have been engaging in the activities of CH and he would like to know about what are other ways to engage. For CH , in the past GPS has done data gathering etc. what are the other ways to contribute , CH should let them know.

Lack of resources – people can't take up work as they have to depend on some sort of financial support. He expressed that they can engage in the activities planned for 28th September ie. Abortion day.

Dr. Nilangi informed that it is CH's failure not able to engage the partner and leverage their presence in the states. There is lacunae in planning at CH. There should be a yearly calendar prepared for CH with fix days [like abortion , MH, RH etc]. Also efforts to do press conference, give out statements and articles in media.

Broader planning of CH needs to be done:

- Mobilise strength of members in their own capacity. Partners can't be expected to do everything as they struggle, instead make them take up what is their forte
- CH can utilize the strengths of partners
- Dr. Alka informed that MAMA Cash application was rejected because of representation of marginalized issue in the committee
- Dr. Nilangi suggested larger body should take decision and smaller body should execute

In context of being representative of marginal communities, Ms. Renu said different partners work with different marginal groups such as SAHAJ- adolescents, GPS with Dalits, Aamhich amche with tribal and they do bring in their perspective in the CH work. Interest and identity are different. It has never happened in the SC group that someone's caste is been probed or identified. She raised the question, 'why that should be exclusively done?', CH can't be tokenistic. There was need to discuss this , should invite Manjula Pradeep.

Dr Subhasri- People have different skills and strengths , differentiation is different .She then highlighted some of the issues such as language barriers as something which bars some people [RUWSEC researcher] form fully participating. She stressed the need to have a mechanism to increase inclusivity as an organisation, and that CH should be multilingual.

Bijaylaxmi: She expressed her apologies informing because of the current commitments in the organisation , she was not able to actively contribute. Also she said she was trying to listen to the discussions and gather understanding of organizational processes hence she wasn't speaking much.

Rahi- asked as to why RH study was done in only few states? Dr. Nilangi responded saying it's not state wise but more as per the marginalised groups and partners who were willing to take up this research commitment., who had strong presence in their geographies.

Ms. Renu further explained the process informing that how the need and methodology of this research was discussed in the past meetings. 2017, there was this tool development meeting in Chennai , before which in 2015 there was a big consultation where different groups sex workers, disability, LGBTQ etc had come and expressed their interest.

In the 2017 meeting , the need for evidence building for RH morbidities was spelt out and CH took up this work and identified groups, these groups brought their perspectives on how vulnerability is add to RH help seeking. Many groups had come to 3 day meeting and there was intensive discussion, people had invested a lot. those who show interest and continuity were finalised.

The resources are less so in the first phase CH could engage the finalised groups who approached in the initial RH meetings and see the methodology and how it would work, what are emerging finding and then think of expanding to more groups. There are resource constraints.

Moving forward, Dr. Subhasri said if Amhich Amche [Dr satish] wants to take up the activity and needs training , CH should do it.

PWN [Positive women's network] on the other hand are struggling for funding support to carry out study. They can't be expected to carry out the study without support , at least some sort of travel reimbursements are needed.

Partners are small organisations, they have small teams and resources and manpower, need to think about support for them for any activity to be undertaken.

Mr Chaturvedi raised question: if it was possible to hold a yearly meetings of all partners and they come together to sign campaign to involve organizations?

Further the possibility of raising funds through regional specific proposal was discussed. If any partner is interested, CH can pitch in and help with regard to putting up proposal.

Dr Souvik stressed that there is need to have a broad annual plan. Members who ever are engaged or interested for them ,CH should have an annual plan , think of distribution.

Youth led organisations – can help with concretising plans for partners. CH takes its own time to decide and plan, but partners might not have that flexibility.

Dr. Nilangi said, 'some alternative ideas have come up'. Organisations write projects, CH will provide technical support and input organisation. Non SC member in that state can also join in to work this out – this model can be thought off.

This discussion is important, there is need to modify new model of CH in decision making and functioning.

Dr. Subhasri informed the discussion on this has happened earlier and suggested that it should be equal effort from both sides- both CH and member organisation.

Ms. Renu asked, 'What were the global processes? What if CHs it's own position papers actively for local and global advocacy. CH need knowledge products ready to be able to take it everywhere.

Ms. Sanjeeta: spoke on the issue of logistics for the CH meeting. Some members felt their views were not taken into consideration while finalising the logistics [especially venue] of the meetings. Members felt they are ridiculed and decisions are taken beforehand without consulting them. This needs to be resolved and discussed.

Dr Subhasri – expressed her view that somewhere the decision has to be taken after listening to everyone.

Dr Nilangi felt these were loose statements and such kind of communication is detrimental to the organisation. Every decision has a rationale. They are taken considering the low cost, availability of members. Also this time Ms. Renu's availability was needed, she couldn't move out due to personal restriction and another important thing was to have an introduction of SC members with the SAHAJ accounts team and discussion over the financial /logistical issues face to face for better understanding. When there is logic given to why so and so venue was finalised, why there are questions raised? It is not fair to have such comments.

Ms. Renu however said that good the perceptions are surfacing and there is opportunity to clarify. Everyone's views are counted and decisions has to be taken within the timeframe by the office bearers.

Dr. Alka suggested to talk about all the issues openly, and not to few members internally. Dr Subhasri suggested that if anyone has any issue, he/she should put out in the larger group. She put forth question like what does this mean for future? Decision making process? Logistics? etc. Talking about RFSU, she said after consultation with every team member, Alka takes the final decision..

With regard to payment process, Ms.Sanjeeta stressed on the importance of hardcopies for approvals to release the payment. In midst of this discussion the SC applauded Ms.Sanjeeta's significant contribution to accounts team. Dr Nilangi was also applauded for her commitment and transparent communication, timely and rational decisions etc.

It was discussed that founders members have brought this ethics and culture to CH functioning.

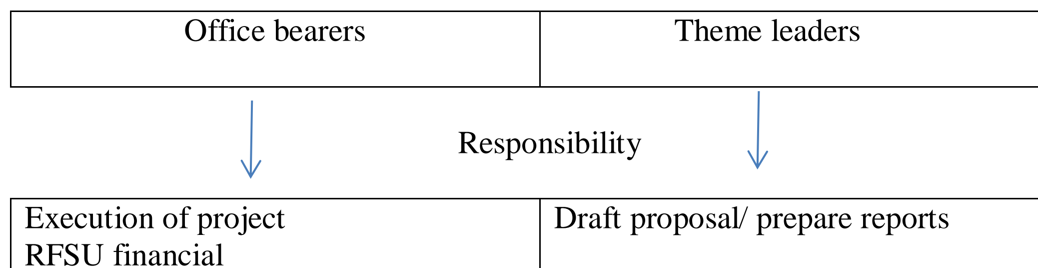
So the decision was taken that after listening and taking note of views from all the members, final decision will be taken by office bearers in timely manner.

Core committee comprises of 3 theme leaders, 2 office bearers [chairperson and financial advisor] and one from fund holding organisation , making it total 6 member core committee. The decision making should be done by core committee and functioning should be taken care by executive committee.

Core committee should work on statement giving.

Not all SC members would be able to comment on all issues, specific topics specific person can share the inputs.

Model could be as following:



Discussion on theme leaders:

Dr Priya has committed for 2 days a month for CH work. But for theme leader there was a need for someone who is more involved and engaged to push the team and keep the work rolling.. Someone who could give more time and inputs.

Few suggestions were to take on board: Dr. Nidhi Shukla, Dr.Sana Contractor as MH theme leaders are they have relevant experience in that area.

Earlier June meeting mentioned names of Vaishali from SAHAJ, Sunanda Ganju, and Smita Bajpai.

Non SC –GBM members : Dr Wani, Ms. Indu, Hilal, Dr Arvinder, Dr. Anita Rego, Ms. Bijaylaxmi, Rahi

Safe abortion team members listed were: Bhuvana, -FRCH, Preet, Dr. Amita, Dr. Sundari, Ms. Radha Arya, Ms. Manjula, Mr. Rahi, Mr. Rajinder

Pallavi could be thought of for MH, Smita also has thought leadership. Dr. Bhuvana can be asked for RH theme leadership.

For decision making, there is SOP that Dr Sundari had suggested. Write that and include in the roles and responsibility
RH histories research : Include expected outputs in the TOR, office bearers to finalise the TOR. Make TOR with the individual and not with the organization as advised by the SAHAJ auditor.

Income tax liability: factor in that money in the payment and accordingly pay so the individual doesn't have to deal with that issue.

Session 2: Joint meeting - SAHAJ accounts team and CH Steering committee members

SAHAJ	Introduction FC + Domestic account	SAHAJ-CH agreement
	FC money should be utilized for FC grant purpose only.	Agree, no subgranting of FC money
	FC money can be paid as Sub Grant to other FC registered NGO with prior approval of grantee.	Agree
	To Meet FC compliance , It is advisable to do Individual consultancy contract.	Agree
CH	SC meeting minutes signed copy maintain at SAHAJ.	Adhoc functioning needs to be streamlined
	CA ask for work/liabilty structure. Who is reponsible for what?	CH structure is there , it can be sent to SAHAJ CH should make a standard template of budget heads
Budget Note	It would be good practice to write a budget note on what is the budget, what cost will be used for what.	Agree, CH should write a note that this cost will go to SAHAJ
Payment	Sahaj - Cheque sign days are Tuesday & Friday subject to availability of Trustees.	Agree
	Request to provide approved payment details with Project name and expense head.	Agree
Event / Meeting / Workshop	Participant list shall match with Travel ticket booking, Room booking and no of food plates billed.	Agree

	If any cancellation - it shall be noted and follow up should be done for a refund if any	Agree , In case not possible, CH should put a note saying prebooked for so and so number that's why the payment was made.
	Expense supporting invoice shall be with the name of SAHAJ.	Agree
	For Cash Travel reimbursement	**Agree**
	Travel form should be filled properly with date, project name, event name , participants name	
	Arrival journey original supporting expected.	Noted
	For auto/taxi - ask for place/area to place/area details instead of the city name. For Petrol reimbursement - reimburse only kilometres instead of the petrol bill.	Agree
	One should not rewrite on the forms/vouchers, it is not acceptable.	Noted, upto Rs 300 vouchers can be provided.
	Submit travel form only after verification, sanctioned sign and Recipient sign in each form.	Agree
	Participants original list.	Okay
	Verify and arrange the required supporting of Travel form and other invoices, get sanction and then courier it with Cash expense summary showing advance and balance left details.	Agree
	Please do not inter transfer amount directly.	Agree
	Please note that butter paper prints get wipe out within 6/7 days. Sahaj does not allow reimbursing to wiped out supporting.	Take the photo and send the soft copy along with the hard copy
	May I request to not to courier any expense details of event direct at account office, it should be first verified by concern person. Supporting should be with the name of SAHAJ.	Agree

Travel Policy	Archanaben would draft standard guidelines for travel and other logistics and send The guidelines to need to be circulated to the participants before every event.	
	The guideline should mention reimbursement policy that participant should preferably look for economic options. One person can't be paid a large sum, sometimes in case of exception, if required, the travel should be approved by the Steering committee members.	
	CH can write a note on the clarity of to and fro payments that sometimes back journey cost more than the to journey. However, for payment for private taxi bills etc. put a cap such as maximum Rs 2000 can be paid.	
Consultancy Invoice -	mail Soft copy of the signed invoice with log within 2 days of next month. Please mention the Invoice date 30/31. Take sanction of your invoices in time. Sahaj is liable to pay TDS up to 6 days of next month.	Agree
Concall	SAHAJ-CH can arrange monthly fix concall between us. If possible it can be on 1st & 3rd Saturday between office time i.e.10-5 to discuss require things.	Agree

Session 3: Concrete Planning of activities for next one year for RFSU project

Following points were discussed :

- Arrow is going to do a solidarity alliance, they have invited CH. CH-ARROW can do it collaboratively.
- CH should be more active in setting the agenda , even if CH gets few minutes , it is okay
- 5 partner meeting is yet another idea
- This is critical strategic RH thing- there is need to think what CH can collaborate upon?
- Rajdev ji informed that they have sent a proposal on family planning and safe abortion to some funding agency
- Arrow has a satellite session and solidarity alliance – If CH decides to do, then it should be up to us as to what to do and on our own terms.
- IWHC: If CH is asking for more grants for project- pad that money, budget needs to be worked out

- CH should showcase our work. It can show case RH work from accountability perspective , RFSU research, CBM that has happened and evidence generation done till now.
- What are the areas that CH want to focus on?
- Abortion work can be presented to increase visibility , Solidarity alliance anyways has abortion theme
- There was a discussion on what can be done at CH to influence that agenda?
- Dr Souvik should pitch in and inform that CH is working on SDGs, rights and explore when is the best suitable space?
- CH as an entity should get into policy advocacy spaces
- Make a google calendar regarding policy opportunities , Ms.Sanjeeta should provide the list
- Those who attend meeting should represent CH or otherwise?
- Person attending meetings should a sent update/report to the group just to inform what is happening?
- There are lot of funding available with In-roads, it could be explored.
- Dr Souvik suggested that IBIS, Matrix, IPAS are together doing stigma abortion scale and there is an opportunity for CH to collaborate and work on this.

Final steps to move forward

To do list for SC members post 5-7th July planning meeting

S.No	Tasks to be done	Person responsible	deadline
1	MOUs for RH histories partners	Ms.Sanjeeta	ASAP
2	Write to IWHC asking for extra funds	Dr Nilangi	11th July
3	IWHC- write mail for 6months no cost extension	Dr Nilangi	Jan 2020
4	Narrative report to IWHC-Check what needs to be done	Dr Nilangi	One week
5	Travel policy guidelines	SAHAJ team	
6	RFSU Abortion advocacy project		
	THEORY OF CHANGE and advocacy will be revised on 2 components Knowledge product component Campaign for 28th September	Dr. Alka	July end
	Advocacy component list	Dr Souvik	July end
	Check available budget for satellite session	Dr. Alka +Ms.Sanjeeta	July end
7	Check translation of **3** FP pamphlets to Hindi[3]	Dr. Alka	Alka to decide (depending on

			receipt of the pamphlets)
8	CommonHealth Website		
9	Content review for Maternal health	Dr Subhasri +Dr.Satish	15th july
10	Content review for Reproductive health	Dr Nilangi+ Swati	15th july
11	Content review for Safe Abortion	Abortion team	15th july
12	Photos suitable for website	Dr.Priya	July end
13	Matrix for CH planning 5 years	Dr Souvik+Ms.Sanjeeta	15th July
14	Monitoring and Evaluation framework	Sunil to send the draft Dr Nilangi+Ms. Renu+Ms.Sanjeeta+ Dr Souvik	10th August Finalize within one week
15	Alternate governance structure for CH	Dr Nilangi	July end
16	Report of the planning meeting	Swati	20th July
17	Send meeting notes to Swati	All note takers	ASAP
18	Activity tracker /google calendar	Swati	July end
19	List of activities /events/opportunities to be marked for CH calendar	Ms.Sanjeeta+ Dr Souvik	ASAP
20	Send travel guidelines of other organisation	Dr.Alka	ASAP