CommonHealth Experts' Consultation on Women-centred Maternal Healthcare

15th & 16th March 2024 at Mumbai

CommonHealth

DOCUMENTATION REPORT

SAHAJ on behalf of CommonHealth
SAHAJ, 1 Shri Hari Apartments,
13 Anandnagar Society,
Behind Express Hotel, Alkapuri, Vadodara,
Gujarat, India 390007
Tel: 91-265-2342539
Website: www.sahaj.org.in
Email: sahaj_sm2006@yahoo.co.in

Contact:
Swati Shinde
[Programme Manager cum Co-ordinator, CommonHealth]
Email: cmnhsa@gmail.com
CommonHealth website: http://www.commonhealth.in

Layout Design: Sanskruti Designers, Pune

CommonHealth Experts' Consultation on Women-centred Maternal Healthcare

15th & 16th March 2024 at Mumbai

CommonHealth

DOCUMENTATION REPORT

Content

List of abbreviations

ANC	–	Antenatal care
ANM	–	Auxiliary Nurse Midwife
ASHA	–	Accredited Social Health Activist
AWC	–	Anganwadi centres
AWW	–	Anganwadi workers
BSKY	–	Biju Swasthya Kalyan Yojana
CDPO	–	Child Development Project Officer
CH	–	CommonHealth
DH	–	District hospitals
DWCD	–	Department of Women and Child Development
FLW	–	Frontline workers
FRU	–	First Referral Unit
GNM	–	General nursing and midwifery
Hb	–	Haemoglobin
HCP	–	healthcare providers
JSSK	–	Janani Shishu Suraksha Karyakram
LAQSHYA	–	Labour room Quality Improvement Initiative
MH	–	Maternal Health
NRCs	–	Nutrition Rehabilitation Centres
PNC	–	Postnatal care
PPIUCD	–	Postpartum intrauterine contraceptive device
RMC	–	Respectful maternity care
SC	–	Scheduled caste
ST	–	Scheduled tribe
TN	–	Tamil Nadu
UP	–	Uttar Pradesh
VHN	–	Village Health Nurse
VHND	–	Village Health and Nutrition Days

Perspectives from the ground: Consultations with grassroots women

Background and Introduction

Maternal health refers to the health of women during pregnancy, childbirth and the postnatal period. Over the decades, much effort has been exerted to improve maternal health world over. However, maternal healthcare remains a major challenge to the global public health system, especially in developing countries. Moreover, the gap in the risk of maternal deaths between developed and developing countries is considered as the most significant health divide in the world. In the years since independence, the Indian government too has taken measures to address maternal health. In 2018, the Government of India introduced the concept of midwifery services throughout the country with the aim to create a cadre for Nurse Practitioners in Midwifery who are skilled in accordance to International Confederation of Midwives (ICM) competencies and knowledge, and capable of providing compassionate women-centric pregnancy care. Whereas this program is still in its inception stage, it raises concerns about overburdening the already overworked nursing staff in the country and altogether ignoring the roles of the Traditional Birth Attendant (TBA) and the Auxiliary Nurse Midwife (ANM) in childbirth care.

The key strategy of the Indian Government today to address maternal health hence revolves around institutionalizing childbirths – this approach encompasses the aspects of incentivizing facility-births, skills training medical and nursing professionals, and providing free services. It once again takes into account a narrow definition of maternal health, i.e., measuring the same through maternal mortality rates, and fails to take aspects of quality of care into its ambit. Maternal mortality remains the key indicator for measuring maternal health in India. Merely incentivizing institutional births does not completely address maternal mortality and neither does it solve the problem of poor quality of maternal healthcare. There is an urgent need to strengthen emergency obstetric services along with the thrust on institutional deliveries if maternal deaths are to be stemmed. Moreover, there is ample evidence to suggest that the very populations these maternal health benefit schemes aim to target are the same populations which are missed; women who hail from the most socioeconomically disadvantaged sections of the country are the ones who most require the financial support for childbirth services, but are the ones who lack access to the same.

CommonHealth is a rights-based, multi-state coalition of organizations and individuals, constituted in 2006, that advocates for increased access to sexual and reproductive health care and services to improve health conditions of women and marginalized communities. CommonHealth has been advocating for a midwifery-led maternal health care programme for several years. In this current scenario where the government is pushing forward a technocentric health facility-based model of midwifery, CommonHealth aims to build a discourse around women-centred maternal health care. For this purpose, CommonHealth adopted a two-pronged approach. CommonHealth engaged with grassroots organizations to derive women's perspectives on what their expectations were out of maternal healthcare, and conducted an experts' consultation meeting for their inputs into building a technically sound, women-centred framework for maternal healthcare. The present report is a documentation of the experts' consultation meeting held in Mumbai on 15th and 16th March 2024. The objectives of the above meeting were:

- To explore and understand, in the context of recent Maternal Health policies and programmes, grassroots women's experiences and perspectives on women-centred maternal health care
- Foster a dialogue with 'experts' to build a discourse on women centred maternal healthcare
- Develop a strategy to socialise the evolving perspectives on women centred maternal health care

Introduction and Background of the Consultation

The meeting began with a warm and heartfelt welcome by Renu Khanna. This was followed by a brief Introduction to CommonHealth by the Coordinator and Programme Manager Swati Shinde.

Introduction to CommonHealth

The genesis of CommonHealth lay in discussions amongst friends in 2001. However, it was formally constituted five years later in 2006.

CommonHealth is a rights-based, multi-state coalition of organizations and individuals, which advocates for increased access to sexual and reproductive health care and services to improve health conditions of women and marginalized communities. Within sexual and reproductive health and rights, CommonHealth concentrates its efforts largely on maternal health and safe abortion. The coalition draws its membership from diverse disciplines, thematic areas and geographies within the country.

Vision CommonHealth envisions 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.

Mission CommonHealth aims to raise visibility of the unacceptably high mortality and morbidity among pregnant women while also highlighting the lack of access to safe abortion services in different parts of the country with a focus on marginalised communities.

The mission of the coalition is to mobilize advocates from different constituencies to:

- Ensure effective implementation of relevant policies and programmes.
- Contribute to the development of new policies and advocate for change in existing ones, when needed.
- Build a rights-based and gender-sensitive perspective among communities, health care providers, researchers, academicians, administrators, elected representatives and the media

CommonHealth's focus is to highlight women's lived experiences and amplify their voices so as to influence the dominant policy discourse.

Swati then led the introductions of the participants. Many participants recalled their long associations with CommonHealth. Some older members recounted how their own perspectives around maternal health and safe abortion had been shaped by their longstanding engagement with the coalition. Around seven participants (from among 25) were first time attendees of a CommonHealth meeting. At least three were the founder members of CommonHealth. Participants were a mix of researchers, programme managers, community-based activists, lawyers, obstetricians, midwives, a 'public health farmer', a 'public health practitioner' and those who wore many of these hats. Since this was titled as an 'experts' consultation, participants were both those who represented 'grass roots' women's voices' – from community based organisations, as well as 'experts' - those who represented health systems expertise, obstetric service provision, researchers, and so on. They came from over ten states across the country. One person attended online. Around four or five participants dropped out at the last moment because of seasonal ill health episodes and other emergencies.

After the rich - and fun – Introductions, which served to reconnect and bond the participants, Renu Khanna went over the design and schedule of the two days, highlighting that the expected outcomes of the meeting were to

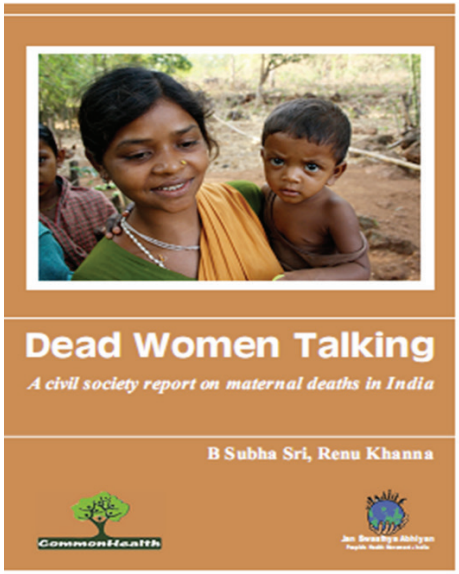
a. Co-create a position on woman centred maternal health care, and

b. To brainstorm on how to socialise this co-created vision, and develop some next steps together.

Overview of CommonHealth's Maternal Health Work

Sanjeeta Gawri presented the history of the maternal health work done by CommonHealth (see Powerpoint 1). CommonHealth frames maternal health not just as a public health issue but as a human rights issue - maternal health as a right that needs to be respected, protected and fulfilled. '*We believe all women and persons have the right to the highest attainable standards of maternal health and maternal health care and the right to the highest attainable standards of sexual and reproductive health'.* Framing maternal health thus identifies specific rights holders and duty bearers – thereby ensuring accountability frameworks, and providing scope for grievance redress. The presentation then went on to locate CommonHealth's maternal health work within the policy and programmatic context of the Government of India – the decreasing Maternal Mortality Ratios (latest figures for India – 97 per 100000 live births (SRS, 2018-20)), the focus on labour room quality standards prescribed by the LaQshya Guidelines, but no consideration for social determinants of maternal health and little consideration for accountability and grievance redressal. Increasing privatisation of health care and thus also maternal health care was also highlighted as a concern. Policy pushes for quality of maternal health care is also leading to centralisation of child births in higher level facilities resulting in women having to travel longer distances for their deliveries.

CommonHealth has done some significant work in the past few years. Social autopsies of maternal deaths - a collaborative civil society initiative by 23 organizations across India being one of the major initiatives. This was named, poignantly, Dead Women Talking[1][2]. Planning for DWT 2 is currently underway.



1 Dead Women Talking text pages (im4change.org)
2 Subha-Sri-B.pdf (harvard.edu))

A second piece of work was monitoring of quality of maternal health care by local communities in select areas of Gujarat. (The picture above shows how women conceptualised maternal health care as a right.) This was a collaborative project with SAHAJ and resulted in several tools for monitoring and community education[3][4][5].

And this meeting was a part of a third major initiative: ***Women-centred maternal health care – Discourse building***. CommonHealth believes that women should be placed at the centre of maternal health care programmes. A series of consultations with grassroots women and frontline workers were conducted in nine geographic locations in India to understand women's current experiences of care during pregnancy and childbirth and their perspectives on ideal care. These findings would be presented at this Consultation for consideration by the 'experts' to arrive at a consolidated position on 'Woman Centred Maternal Health Care.'

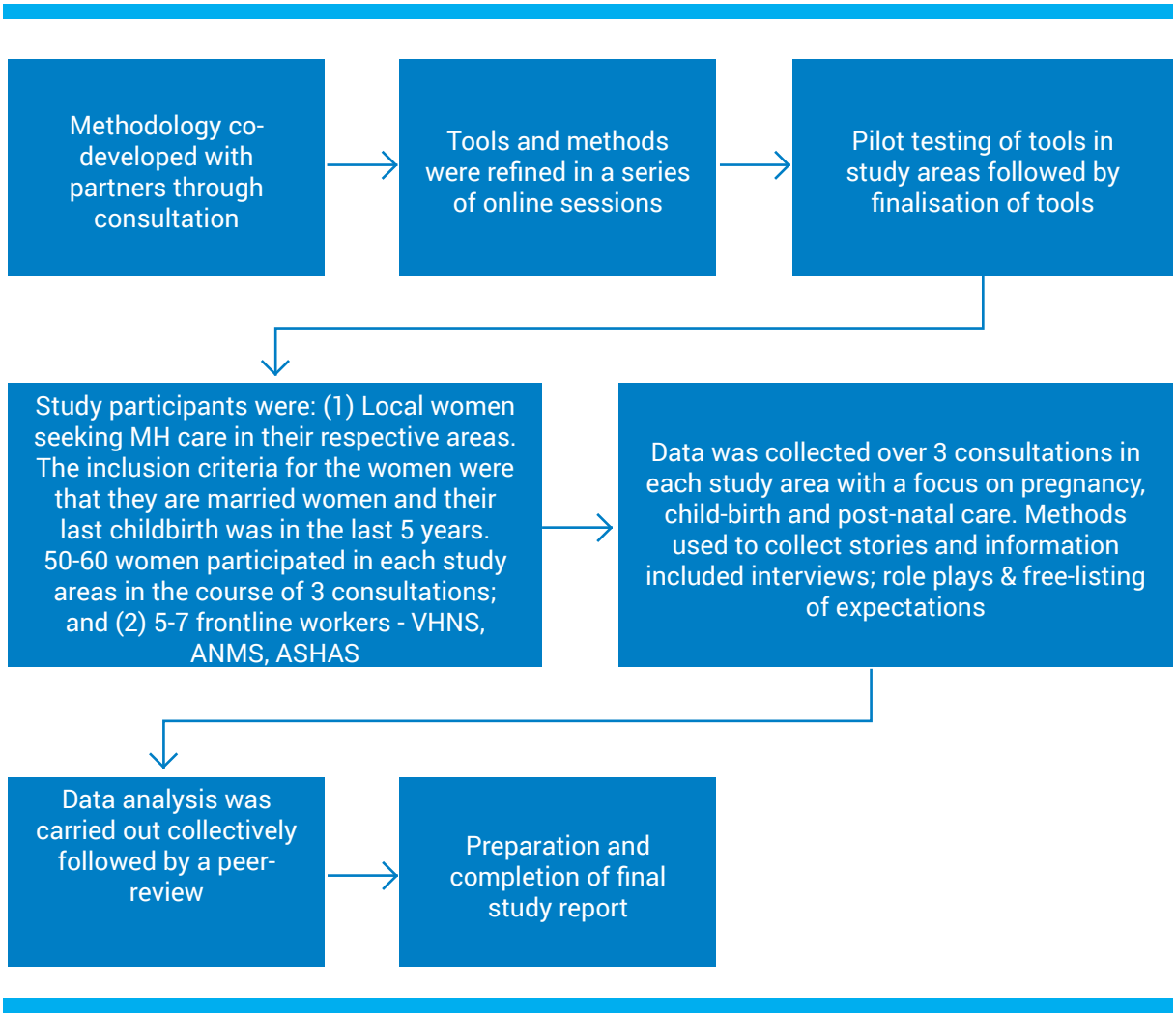
3 Can community action improve equity for maternal health and how does it do so? Research findings from Gujarat, India - PMC (nih.gov)

4 13N_Recognizing Maternal Health as a Community Issue_Zararia.pdf (esocialsciences.org)

5 How does social accountability contribute to better maternal health outcomes? A qualitative study on perceived changes with government and civil society actors in Gujarat, India — Vrije Universiteit Amsterdam (vu.nl)

Study Methodology

What follows is a brief description of the study methodology which was developed collectively in 2021 in a consultation with all the study partners. The steps followed in the study were as follows:



The local reports were disseminated and used for advocacy by the partners with the relevant stakeholders in their respective regions.

In line with the theory of 'intersectionality', the study attempted to capture the experience related to maternal health care of poor and rural women with an emphasis on marginalisation based on gender, caste, ethnicity, religion among others. Each study partner, therefore, focussed on specific groups of women in their respective areas (see table 1).

TABLE 1 Study partners & participants

Study partners	Location	Study participants (Focus groups of women)	Study participants (FLWs)
RUWSEC	Chengalpattu, Tamil Nadu	SC & ST women	ANMs, ASHAs, VHNs, AWWs
DEEPS	Dharmapuri, Tamil Nadu	Included SC women and women with disabilities	
SAHAJ	Vadodara, Gujarat	Women living in urban slums?	
Amchi Amchya Arogyasathi	Gadchiroli, Maharashtra	ST women	
Sahayog	Odisha	Tribal women without legal recognition; daily wage labourers & landless	
Grameen Punarnirman Santhan (GPS)	Azamgarh, Uttar Pradesh	SC women	
Hashiya Socio-Legal Centre,	Ranchi and Khunti, Jharkhand	Rural Tribal WomenSC women?	
Shikhar Prashikshan Sansthan (SPS)	Mirzapur, Uttar Pardesh	SC women, (Mushahar community) Wwomen	
SOCHARA	Vidisha, Bhopal Madhya Pradesh	Rural SC/STUrban poor women	

Social inequities and intersectionalities in maternal health policies

This section captures the broad context to foreground the discourse building on Women Centred Maternal Health Care. The first part of this section traces the history of global and national maternal health policies and programmes. It draws from a Background Paper and literature review commissioned by CommonHealth[6] in preparation for the discourse building on women centred maternal care initiative. The second part of this section examines maternal health from an intersectionality perspective and is based on a presentation by Dr. Aditi Iyer during the Consultation.

History of Global and National Maternal Health Policies and Programmes (PPT 3)

Figure 1 shows some of the major milestones in the global policy discourse around maternal health.

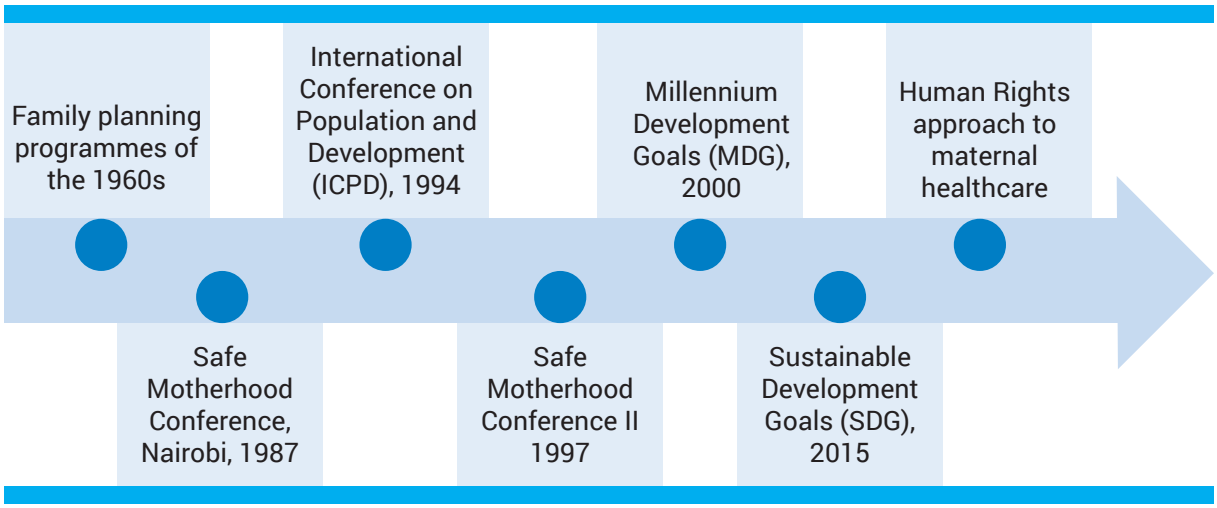


Figure 1: An overview of Global Milestones in Maternal Health policies

Between the 1970s and 1990s, the World Health Organization promoted traditional birth attendant (TBA) training as one strategy to reduce maternal and neonatal mortality. In 1972, 24 countries had some form of TBA training and by 1982, fifty-two countries were providing training programs for TBA. In 1982, WHO was confident that with stronger and expanded programmes, trained health workers (which included TBAs) would attend two-thirds of births by 1989. At the Safe Motherhood initiative launched at the Nairobi Safe Motherhood Conference in 1987, the framework encompassed the need to improve women's status, educate communities, and strengthen and expand core elements of maternal health—antenatal care, delivery care, and postpartum care—at the community and referral levels.

6 Vernekar D, B Subha Sri, Khanna R (2021). Maternal Health Policies in India: A background paper, CommonHealthR

A decade later, the 1997 safe motherhood conference in Colombo put its thrust on "safe deliveries" to reduce maternal mortality, and the "non-medical or scientifically not proven" approach of TBA training was relegated. Policy makers assumed that practical difficulties such as poor literacy and lack of "scientific knowledge" was preventing trained TBAs from effectively lowering the MMR in countries that had invested in TBA training. Today, the global thrust lies on skilled birth attendance which is to be provided by trained medical professionals such as nurses and doctors – the role of TBA in carrying out deliveries has been increasingly seen as irrelevant or ineffective. This is in spite of the fact that in countries like India, TBA, also known as *dais* play a vital role during childbirth, especially in rural and low-resource settings – they not only carry out the delivery, but also provide emotional support and comfort to the woman in labour.

Figure 2: The global discourse on Traditional and Skilled Birth Attendants

The traditional birth attendant came to be defined as "a person who assists the mother during childbirth and who initially acquires skills by delivering babies herself or through an apprenticeship to other TBA"

WHO defined a skilled birth attendant as: *an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-natal period, and in the identification, management and referral of complications in women and new-borns* (WHO, 2004).

WHO definition of skilled birth attendant (2018)

The 2018 definition of skilled health personnel (competent health-care professionals) providing care during childbirth (often referred to as "skilled birth attendants" or SBAs)

Skilled health personnel, as referenced by SDG indicator 3.1.2, are competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards. They are competent to:

1. provide and promote evidence-based, human-rightsbased, quality, socioculturally sensitive and dignified care to women and newborns;
2. facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and
3. identify and manage or refer women and/or newborns with complications.

In addition, as part of an integrated team of MNH professionals (including midwives, nurses, obstetricians,

paediatricians and anaesthetists), they perform all signal functions of emergency maternal and newborn care to optimize the health and well-being of women and newborns.

Within an enabling environment, midwives trained to International Confederation of Midwives (ICM) standards can provide nearly all of the essential care needed for women and newborns.* (In different countries, these competencies are held by professionals with varying occupational titles.)

Figure 3 shows the evolution of maternal health programmes in India after independence.

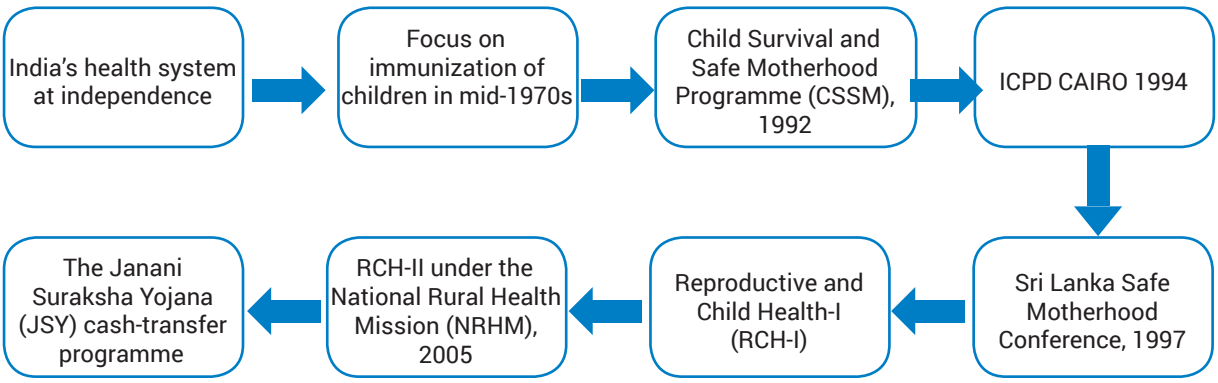


Figure 3: A historical perspective of maternal health policies in India

Following the International Conference on Population and Development in 1994, the Indian Government started the process of re-orienting the family-planning and MCH programmes into the Reproductive and Child Health-I (RCH-I). The RCH-I programme added interventions to those of the CSSM, including treatment of reproductive tract infections, sexually transmitted diseases, establishment of blood-storage units, referral transport, access to safe abortion, and additional nursing staff for the PHC for round-the-clock maternal health services.

In keeping with the global discourse that skilled birth attendants were more effective at lowering the MMR than TBAs like *dais*, the training of TBAs was eventually discontinued. With the starting of the National Rural Health Mission (NRHM) in 2005, improved primary health care gradually became more accessible to the majority of Indians who live in rural areas, and from this increased accessibility to hospitals came a trend of increased institutional deliveries. Hence, while the traditional *dais* were ignored, concurrently, women and ASHA workers (Accredited Social Health Activist) were monetarily incentivized for every institutional birth. The popular international discourse led to the RCH-II Programme excluding *dais* completely as skilled birth attendants. This subsequent marginalization of *dais* included not only encouraging women monetarily to avoid their services, but more importantly included a gradual halt of the TBA training program and provision of TBA kits.

Figure 4 shows the maternal health programmes and schemes in India in 2024.

Figure 4: maternal health programmes and schemes in India

Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) framework of 2013	Major government flagship programmes under this framework: Janani Suraksha Yojana (2005) and Janani Shishu Suraksha Karyakram (2011)	JSY evaluation and launch of Janani Shishu Suraksha Karyakram (JSSK) in 2011	Pradhan Mantri Surakshit Matritva Abhiyan (2016) and the Surakshit Matritva Aashwasan (2019)	Training programmes to improve the quality of clinical care	LaQshya guidelines; Midwifery services initiatives of 2018 by the government

Critique from an equity and intersectionality perspective

Today the situation is that India's MMR has decreased substantially. But this decrease hides the inequities that exist. While MMR had decreased in all areas since JSY, it had declined four times faster in richest groups compared to the poorest, resulting in increased inequalities. The national coverage of JSY was at 36.4% in 2015-16. Research indicates that there is a need for improved focus on the poorest women by maternal health schemes. Data shows that economic status, religion and caste play an important role in promoting inequalities in the utilization of these services.

The aspects of caste and class were further substantiated by Dr. Aditi Iyer's presentation based on the work in Koppal District of Karnataka[7, 8]. Through the pre NRHM examples of two women who died in Koppal District, Aditi showed us how intersectionality plays out in the maternal health arena. The first story was about a 22-year-old poor woman, living within close proximity of a primary health centre, who died not because of lack of access but because of a complex combination of many factors. The second story was about an upper caste 17-year-old from a well off family who died of high blood pressure. The two maternal deaths showed the team that the problem was not merely of poverty or women being ignorant but gender and of low value of women's lives. '*Gender makes women invisible, reduces the value of women's lives.*' The invisibility of maternal deaths is further exacerbated by their caste – deaths of *dalit* women were not known or acknowledged by the rest of the village, and not counted by the health system. Gender and caste are two aspects that stood out through the intersectionality perspective. Aditi also spoke about 'embodiment'[9] – how women's bodies tell the stories of their lives, and their deaths. Verbal autopsies of maternal deaths provided several hints of the deprivations and traumas of each woman's life.

There are four or five pathways in which gender and intersectionality affect outcomes in context of programmes and policies. Aditi went on to describe a modified AAAQ framework for analysing maternal health and discussed pre NRHM and post NRHM scenarios using this framework.

- A for Acknowledgement – pre NRHM as described earlier, there was very low value for women's lives, certain women were practically invisible. Women did not have voice, their value was acknowledged only as mothers or as future mothers.

7 Iyer, A. (2005). Gender, Caste, Class and Health Care Access: Experience of Rural Households in Koppal District, Karnataka, Trivandum, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal. Institute for Medical Sciences and Technology.

8 Iyer Aditi, Sen Gita, Östlin Piroska. (2008). The intersections of gender and class in health status and health care J Global Public Health

9 Krieger N. Embodiment: a conceptual glossary for epidemiology. J Epidemiol Community Health. 2005 May;59(5):350-5. doi: 10.1136/jech.2004.024562. PMID: 15831681; PMCID: PMC1733093.

- The second A is for Accessibility of services, entitlements. Pre NRHM, the onus of caregiving was on families. They had to arrange for finances for emergencies, for transportation. Access to services was a problem.
- The third A is for Accountability. Pre NRHM there was no accountability for service provision or quality of care. Service providers had poor skills. Providers were not trained. Normalisation of women's ill health was the paradigm. There were no mechanisms for demanding Accountability for the care provided.
- Q is for Quality of care. No-one was responsible for women's safety. No-one cared to listen to or consider women's experiences of service provision.

Post NRHM, according to Aditi, things changed dramatically, at least in Karnataka. ASHAs were incentivised to take women to health facilities, the 108 service came into existence, so Access improved, even though Acknowledgement remained a gender issue. Accountability and Quality also still remain issues. Adverse practices like inducing labour, and poor skills of providers are still prevalent leading toMaternal deaths and these deaths are kept hidden – cause of death is often written as 'she died of pulmonary embolism'. LaQshya is an excellent potential intervention in terms of addressing Quality and Accountability. The detailed guidelines and checklists could be promising, but for the fact that the woman is invisible in these! These are sets of great directives for providers and for managers to improve the infrastructure of the labour room, but the birthing woman is completely absent in these. There are a lot of implicit and explicit biases and the prejudices of the health care providers continue. Their behaviour is based on stereotypes – migrants and minority women continue to be treated with disrespect. The other weak spot of LaQshya is that women's autonomy is denied – for example, the birthing position, or her desire to have a companion in the labour room. In Karnataka, PPIUCDs continue to be inserted without the women's prior consent and sometimes even without her knowledge.

And so, according to Aditi, these are some of the issues – gender and intersectionality - that have to be brought to the forefront when discussing woman centred maternal health care.

Panel presentations by study partners: Issues and concerns of women seeking MH care

Renu Khanna chaired the first 'fish bowl' discussion in which the study partners from Shikhar Prashikshan Sansthan (Mirzapur, Uttar Pradesh), DEEPS (Dharmapuri, Tamil Nadu), Amhi Amchya Arogyasathi (Gadchiroli, Maharashtra), and SAHAYOG (Odisha) presented the key challenges and concerns of the research participants. If there were any unique challenges not covered in the accounts of these four organisations, participants from the four remaining research sites added these.

The issues faced by women (as well as their expectations presented in a later session) were categorised as those at:

i. the family or household level
ii. the community level
iii. in their interactions with frontline workers
iv. at the level of the health systems

Issues and concerns of women at different levels

At the **individual or personal level**, the issues were mainly related to nutrition. Misconceptions are prevalent in Odisha that in-take of iron tablets would lead to a large foetus and therefore would require c-section. So, women resist eating iron folic acid supplements. Although nutritional programmes for pregnant women in Maharashtra include provision of a protein-rich meal to be eaten in the AWCs as a part of their ANC, women often take it home and distribute it among their family members. From the time of ANC, women reported feeling considerable mental stress owing to the expectations of the healthcare providers or frontline workers and the contradictory pressures at home from family members.

Women reported a lack of support from the **home/family.** This included no help in sharing household work, restrictions in diet, enforcement of norms regarding physical activity, being blamed for poor health conditions. Some women also reported domestic violence during the pregnancy and postnatal period. For example, in Dharmapuri, TN, women were not allowed to drink water immediately after birthing. In Mirzapur, UP, women were mistreated and reprimanded by their family members for their poor health conditions. Women complained

about the lack of guidance and attention across different stages of the pregnancy period. Spouses are not supportive of women within the household. In Odisha, women shared that their spouses do not help them during pregnancy and do not accompany them when they visit the health centre. Also, in Odisha, the first pregnancy is considered somewhat risky and so women, who work as daily wage labourers, do not go to work but do all the work at home. In the second or third pregnancy, families expect women to go to work up to the last trimester. Women are compelled to undergo multiple pregnancies owing to son preference.

Lack of family support that the women experienced extended into the **community.** In Dharmapuri, women felt they received little to no support from the community barring at the time of *Sreemantham* (similar to 'god bharai' गोद भराई or baby shower). Women expect support and care from their households and communities during pregnancy, including being treated with kindness by their mothers-in-law, having their preferences respected (e.g., choice of birthplace), and receiving emotional support from their husbands during delivery. They also desire respect from hospital staff and relief from household duties, especially if they have children, and seek to avoid pressure to have children immediately after marriage

At the **public health system level**, women reported several issues like disrespectful treatment, nonavailability of staff, services and entitlements, poor health facilities, infrastructure and long waiting times.

- *Lack of services*. Women do not get any services other than tests for Hb levels during the Village Health and Nutrition Day (VHND). Ambulance service, basic medicines, blood and materials are unavailable or irregularly available in health facilities. E.g. in Dharmapuri, oral glucose used for lab testing during pregnancy has to be procured from outside. At the PHC, only Hb and urine tests are carried out. Women shared that they are forced to visit other facilities for any other tests or services. Often ultrasound facilities are not available in lower facilities and so women visit either the DHs or private facilities. In Mirzapur, a woman reported giving birth to a baby with disabilities and felt this was because ultrasound scans were not conducted during her pregnancy. Scans at private facilities lead to out-of-pocket expenditure. Lack of proper clinical examination of pregnant women in health facilities was identified by women as an issue as also a complete absence of postnatal care in UP. In Tamil Nadu, the absence of female gynaecologists at health centres was recognised by the study participants as a concern.
- Poor infrastructure Absence of basic facilities such as electricity, especially at night, and adequate beds were shared as common concerns in health centres. The lack of sanitation facilities in health centres was raised as an issue by women and by frontline workers. Where there are sanitation facilities, they are not maintained or cleaned regularly. Also, newspapers are provided for cleaning the gel from the abdomen after an ultrasound scan as there is a lack of tissue paper. There is considerable rush at the

facilities on designated days for ANC. Given the rush, there is no privacy during check-ups and women end up spending the whole day at the facility waiting for their ANC check-up.

- *Disrespectful treatment.* Women shared several instances of their disrespectful treatment in healthcare facilities by healthcare providers. Women in Mirzapur, UP shared that they are reprimanded when their condition deteriorates while at the health facility. Health providers blame them for delayed seeking of care or for going to private health facilities. Women pointed out that they are treated in healthcare facilities as 'patients' rather than 'mothers'. Instances of obstetric violence at the health facilities were shared by women. Women shared that there is pressure from healthcare providers to get sterilisation or tubectomy done if they have a son or more than a couple of children. No informed consent is taken at the time of insertion of PPIUCD.

A woman was admitted in a government facility for birthing. While she was lying in bed, she realised the dai in the facility was attempting to remove something from under the bed. She looked under the bed to find the corpse of a child/baby. She was so traumatised that she left the hospital immediately.

Sandhya (SPS) shared the experience of a study participant from Mirzapur, UP

Informal payments. Women complained about informal payments for free services such as c-sections and transport. In Gadchiroli sub-district hospital for e.g., doctors charge for c-section operations.

A pregnant woman with disabilities was charged Rs. 50 each time she was taken to the toilet in a wheelchair.

Suresh (DEEPS) shared the experience of a study participant from Dharmapuri, TN

Challenges for women due to faulty policies and implementation. BSKY (Odisha state insurance scheme) is applicable mostly in private facilities. Often, people are not registered under the insurance scheme and so are not able to avail the services under the scheme. In TN, women said that since the pandemic, there has been a shortage in food supply at health facilities. In UP, they said provision of food under the JSSK is absent. In addition, the two-child norm applied to certain schemes deprives poor and marginalised women from availing services or receiving benefits.

Poor SC women are mistreated and discriminated against…Healthcare providers keep in mind the social status of the women who come to them for treatment…If you pay the providers, then they might treat you with a little respect and be more attentive.

Sandhya (SPS) shared the experience of a study participant from Mirzapur, UP

During the consultation, we focused on two experience sharing by each partner because many experiences were similar across the board. What I feel is that we need to have a summary or bullet points of commonalities to give an idea of what picture is emerging and then these subheadings will be add on. Else, it doesn't look structured. I went through each partner's report and many findings are similar. So, those similarities can be drawn from there.

About their **interactions with Frontline Workers (ASHAs, ANMs, VHNs)**, women reported corruption and non-responsiveness. Informal payments are reportedly charged by most FLWs. ANMs and ASHAs were seen to be corrupt and mercenary as they receive commissions from other sources e.g. diagnostic centres or are paid incentives for their labour. ASHAs are expected to pay for the transport to the institution for childbirth. However, often they do not pay and if they do pay, then in some places like Mirzapur, the women had to work at the ASHA's homes to repay her for the payment made. In Mirzapur, women shared that they rely so much on the ASHAs, but often ASHAs either do not want to come or are late in providing support.

Power dynamics impact both the women and the ASHAs - as the ASHAs are seen to be upper caste, the women feel they must align with and are marginalized by the existing unequal power dynamic between them. The ASHA who is to be a bridge between the community and the public health system herself is struggling currently to retain her position with both. There is distrust on the part of the women she is to support and there is disdain on the part of the health providers in the facilities.

Other challenges that women mentioned would result from structural factors, like caste, infrastructure, social and gender norms. Dalit women shared that often they do not receive the same level of treatment or information as the richer and more influential upper caste women. Also, although government schemes are primarily for vulnerable and marginalised groups it is the upper castes and class groups that benefit most from them. Roads and transport facilities in rural areas lead to a host of different issues. In Mirzapur, UP. transport facilities are not available to reach the health facilities. In Dharmapuri, the utilisation of the transport facility provided by the Tamil Nadu government is very poor – and typically, spouses take the pregnant women in their private 2-wheelers to the health centres for birthing. In Mirzapur's context, in the absence of their partners/spouses who work as migrant labourers, the women are heavily dependent on the public health system and the frontline workers.

Key issues faced by Frontline Workers

One part of the study was also to gather experiences and perspectives from health care providers in relation to women centred maternal health care. This section reports on what the four organisations found from narrations of FLWs. FLWs experienced challenges from both the health system side as well as the community side. ASHAs particularly feel that they are discriminated against and disrespected. On the one hand, people rail against them for taking incentives or payment while healthcare providers are not supportive of their work.

Health system side challenges. FLWs shared about a lack of support from doctors and nurses and poor behaviour and mistreatment at the hands of their superiors. This is seen especially in cases of referrals to higher facilities. Basic facilities in referral centres for the FLWs are absent. There is no provision for ASHAs to stay at night in health centres when they accompany women to the facilities. ASHAs shared that their incentives or payments is very low. In UP, it is Rs. 600 per delivery. Maternity benefit schemes in TN lead to friction between couples and ANMs, so often ANMs do not appreciate being involved in the provision of the scheme.

Community side challenges. While the women said that FLWs did not provide them services, the FLWs felt that they were often expected to provide unpaid or unacknowledged care work by women or their family members. ASHAs complained about how women don't pay heed to their suggestions and advice.

Panel presentations by study partners: Women's expectations and recommendations

Sanjeeta Gawri chaired the second fishbowl session with study partners to distil women's main recommendations towards developing a discourse on women-centred maternal health care. In this round, representatives from Grameen Punarnirman Santhan (Azamgarh, Uttar Pradesh), Hashiya Socio-Legal Centre (Ranchi, Jharkhand), RUWSEC (Chengalpattu, Tamil Nadu) and SAHAJ (Vadodara, Gujarat) led the discussion with supplementation of additional points by the others.

From the family and community, women said that they wanted support during their pregnancy and after childbirth. This support was in terms of nutrition, rest and freedom from violence and mental stress. In Chengalpattu, TN, women demanded families and communities refrain from applying restrictions especially related to their diet and rest taken during pregnancy and after childbirth. In Gujarat women said that they want peace in the family during pregnancy. Spouses/partners, according to women, should support the women throughout the pregnancy and postnatal period. Specifically, given the state of roads and transportation in rural areas, spouses/partners were expected by the women to accompany them to health centres whether for check-ups or for birthing. In UP, women said that son preference within the family and community needs to be addressed. Women were often held responsible for the sex of the child and suffered stigma and blame on account of this misconception. Concrete steps to address this gender inequality needs to be put in place at various level across the entire system. In Jharkhand, women asserted their right to live without fear of harm in the context of domestic violence they experienced during pregnancy. Immediate steps to stop violence against women within households and communities need to be taken. Any discrimination within the household against the woman must stop. Respectful and fair treatment is to be ensured in the marital home.

We want a peaceful environment at home.

Sangeeta (SAHAJ) shared the demand of a study participant from Vadodara, Gujarat

While women is all the study areas expressed their **expectations from the health system**, there was also a sense of helplessness '*its not as if these things are not known… everyone knows that an Obs- Gyn doctor is necessary … or that complaints for informal payments should be acted upon… but they are not.*'

Women wanted that all ANC- PNC services must be ensured and delivered without fail including four ANC check-ups, blood tests, urine tests, take home ration, sonography etc. Women expect to be registered for ANC at the earliest so they can avail related services of health and nutrition. They said that designated ANC days or VHNDs could be carried out over 2-3 days considering the high number of women who need attention. It would also be great to ensure home visits by VHNs or ANMs. To the extent possible, all tests should be carried out during the VHND and VHNDs should be conducted as prescribed and not tokenistically. Postnatal care should be ensured and FLWs should be incentivised to support women in this period as well. Common health conditions and endemic diseases should be borne in mind while caring for pregnant women. Birth companion, or a 'friend' right from the stage of pregnancy to post-natal period, along the continuum of care, was desired. Interpreters maybe be required in health facilities so that pregnant women can express themselves easily.

Maternity benefit schemes can be very confusing. The requirements to avail these schemes need to be simplified.

Nidhi shared the demand of a study participant from Uttar Pradesh

Ending disrespectful and abusive treatment of women at health facilities was echoed by women across the study sites. They expect the health care providers to be more sensitive and considerate in their interactions with them. Women demand an *end to all forms of out-of-pocket expenditures* and informal payments at public health facilities. In Tamil Nadu, SC/ST women specifically raised these points. There should be no adverse repercussions to such cessation of payments. Women demanded ending all forms of coercion exercised by HCPs in health care facilities e.g. insertion of PPIUCD, female sterilisation as a condition for abortion, or after delivery etc.

All aspects of *availability of health services* should be ensured. Vacancies for HCPs should be filled. Women doctors and surgeons were seen as essential staff in health facilities. All critical and essential drugs and equipment should be available in public health facilities and provided free of charge to pregnant women. All basic infrastructure and amenities such as safe drinking water, clean sanitation facilities, place to rest etc. should be ensured in all

public health facilities. The women in Jharkhand said that sometimes extreme weather conditions such as heavy rains can prevented them from reaching or leaving the health facilities. Appropriate provisions should be made so women receive the care they require during pregnancy and/or birthing, for example, birthing huts closer to their homes.

The system perpetuates the practice of tipping or informal payments… After complaints were registered against demand for informal payments there was pushback from everyone in the system. Eg. the CDPO spoke in favour of their staff when they were charged with demanding informal payments.

GPS (Azamgarh UP) – Rajdev Chaturvedi

These women are daily wagers, they cannot be expected to pay for every service they avail in the facility.

RUWSEC (Chengalpettu, TN) - Sreelakshmi

Violence against women including domestic violence during pregnancy has been completely normalised…our women-centred maternal health discourse must address violence against women.

Hashiya (Jharkhand) - Apurva

Ensure awareness about all government schemes related to maternal health. All efforts should be directed towards ease of availing benefits under the schemes. This would include support in documentation required for each scheme. Maternity benefits and other related schemes, which are often state-specific, should be extended to migrant groups who come from

other states. Timely payments under all maternal health schemes should be ensured. All barriers to avail maternity benefits should be removed, for example, change of name on ration card and Aadhar card after marriage. Ombudspersons should be available for the women to ensure she is able to avail of all entitlements.

Several suggestions came up for *ensuring accountability of health systems*. Regular social audits and community monitoring mechanisms should be operationalised to keep the system accountable. Robust grievance redressal mechanisms should be developed and operationalised to deal with complaints of women. Feedback mechanism should complement the grievance redressal system. Women should be able to register or share their feedback through voice notes, feedback forms, photos, videos etc. as per women's capacities and convenience.

From the Frontline Workers women's strongest demand was the cessation of all informal payments. The women expect sensitive and considerate treatment by FLWs along with prompt and timely support during pregnancy and after birthing. This is their demand from all levels, including from staff nurses in hospitals where they demand informal payments or send women out to buy medicines. In UP, women stated that nutrition must be provided through the AWCs.

Some **expectations of women related to structural factors**. Their narratives suggested that ending violence against women forms a key component of women-centred maternal health discourse and practice across the entire system – from individual to interpersonal, community, society, and policy, as does ending pervasive gender inequality such as son preference. All of these need to be addressed through women-centred actions, one example is provision of paternity leave after the birth of every child. Women's experiences also point to a need for regulation of private facilities and a ceiling applied to charges levied for services in these facilities.

Front Line Workers' expectations

FLWs' expectations related to women centred maternal health centred around reduction of work load, more resources including assistance to perform their duties better, support like capacity building and respect from all quarters.

ASHAs demand basic amenities be provided while they are on the job e.g. an area to rest, clean sanitation facilities etc. They should be relieved from the burden of excessive reporting so they can focus their efforts on preventative measures such as awareness campaigns. ASHAs wanted a reconsideration of their workload especially the size of population they are expected to cover. In Jharkhand, ASHAs demand the status of bona-fide health workers and to this end seek valid identification. Also, no additional services outside of their mandate should be expected or extracted of them. ASHAs wish for respectful treatment by all they work with – HCPs, pregnant women, family members of women they support, other staff at health facilities, staff at referral facilities etc.

The ANMs wanted a helper/cleaner to clean up after the birth. They also want basic equipment in working condition and adequate supplies. A need for a birth companion is identified along the lines of the *doula* who supports a pregnant woman throughout the pregnancy period. In Jharkhand, the government is recognising this need however without considering proper remuneration or acknowledgment of the role.

Proper, relevant, and regular training and capacity building all FLWs should be ensured.

Synthesis of study findings: *What women want?*

Following the discussions on the obstacles faced by women on their maternal health journey and their recommendations towards a women-centred maternal-health discourse and practice, Dr. TK Sundari Ravindran synthesised the study findings to present '**what women want**?'. She shared at the outset her objective in the presentation was to cull out action points from the study findings.

Here is where we will have to think 'which woman-centred?' Is it only pregnant woman centred or ASHA (& other) worker-centred?

TK Sundari Ravindran

Expectations voiced by women during the consultations

A. Expectations from spouse

- Women demand their right to self-determination and agency to make decisions related to pregnancy and birthing care. Some women do not appreciate being accompanied by their spouse during their hospital visits as this impinges on their freedom to do as they please – eg make purchases in nearby stores, take an autorickshaw if buses are not plying etc. Ultimately, women should decide what works for them.
- They expect to have cash in their own hands so they can use it as they see fit when they visit health facilities or get admitted to a facility for delivery.
- Spouses or partners should be 'birth companions' and women would like them to be present during birthing.
- Spouses should take the responsibility of prevention of pregnancy and use contraceptives instead of relying on the women for this.

B. Expectations from marital family

- Women hope that there will be no pressure to have children immediately after marriage. This affects the woman's peace of mind. In fact, many women are undergoing fertility treatment within a year of marriage to have children as per the demands of the martial home.
- There is need to support women in adhering to the healthcare provider's advice.
- Care and support should be ensured for all pregnancies and not limited only to the first pregnancy. Women also expect to be supported and cared for in case of mishaps such as miscarriage, stillbirth.

C. Expectations from community

- There should be no pressure to have children immediately after marriage or any pressure to have sons.
- Community should be prepared to provide physical and financial support in case of emergencies during pregnancy and/or birthing.

D. Expectations from FLWs

Sundari Ravindran pointed out before sharing women's expectations from FLWs, that it would have to be understood **which** woman will be at the centre of our maternal health

care – would it be the pregnant or **birthing woman or** would it be the **woman worker** who supports her?

- Women expect ASHAs and AWWs to be nurturing and provide moral and emotional support during pregnancy, besides health information and services.
- During her monthly visits, the ANM should conduct group sessions for pregnant women on rest, diet, check-ups, danger signals, and mental and physical preparation for childbirth. She should also provide information on postpartum care including postpartum contraception.
- Spouses and family members should also be counselled by the ASHA/AWW on care and support for the pregnant woman.
- When a woman repeatedly misses VHND attendance, the ANM should make a house visit and provide healthcare and advice as needed.
- The ANM could send reminders for scan and check-ups in PHCs via mobile phones. They should respond to calls from pregnant women.

E. Expectations from the public health system

- Contraceptive services for reversible methods should be provided at the community level on a regular basis in all settings.
- For ANC:
  - ✓ In some settings where lunch used to be provided to pregnant women coming for monthly check-ups, women regretted the withdrawal of this scheme.
  - ✓ Testing for gestational diabetes, hepatitis and thyroid and Iron-sucrose injections were mentioned in some settings as essential services that should be available.
  - ✓ Human resources in the PHCs should be adequate to cater to the volume of pregnant women coming for ANC.
  - ✓ Fixed days for ANC is a good idea, but a woman coming on another day should not be turned away.
  - ✓ Screening for domestic violence should be made routine as part of ANC and staff should be trained in how to support women who have been subjected to domestic violence.
- For birthing:
  - ✓ Birthing wards should have good infrastructure - adequate number of beds kept clean, protection from mosquitoes and pests, clean toilets, fan and so on. Women

have especially complained about the heat they have to endure in wards and delivery rooms.

- ✓ Women should receive support from the nurses for initiating breastfeeding.
- ✓ No woman should be left unattended when she is in labour. There should be provision for a birth companion, and a nurse and doctor should be on call. No woman in labour should be left to the care of a trainee doctor alone.
- ✓ Taluk and district hospitals should be equipped for providing care for any emergencies during delivery, including blood transfusion, and should not refer patients to higher level facilities or the private sector.
- ✓ Unnecessary referrals from CHCs and PHCs of women in labour to higher-level facilities by nurses should stop.

- Not providing pain relief during episiotomy is a major abuse and should not happen (one site).
  - ✓ Insertion of IUD postpartum, without the woman's knowledge or consent should stop.
  - ✓ Unnecessary c-sections should be avoided. When c-sections are performed, clear explanation should be provided to the woman on the reasons for this.

F. Expectations requiring policy and programmatic changes

- The number of nurses in the delivery wards should be planned to ensure that no woman will be left unattended.
- Tribal women prefer delivering close to their homes, in health subcentres. HSCs in tribal areas should have experienced ANMs who are skilled midwives.
- There should be systems to ensure that private health facilities provide good quality maternal health care and do not carry out unnecessary procedures or investigations

After listening to women's voices from the ground and Sundari Ravindran's synthesis based on the contents of the nine field reports, the next session invited 'experts' to comment on what they had heard and also add their perspectives from their own disciplines and practice. The next section captures what 'experts' had to say.

Experts' comments on developing a women-centred maternal health care discourse & practice

Dr Sharad Iyengar chaired this session and his opening remarks set the context for the experts to share their respective views on a women-centred maternal health care discourse and practice. He stated , to begin with, that it is important to bear in mind that the maternal health programme in India has been primarily mortality-driven. It was understood that to reduce maternal mortality in the country, standard maternity care should be provided along with emergency care to manage complications during pregnancy or childbirth. This has led to standardisation of care, on the one hand, and rendered women passive recipients of care, on the other. Secondly, it has also been a largely welfare model where conditional cash transfers are made at several stages of the cycle. Often women are unable to meet these conditions owing to a variety of issues including lack of required personal identity documentation. Thirdly, the maternal health programme doubles up as women's fertility control programme through the administration of either temporary or permanent methods of contraception after childbirth, with or without women's knowledge. Clearly, there are various agendas attached to the maternal health programme in the country.

Women have become passive recipients in the maternal health programme.

Sharad Iyengar

A. Human resources in maternal health care by Dr. Prakasamma M.

Against this backdrop, Sharad Iyengar invited Dr. Prakasamma M. to share her views on the theme of human resources in maternal health care.

Prakasamma commenced by drawing attention to two important terms used in the main agenda of the consultation – 'maternal health' and 'women-centred'. She asserted that indeed women must be at the centre of maternal care given - **women** are the ones who become mothers. There cannot be any other form of maternal health. Having to emphasize 'women-centred' maternity care is a matter of concern. And perhaps an oxymoron?

Prakasamma shared how this perspective and drive led to the conceptualisation of the **'birthing temple'** where the woman is at the heart of the temple – the sanctum sanctorum – and all the healthcare providers are around her to provide appropriate care.

Over time, maternal health has been reduced to childbirth and this is what guidelines such as LaQshya accomplish. The focus is on the childbirth aspect of the entire continuum of pregnancy and is situated in the 'labour room'. What is missing is the continuum of care – from pregnancy to postnatal care. In fact, while thinking in terms of 'motherhood' then it would encompass all the changes experienced by women through their bodies.

It is important to understand the concept of 'maternal health' to think about human resources in maternal health. We must reconsider the use of the word 'labour' for birthing as it conjures the image of labourers in a factory with little control over their work or production. So, this context and perspective lays the foundation to understand the human resource requirements for birthing.

She shared her experience as a public health student fifty years earlier, when visits with the VHNs helped her understand how they conduct home births and how they treat women during the birthing process. *Dais* and ANMs who worked well together were a great source of inspiration. Two women working together to support another woman through her birthing – there was a lot to learn there.

This goes to show that women were supported by other women who had the technical knowledge and skills to assist birthing. Unfortunately, the cadre of *dais* as a human resource for maternal health has disappeared and this has led to a civilisational shift in maternal care. Also, another human resource - the ANM is the only other HCP who is trained for about two years as a 'midwife'. While the level and duration of their training can be questioned, they were the ones available and supporting women in pregnancy and childbirth. In 1997, both the *dais* and ANMs were deskilled and disempowered by design to be replaced by qualified obstetricians and nurses. Women at the grassroots and the peripheral subcentre levels, were deprived of these two kinds of skilled maternal health workers. There was a thrust from the international communities towards integration of what was seen to be 'properly skilled and trained midwives'. The fact of the matter is that India already had this in place in the form of *dais* and ANMs.

Obstetricians are highly trained doctors specialising in emergencies and abnormalities during childbirth. They are not required for every childbirth. Nurses are trained to treat all their clients as patients and expect those who are admitted in health facilities, in a way, to hand over their bodies to nurses. Government of India recently released midwifery guidelines where the nurse is seen as a midwife. However, nurses see women as 'patients' which women are not, unless there are complications in the pregnancy and at the time of childbirth.

Given nurses' workload, it is not realistic to expect them to deal with each pregnancy in the facility or in the community. Managing a pregnancy includes ANC, childbirth, PNC, immunisation etc. This is not possible for nurses. Based on previous research and

experience, Prakasamma recommended that at the district hospital level at least four midwives should be recruited. One for each of the three shifts and one midwife between shifts or for relieving. This is because women can arrive at the facility at any given point for birthing.

To conclude, it is important to remember that 80-85% deliveries or childbirths do not require a doctor. Doctors are trained to 'intervene', to handle complications and thus will unnecessarily medicalize every birth. An obstetrician should be on call for every birth and ready for a referral whenever needed.

B. Technical Quality of Care by Dr Radha Reddy

The chair of the session invited Dr Radha Reddy to share her views on technical quality of care related to maternal health while also posing a question about any future possibilities of electronic, IT-based, remote monitoring of pregnancy or childbirth.

Radha Reddy started by briefly touching upon the Fernandez Hospital's involvement in the domain of midwifery over the years. Midwives trained at the hospital complete an 18-month course which meets global standards including of respectful maternity care. Typically, in their setting, the emphasis is on non-pharmacological pain relief during the birth process. It is understood that low-risk pregnant women do not require any interventions including induction of labour or episiotomies. In their practice, the midwife goes through the whole birthing process with the pregnant woman.

The Telangana government in 2016-17 moved towards incorporating midwifery within the state maternal health programme. At that point, one administrator had posed the question of how attitudes and practices can be changed along with improving birthing skills among HCPs. The 18-month midwifery course is designed to address providers' attitudes and behaviours. As a result of this shift in approach and perspective in the maternal health programme, the district with the highest rates of c-sections saw a significant increase in normal spontaneous birthing. It was noted that primigravida mothers were provided midwifery support in government settings. There are in fact testimonials from the field that women request for midwives to be present with them.

Within this approach to maternity care, the birthing position is determined by women– this can be squatting, standing – as per her wishes and the maxim followed is to 'listen to the body'. It is not clear how much technology can really support in maternity care. The underpinning motivation is to actually 'humanise birth' and in line with this even the use of the term 'deliver' is avoided. Further, midwives provide the 'human touch' through psychological and emotional support to mothers.

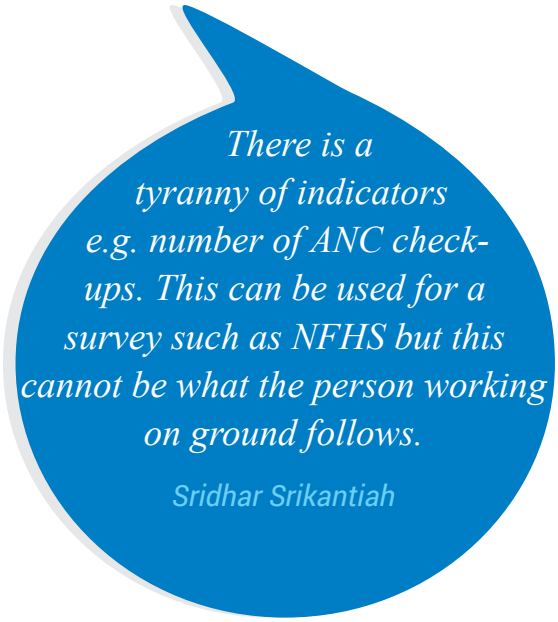
C. Continuum of care by Dr Sridhar Srikantiah

Sharad Iyengar set the background for the theme of **'continuum of care'** by pointing out that the organisation of maternal health services is heavily focussed on antenatal and birthing care. Currently, the national maternal health programme has little or no intervention in the postpartum period. The health system appears geared towards solely towards the insertion of a PPIUCD after childbirth. Additionally, clarity of outcomes with any degree of postpartum care intervention is missing.

Dr. Sridhar Srikantiah responded by saying that maybe the question to ask is, why governments do not designate a State Program Officer for women's health, instead of only for maternal health or family planning? Would that not be necessary to ensure continuum of care, rather than depend on currently fragmented structures? One reason for the lack of attention to a lifetime continuum of care appears to lie in structural issues in the way health systems are organized, where traditionally, only the maternity period is emphasized, which in turn restricts services available in the health facilities to maternity services – there is no systemic priority for gynecological services to take care of menstrual problems or reproductive tract infections, for instance. To reiterate a point made previously, maternal health is organised around reducing maternal mortality and this is evident in the guidelines centred on high-risk pregnancies, institutional deliveries, certification for blood transfer, FRU functionality, caesarean section rates, blood transfusion rates etc. This perspective also naturally 'dehumanises' maternal health by reducing the woman's health to a series of technical interventions, rather than emphasizing caring for her as a woman through her entire life, responding sensitively to her needs. A structural solution that reimagines the way an officer in a decision-making position thinks of mothers – or women – could help.

At the same time, even the provision of such interventions is perfunctory, often with little benefit to the woman. For example, in Bihar 2-3% women who come in for birthing to government facilities have hypertension, presumably pregnancy induced hypertension (PIH). However, of the lot examined during ANC check-ups, the percentage of women with hypertension is less than 0.1%. PIH is clearly not identified during ANC check-ups, when it must be picked up if severe forms like eclampsia are to be prevented. So what sense does the standard of three or four ANCs make if the quality of the ANC does not pick up hypertension in pregnant women? Similarly, anaemia could have been addressed before pregnancy. Pregnancy related anaemia is a physiological response to a pregnancy, worsening the already low baseline haemoglobin levels, given that most

women are anaemic. So, the important question is - why should we wait for pregnancy to correct the anaemia? Is it not important for a woman to be free of anaemia even if she is not pregnant? The current Anaemia Mukt Bharat guidelines emphasize a life-cycle approach on paper, but the emphasis on the ground continues to be on pregnancy – a good example of how, even from a technical point of view, continuum of care makes more sense. But the otherwise well-conceived program is restricted by traditional implementing structures. If support and care is to be provided through the life cycle of women, then the health system needs to frame itself in an adequately larger perspective.



An important reason why thoughtful implementation design is rare is that central government guidelines very often become 'bibles' not to be strayed from. While all guidelines state that they may be adapted locally, in practice, almost all operational details are dictated by the written guidelines and the concerned officials of the MoH insist on implementation as directed. Effectively, state governments and implementing staff are held accountable for *processes* prescribed by the Health Ministry, rather than for *health outcomes*. All the work becomes about filling of multitude of forms, rather than providing the care that a woman requires. This form of pervasive centralisation wherein the Health Ministry dictates everything needs to be re-examined. For example, why should middle level managers and leaders in public health programs be reduced to functioning as bearers of instructions from above, and couriers of data from the field to the state and centre? Is it not possible to trust them to fulfil their professional roles and deploy resources available to them for the greatest benefit of the people whose health they are mandated to safeguard? Do they really need to be micromanaged? Can they not be trusted to adapt central government guidelines according to their context, with the offer of support from the state and central levels when required? The roots of 'functional problems' are 'structural problems'! And they need structural solutions. Currently, there is central government mandate for each state to set up a public health management cadre. This is a good opportunity to push for restructuring state health system for improved functionality, and strengthening the capacity of district and state level program leadership to adapt central guidelines to local contexts, for making health programs more sensitive and effective. An example of a pervasive problem that such restructuring efforts can potentially resolve is the operational integration of 'vertical'

programs. At present, HCPs (last mile providers of all services in health facilities as well as outreach programs – doctors, nurses, ANMs, ASHAs, etc, and their immediate supervisors and managers) have numerous supervisors they are answerable to (state and district level program officers of all vertical programs, such as maternal, child, FP, immunization, TB, malaria, etc,). Each vertical silo has its prescribed needs – protocols, data formats, schedules, even styles of functioning – without reference to other vertical programs, despite the fact that the last mile service providers are common implementers of all programs. This results in confusion about priorities, duplication of effort and inefficiencies, and typically, the vertical programs with the highest clout get their work done, pushing aside other programs. Such a system also lends itself to easy dominance of one program over others, irrespective of its local relevance. Instead, if one additional 'vertical' were created, running from state to district levels to manage operations of all 'vertical' programs, implementation design would potentially be far more efficient, realistic and fair to all programs. The leadership of this 'operations' vertical would then be experts in designing and managing field operations, including managing human resource, supplies and fund flows, and would be held accountable for coverage and quality of the services of all programs. They would have the responsibility and authority of improving the health outcomes in their districts and blocks. Domain experts for each program such as maternal health, child health, vector borne disease, NCDs, etc, would function at state and district levels, not to manage operations but to monitor the technical integrity of interventions, suggest changes to technical interventions as needed, and be given credit or otherwise for impact achieved or not achieved, given good coverage and quality. At least one state is considering such design, and such experiments should tell us if we are getting closer to become better at adapting central guidelines meaningfully to local contexts and making health services more sensitive and respectful of local needs.

A related point is who decides on such matters and learns from the consequences to gradually build sustained and systematic institutional memory within health departments? It is the state, district, and block middle-level officials who will continue in the same department their whole lives, who need to be given more opportunities, responsibilities and authority to achieve health outcomes. The relative roles of this 'technocracy' and the bureaucracy need to be rebalanced. This should also encourage the system to learn to be more empathetic to clients and people than only to signals from 'above'.

Specifically, regarding the matter of **referrals** that came up in the earlier discussion, the suggestion is to not rely solely on state ambulance services, if they are not adequate. State governments also adapt, particularly in crisis situations. In Bihar, in the context of encephalitis which is a hot political issue given the high mortality of children, the government encourages local communities to keep vehicles ready for

emergency response. This was in addition to deployment of available ambulances – just to make sure all bases were covered. Similar local preparedness has been attempted and should be ensured for pregnant women as well, to substitute government ambulance service. Every village should have its own referral plan – the AWW, ANM and ASHA should know *where* referrals will happen for different conditions and *how* they will happen (*who* will take them). For instance, until recently less than 30% of women taken to government hospitals for institutional delivery in Bihar used government ambulances: locally, transportation is available, and people will prefer them where they are less certain about government services.

> *Infertility, twin-births, and other high-risk pregnancies receive no special care in the urban health system… given the burden on the system they are barely able to support anaemic cases.*
>
> *Poornima Nair*

Lastly, on the other point mentioned, while we have been on one hand battling with the problem of adequacy of nurses in government facilities, Bihar has seen an exponential increase in licensed ANM and GNM schools which can be predicted in the near future to lead to the production of more nurses than can be absorbed within the system. There is also the issue of the quality of this human resource. A similar situation is witnessed in Uttar Pradesh. Creative solutions for the management of this newly trained cadre should be devised and shared with the state governments.

D. Urban health system by Dr Poornima Nair

Dr Poornima Nair presented a combination of challenges and recommendations in the urban context. To begin with, there is a need to revisit the terms used to address women in urban settings. There is a tendency to address pregnant women simply as 'ANC' or 'PNC'. There is a huge concern related to gaps in women's identity documentation – either they are not updated after marriage and their movement to urban areas or are missing. This affects their ability to avail maternal health services where they are residing. In addition, in urban areas, infertility and associated high-risk pregnancies have become commonplace. There is a high incidence of twin-births in urban settings. Appropriate care and treatment of these high-risk conditions are currently absent in the urban public health system. Additional care for vulnerable urban groups is missing. It was noted that direct benefit transfers do not keep up with the increasing living expenses in urban areas. Also, 80-90% women who are in the workforce from these settings are in the informal sector. They are, therefore, by design, excluded from the

Maternity Benefit Act. It becomes important to understand continuum of care in this context.

Indicators for women's health are not tracked. Only anaemia is tracked. This group should also suggest relevant indicators.

Urban communities are not as homogenous as rural communities and so, there is a need to focus on collectivising people in urban slums. In postnatal care, breastfeeding support and care needs greater attention. Within this it would be useful to examine the push for milk substitutes by private and public health practitioners. There are implications of milk substitutes for both child and maternal care. There is also a dire need to address the risk of disability during pregnancy which is often ignored. The stigma attached to c-sections can affect women's mental health condition post-delivery. Further, FLWs are overburdened and under-paid in the urban setting. The ASHA or the community health volunteer is not a recognised government staff which makes their work even more challenging. There is no social security, poor working conditions reduce their motivation and push them towards wrong and corrupt practices. What does all of this mean for 'women centred' maternal health care?

E. Additional inputs by Dr Shilpa Karvande

Dr Shilpa Karvande shared additional inputs based on her experience of working with women with co-morbidities such as leprosy, HIV, TB, mental health conditions along with adolescents, women care givers and women care seekers. Women-centred care should consider adolescent mothers who are not prepared for pregnancy. There have been instances in a tribal district of Maharashtra where adolescent mothers were not prepared for longer hospitalisation of their new borns owing to complications. They have committed suicides behind the district hospital. Maternal mental health needs to be considered.

In vulnerable areas, HCPs deal with mothers and their malnourished children in the first 1000 days. There is a need to work with HCPs in NRCs on how to communicate with women and their families related to their financial issues, preparing different foods, healthy behaviours etc. These women themselves are malnourished and there are intergenerational effects of malnutrition. Regarding the HR capacities, training of HR in the pre-service period is essential. Recognising the hierarchies in place, sensitisation of doctors on respectful behaviours with nurses and midwives should be ensured. Capacity building of HCPs must be designed based on adult learning methods which are more interactive, skill-based, cafeteria approach-oriented and are self-driven. All of this has implications for Respectful Maternity Care.

Stress management of FLW including their work-life balance needs greater attention. Tools for effective referrals, primary management of cases, team training etc. have been used in other countries to improve managerial or organisational skills over and above clinical skills of HCPs. Lastly, the appraisal of FLWs' performances must include qualitative indicators of their work rather than capturing solely their number of visits, registers, cases etc.

RMC is a give & take process. It is also related to how women care providers and others are dealt with by other people – by the system or their seniors. We all know about the hierarchy within the system.

Shilpa Karvande

Questions and comments

- Dr Aditi Iyer pointed out that the session highlighted all the structural factors that serve as barriers against women centred care including a medicalised system, mortality-driven programmes, disempowerment of midwives etc. So then is women-centred care a pipedream? Are we saying it is not possible in the public sector and that it's only possible in NGOs or the private hospitals? But most of us believe in the public system as it caters to disadvantaged women. So then, what will it take and what is the timeline we are looking at?
- Dr Arun Gadre, taking Aditi's point ahead, offered a possible solution. He suggested that at the PHC level, all doctors (even BAMS) and nurses should be trained to provide post-operative care. All PHCs should have operation facilities so that these facilities are available in rural areas, closer to where women need them. Taking Prakasamma's point forward, excellent training for ANMs and nurses should be ensured – Obs and Gynecs should be the backup only. He also raised the issue of 'passive privatisation' in which the public health system is rendered non-functional so that people are forced to go to private sector. Finally, a new medical protocol in UK is that c-sections are provided on demand based on the woman's wishes. The pregnant woman is sent to the counsellor and if she stays firm on the decision of getting a c-section even when there is no medical indication for it – it will be done. He asked whether this is women-centred maternal health care?
- Dr Sharad Iyengar responded by asking whether the large-scale structural issues including privatisation are inimical to women-centred maternal health or are there some critical levers to make some substantive impact? He pointed to the politics where government is attempting to please women. If they are not happy, then there is probably some room to work. So women's expression of their dissatisfaction and demanding better services needs to become a political agenda.
- Dr Radha Reddy suggested that women-centred care needs to necessarily keep women's choice at the centre. E.g., in a rapid appraisal among women it was clear they want their partners or spouses as their birth companions. This finding was taken to facilities to show how they were not listening to the women and their choices. Their work with midwives has shown that women centred care is not utopian, it is absolutely possible.

- Renu Khanna shared how in Nepal there are separate birthing units and women may choose to be in these private spaces. In these private spaces, it is easier for partners to be present. Also, in a gender mainstreaming training in Odisha with nodal officers, the head of the ambulance service pointed out how the ambulance team is always male. He seriously considered including women as part of the ambulance team after the gender mainstreaming training. There were several challenges with this idea that needed to be ironed out including how the safety of these women in the ambulances will be ensured, how their families will agree to them doing this kind of night duty. Yet, it was interesting that the nodal officer was thinking along those lines.
- Dr Bhuvaneswari Sunil shared in her experience, given an opportunity, women identify the basic minimum support they require from the family, community, public health system as seen in the study findings. However, there is a need to equip women to dig deeper so they articulate further what all they need from the system.
- Dr Sundari Ravindran pointed out the study was indeed an exercise of women sharing what they need and expect from the system. What we need to conclude with is that there is a need for more such spaces where they can clearly state what they expect under specific heads/themes.
- Sonali, SNEHA, shared her experience of working with Mumbai's marginalised communities and how different departments are unable to work together to complement human resource needs. However, Dilaasa is an example of how departments can be made to converge. Civil hospitals under the NHM can refer women to 'Dilaasa' centres which are set up to tackle domestic violence and mental health issues among women. This is an example of using the existing resources within a hospital to address women's violence and mental health issues. There is a need for ongoing capacity building of staff such as ASHAs who are trained once in their lifetime. SNEHA has also initiated a programme with FLWs to support them through their work stress. This is a demand made by FLWs. Finally, a mutual support system is being piloted by SNEHA in urban Mumbai (where home deliveries are still taking place) through 600 volunteers, so support is available to pregnant women any time of the day and night. This is a neighbourhood-based system to support the prevention of maternal and child mortality.

DAY 2 (16th March 2024): Building a discourse on women-centred maternal healthcare

Plenary presentations by groups

The day began with group work based on what participants had heard on the previous day. The objective of this exercise was to suggest actions points which could enhance maternal healthcare provided to women, at different levels, viz.:

A. Women's individual, family, and community level

B. Frontline worker level

C. Health facility and provider level

D. Programme and policy level

The participants went into four groups as mentioned above. The groups were instructed to come up with actions that are (1) feasible, and (2) have potential to succeed (as opposed to being idealistic situations/suggestions).

Given below are the reports of each group presented in the plenary session. The session was chaired by Dr. Sridhar

A. Women's individual, family, and community level

(Group members: Sandhya, Sanjeeta, Suresh, Balu, Sreelakshmi and Priya)

Action points put forth by the group.

Creating an enabling environment for women centred maternal health care

- Addressing social norms (including among service providers) such as, reducing burden of contraception on women, reducing pressure of childbearing and son preference, information to girls about abortion.
- Male engagement (with husbands, family members and community leaders) with regard to roles and responsibilities related to women's health, e.g. contraception,

ANC utilization, shared responsibility of pregnancy, prevention of and addressing gender-based violence

- Support/resource centres at neighbourhood and panchayat levels, including provision of IEC materials which are women-friendly, not text heavy and art/ illustration-based information

Accountability measures

- Strengthening existing systems/structures like Mahila Arogya Samitis and other spaces under NHM so that women can articulate what they want, articulate their experiences with health systems. Making convergence meetings between departments functional.
- Establishing of grievance redressal mechanisms at facility and community level

With women's collectives

- Deeper engagement to generate awareness about aspects such as ANC/PNC, THR, IFA tablets, right to abortion, benefit schemes, rest, food intake, etc., Taking care to ensure that this is through a two-way dialogue to understand their concerns and respond appropriately to them.
- Working with existing women's collectives and strengthening/supporting their formation with an overarching perspective of gender equity, inclusive and intersectional lens, and working with men parallelly
- Helping women to develop their own charter of demands and action related to women centred health care

B. Frontline worker level

(Group members: Satish, Vijaylaxmi, Sandhya, Rajdev, Bijaylaxmi)

Action points put forth by the group:

Capacity building of FLWs

- Engagement with FLW in different states at different levels i.e. ASHA, AWW, ANM, MPW, MHW
- Capacity-building of FLW with regard to *what is women-centric healthcare*, *what is their role to ensure women-centric services*, other aspects which influence women's health outcomes (gender, violence, mental health, etc.)
- Usage of person-centric language (instead of technical/derogatory language, for example, calling women 'cases', or 'patients')

- Knowledge-building on schemes for women, process to avail of benefits, grievance redressal systems, if any, and how to use them effectively

Strengthening Community Processes and Community Institutions

- Revive/Introduce Community Action for Health (like in Tamil Nadu and Maharashtra) in remote villages
- Capacity-building of VHNSC members about women-centred healthcare and how they can have a supporting hand in building a beautiful village where all women enjoy the best of physical, mental and emotional health.
- Women-friendly and inclusive VHND, immunization space and sub-centres.
- Provide all basic amenities such as food, hot water, etc. to all sub-centres that have delivery facilities

C. Health facility and provider level

Action points put forth by the group: (Jennifer Laing, Sundari Ravindran,

Provide a positive birthing experience…

- … which includes: following WHO guidelines viz. choice of birthing position, birth companion, communication, respectful maternity care, **and** additional factors like: food; communication with women; birth companion (including relatives oriented during the ANC); ensuring all essential equipment and supplies; emergency mobile team (hub and spoke model) to reduce unnecessary referrals; maternity huts; women choosing place of birthing; all what the group termed as *Midwifery philosophy of care* with dignity and respect
- Transparency and accountability in fees, give families pamphlets as part of birth preparedness and include this aspect to prevent informal payments.
- Responsive care of women with disabilities including mental illnesses
- Free ambulance services

Design of space

- For example, for women with disabilities low beds, friendly waiting areas with IEC material with infographics and TV screens to show videos in local languages, display posters on charges and rights and responsibilities within health facilities, all in local languages.

*P**rocesses***

- Sensitization of all facility staff including chowkidars. Evoking empathy amongst all facility staff. No violence on women, even during ANC and PNC
- Stop irrational and harmful practices in facilities.
- Recognition and rewards for individuals as well as facilities doing commendable work
- CommonHealth members can be resource hubs for this kind of sensitisation – making educational resources, providing training.

D. Programme and policy level

Action points put forth by the group:

This group looked at their task along three dimensions: Existing policies and programmes that need to be strengthened, gaps in existing policies and programmes that need to be filled, and policies, practices that are not woman-friendly and we need to oppose.

- Establishing a mechanism for taking into consideration women's expectations and feedback through methods such as CBM and RKS
- Community-based monitoring to be strengthened and made functional for a woman-centric approach
- Strengthening a post-partum care programme as a continuum for one year after birth or till next pregnancy
- Working with two or more states to establish a midwifery cadre piloted contextually and then bring to policy level for upscaling. Should this be a new cadre? Or ANMs and Staff nurses to be trained in midwifery? This question needs to be discussed.
- Birthing facilities to be decentralized and closer to homes for personalised birthing experiences (travel time to be 1 hour or lesser – for example Sub Centres should be equipped as birthing centres). These centres should be women-centric and competent (to handle complications) and have adequate facilities
- Allocate separate budget for women-centric maternal health and universal health coverage
- Pre birth consultations and consent – for example on IUCD insertion post birth.

The next session was designed to prioritise the material emerging from these group discussions so as to develop a position on Women Centred Maternal Health Care.

Developing a position on women centred care

Sundari Ravindran facilitated the prioritisation exercise. All the participants were asked to write down on a piece of paper what according to them were the **three key areas of action** with regard to women centred maternal healthcare. These actions have to be feasible and have a potential for success. The participants were then asked to discuss the same within their respective groups. Each group had to then collate all suggestions, prioritize them, and come up with three to four key points of action.

The group-wise priority points were as follows:

Group 1

- Creating platforms or mechanisms to share information of women's health rights and entitlements, eg VHND can be one such space where a number of community groups are gathering.
- Community-based monitoring
- Effective redressal mechanisms
- Capacity-building of FLW and all health workers on women-centric health care
- Male engagement for safe motherhood/positive birthing experiences of women
- Youth sensitization (especially for boys) on SRHR

Group 2

- Galvanizing existing institutions (e.g. VHNSC, women's collectives, SHG) on gender justice
- Accountability mechanisms e.g. women's feedback should be ensured and grievance redressal
- Sensitization/perspective-building/awareness across the system
- Women's charter of demands with women leading the conversation
- Working with boys and men for addressing gender and social imbalances

Group 3

- Ensuring accountability at the community and systems level – eg. For JSSK enforcement increase community awareness through well deigned local language infographics. Or mobile apps.

- Capacity-building in skills and sensitization towards women centred health care
- Birthing close to home (with one hour of her home), eg. birthing huts
- Dignified and respectful childbirth experience – eg position of bed

  A strategy could be to work with the system by suggesting a menu of ideas, consult them to identify spaces, identify champions, and co design an implementation plan with them. Be a resource for them.

Group 4

- Establishing a system for consulting women and communities (by engaging civil society) reduce information asymmetry so that women can access rights and raise grievances
- Introduce and strengthen continuum of care right from the broadening of post-partum care and contraception to at least upto one year after birth or the next pregnancy, and provide adequate and appropriate nutrition throughout
- Facilitate births as close to home as possible with competent midwives and facilities
- Establishing a midwifery cadre from the existing ANM, GNM and midwives

As illustrated above, there were a lot of commonalities and recurrent themes in the points put forth by the four groups. Sundari summarised the discussions as follows.

Ensuring accountability at the community and systems level

The actions that came under this heading had to do with: creating platforms or mechanisms to share information of women's health rights and entitlements; establishing a system for consulting women and communities (by engaging civil society) reduce information asymmetry so that women can access rights and raise grievances; galvanizing existing institutions (e.g. VHNSC, women's collectives, SHG) on gender justice; activating community-based monitoring and effective redressal mechanisms

Preparing human resources for women centred maternal health care

There are a series of action points under this heading: establishing a midwifery cadre from the existing ANM, GNM and midwives; capacity-building of FLW on women-centric health care; sensitization of **all** facility staff including chowkidars to evoke empathy and stop all forms of violence on women, including during ANC and PNC, and to stop irrational and harmful practices in facilities.

Another important point that recurred throughout the consultation was that Front Line Workers, Nurses and other staff providing maternal health care, also have to be looked after

– their own safety, dignity, and motivation has to be ensured. These women have also to be considered as central within the concept of women centred maternal health, in addition to pregnant and birthing women.

Introduce and strengthen continuum of care right from pre-pregnancy, provision of quality of ANC (which includes issues like their rights and responsibilities, consent for post birth contraception), broadening of post-partum care and contraception to at least upto one year after birth or the next pregnancy, and provide adequate and appropriate nutrition throughout

Philosophy of midwifery should inform the birthing process closer to home either through well equipped and competent sub centres or birthing huts, or through the hub and spoke model.

Changing community norms around maternal health: to reduce pressure on women, prevent violence against them, enhance community support, and enhance men's role and their support and care for their wives and all women; reducing information asymmetries.

A strategy of working on these ideas is to identify champions within the system and work with them on this menu of ideas related to women centred maternal care, create ownership. CommonHealth members and collaborators can be local resource groups to support these processes.

Prakasamma reinforced that the 'philosophy of midwifery' as the core of woman centred maternal health is a message that must be amplified amongst all advocates.

Another idea that was mooted was a name or logo for this effort – *Journey of Change towards Gari-Maa*. *Garima* means dignity. There was a debate around this term because of its association with nationalist pronouncements of the country's *Garima*! Another viewpoint was that woman centred health also includes abortion and so an emphasis on '*ma*' and mothers may be exclusionary?

Discussion on strategies and relevant actions for follow-up

Chair: Renu Khanna

Swati led a brainstorming exercise on what CommonHealth could do to take this entire discourse forward. What can CommonHealth do with its members? What strategies could CommonHealth as a coalition take up? The suggested strategies had to be: (i) feasible, (ii) across geographies, (iii) across different levels/platforms, and (iv) across capacities. Swati responded to a question about the structure and composition of CommonHealth. The coalition has 350 individual members in 24 states, with 55 institutional members and 14 steering committee members.

Developing a narrative on women-centred maternal healthcare

Sundari suggested building a narrative around women centred maternal health – rights-based, putting women at the centre. Renu Khanna said that a position paper could be developed by CommonHealth on "women-centred maternal health care", to build a common understanding amongst the entire membership. A list of messages on women-centred maternal health could be developed. These would be 5 to 7 things easy for people to remember; and can be translated into local languages for wider reach. Aditi Iyer suggested using social media for communicating these messages which continue to build the narrative. Mr Balu also suggested developing podcasts based on positive stories of woman centred maternal health care which could be disseminated on social media.

Dr Sharad Iyengar spoke of the **need for having indicators on what was considered women-centred maternal health** at three junctures: end of pregnancy, after delivery, and one year after delivery. This would make the concept of women centred maternal health clearer.

Ms Sanjeeta spoke of creating a non-negotiable list of points, i.e. a Resource Package or a tool kit with regard to woman-centred maternal healthcare. The WHO Guidelines could become a part of this package. Ms Sandhya opined that in the areas they work, written material which is text-heavy was not beneficial, and voiced the need for pictorial representation of information. Using appropriate language in women-centred healthcare messaging.

Ms Bijaylaxmi spoke of the need to replace techno-centred language in messaging (by CommonHealth). Adding to this, Dr Prakasamma spoke of how one time, the word 'labour' (for childbirth) was mistaken as 'labour' (as in human resources and employment) by one labour union minister. Sandhya mentioned the need for inclusive language – pregnant woman or pregnant person?

Renu Khanna nominated Dr Prakasamma to review the language thus used by CommonHealth. Dr Sundari Ravindran added that Dr Sharad must review the narrative/indicators for women-centred maternal healthcare. A working group was created to create messages for social media – Apurva, Srilakshmi, Sandhya, Bijaylakshmi, Jenny volunteered to be part of the group.

Dissemination of information to stakeholders: What and How

A question raised by Dr Prakasamma was how would this information be conveyed to the government and stakeholders like professional associations. She voiced that the reports (say through press conferences) must be shared immediately with government and relevant organizations. Secondly, she raised the question of how to increase the base of CommonHealth; even if not active, individuals and organizations can take back information and use it accordingly. Mr Rajdev suggested that since 11th April is National Motherhood Day, there could be ways this initiative could be linked to the same, such as disseminating to the media, doing press conferences in different states. Renu suggested that existing CommonHealth members must take the initiative to hold regional meetings, then the Steering Committee could include the same in the yearly plan. Moreover, information on any state meeting held by CH must be shared with other CH members and states, and the information and discussions thus generated be hence shared.

Ms Swati spoke of the plan of national dissemination of the findings if the present project, and Dr Subasri suggested that a commentary be written on the outcomes and key points of this two-day meeting in the Sexual and Reproductive Health Matters Journal.

Priya John also asked how governments could be meaningfully engaged with since she opined that with reference to CommonHealth's work, it was a politically challenging situation at present. To this, Renu Khanna replied that we are constantly discussing these issues, and in different states, there are opportunities and openings which can be utilized, for example, the work Ms Apurva Vivek had carried out in Jharkhand, or Mr Rajdev had carried out in Uttar Pradesh.

Working with different women populations

One of the participants also felt that in the two-day workshop, the context of 'urban areas' was largely ignored, as focus was on rural marginalized populations. Priya John voiced that intersectionality must be taken into consideration; however, it is observed that the differences between different identities and communities are highlighted a lot, but there is also a need for solidarity to be developed so that all can come to work together. To this, Renu Khanna proposed that Priya John help the CommonHealth team to review this aspect in its work. Sanjeeta Gawri proposed that there be another large-scale consultation of CommonHealth, similar to the dialogue which was held in 2016, which brought different campaigns and alliances together.

Expansion of CommonHealth coalition and its activities

Ms Meenaxi asked how CommonHealth could be expanded, and if rotational meetings could be held in different states. For expansion, Sharad Iyengar suggested bringing in retired government officers and medical college faculty. Ms Swati elaborated upon the regional meetings held by CommonHealth. She said that though regional meetings of CommonHealth were being held, northeast India had been a challenge. However, recently there had been a workshop in Guwahati on abortion rights, and the participants there had actively discussed issues and created WhatsApp groups, etc. to take forward the discussions. Ms Swati also put forth the need for all CommonHealth members to voice their needs and engage actively with CommonHealth, e.g. if they need a workshop on a certain topic, IEC materials, etc. so that CommonHealth can address the same.

Conclusion

Ms Sanjeeta concluded the meeting by recapitulating the process and the tangible outcomes. She listed the outputs of the present meeting viz.:

i. Documentation report (to be finalised within six weeks ie by early May)

ii. Narrative on women-centred maternal health

iii. Key messages to be disseminated with regard to women-centred maternal health

iv. Creation of a resource package

v. Plan to effectively utilize social media (including podcast, etc.)

vi. Commentary for SRHM.

Ms Sanjeeta ended the two-day meet by asking what the participants felt about being a part of the meeting.

- Sandhya said the action starts now!
- Apurva said that though one may face challenges in doing this work in their respective contexts, such spaces help reinforce one's belief that one is not alone in carrying out such work, and fills one with a sense of belonging. *'We are part of the bigger plan to make things better for women.'*
- Dr Prakasamma said *'I got hope.'* It was heartening to see youngsters working towards this cause even if there was a lack of funds in this field.
- Subhasri attending online said that it was a great meeting with rich discussions, narrative building happens at the larger level. The discourse at the global and national levels needs to be countered, maybe through opinion pieces and scientific writing.
- Ms Bijaylaxmi said that she was quiet because she was absorbing and learning a lot. It felt very nice to meet everyone.
- Priya John suggested that the women themselves can be a part of these meetings as they were the actual "experts" of their experiences. '*Why are we talking about them without them?*' Sanjeeta responded by accepting this viewpoint. Renu pointed out that though this would be an ideal situation, it may result in tokenism and may not be operationally feasible. Also, the members had held consultations with these very women the essence of which was presented in this forum.

Annexure 1 – List of Participants

S. No.	Name	Organization/Affiliation	State/City of residence
1	Nilangi Sardeshpande	CommonHealth	Pune
2	Sandhya Gautam	SEHER	Delhi
3	Apurva Vivek	Hashiya Socio-Legal Centre for Women	Ranchi, Jharkhand
4	Suresh Dhandapani	SOCHARA - MNI	Chennai
5	Rajdev Chaturvedi	Gramin Punarnirman Sansthan	Azamgarh Uttar Pradesh
6	Aditi Iyer	Ramalingaswami Centre on Equity & Social Determinants of Health, Public Health Foundation of India	Bangalore
7	Balasubramanian	Rural Women's Social Education Centre- RUWSEC	Tamil Nadu
8	Sandhya Mishra	Shikhar prashikshan sansthan	Mirzapur, UP
9	Srilakshmi.N	Rural Women's Social Education Centre, RUWSEC	Chennai
10	S Sridhar	Piramal Foundation	Vadodara Gujarat
11	Bhuvaneswari sunil	ARMMAN	Mumbai
12	Bijayalaxmi Rautaray	SAHAYOG	Bhubaneswar, Odisha
13	Sushma Shende	SNEHA,Maternal Child Health,Program Director	Maharashtra,Thane
14	Jayshree Satpute	Nazdeek	Delhi
15	RENU KHANNA	SAHAJ	VADODARA
16	SHILPA SANTOSH KARVANDE	Foundation for Medical Research	Maharashtra/ Pune

S. No.	Name	Organization/Affiliation	State/City of residence
17	Sharad Iyengar	Action Research & Training for Health (ARTH) Society	Udaipur
18	Poornima Nair	Apnalaya	Mumbai, Maharashtra
19	Dr. Satish Gogulwar	Amhi Amchya Arogyasathi	Maharashtra
20	Vijaya laxmi Waghare	Amhi Amchya Arogyasathi	Maharashtra
21	Jennifer Llang	Roots to Branches Foundation	Guwahati
22	Dr. Paridhi Jha	Foundation for Research in Health Systems, Bengaluru, India	Mumbai
23	Jayshree Satpute	Lawyer	Delhi
24	Dr Radha Reddy	Fernandez Foundation	Hyderabad
25	Cheryl Nathanel Anandas	Apnalaya	Mumbai
26	Vanita Choundhe	SNEHA	Maharashtra

Annexure 2 – Schedule of the Consultation

Agenda: Experts Consultation on Women-centred Maternal Health Care

15-16th March 2024

Venue: Hotel Mumbai House, Andheri - Kurla Rd, opposite Courtyard Marriot, J B Nagar, Andheri East, Mumbai, Maharashtra 400093

Day 1: 15th March 2024

Perspectives from the ground: Consultations with grassroots women

Objectives

- Explore and understand, in the context of recent Maternal Health policies and programmes, grassroots women's experiences and perspectives on women centred maternal health care
- Foster a dialogue with 'experts' to build a discourse on women centred maternal health care
- Develop a strategy to socialise the evolving perspectives on women centred maternal health care

Time	Session	Facilitator/Chair
9.30 am - 10.00 am	Registration	
10.00 am - 10.10 am	Welcome and objectives of the consultation	Renu Khanna
10.10 am – 10.40 am	Introduction of participants	Swati Shinde
10.40 am – 11.00 am	Brief introduction to the Maternal Health thematic work by CommonHealth *(Brief overview of CH work under MH theme)*	Sanjeeta Gawri
11.00 am – 11.15 am	Tea break	

11.15 am – 12.00 pm	Social inequities and intersectionalities in maternal health policies • Historical overview of Maternal Health policies and programmes in India • Critique from an equity and intersectionality perspective Open discussion *(Reflections from participants/comments)*	Chair: Leila Varkey Durga Vernekar (15 mins) Expert comments: Aditi Iyer (15 mins) 10 mins
12.00 pm- 12.05 pm	Discourse Building on Women's Centred Maternal Health Care: Introduction to Study and Methods	Presenter: Renu Khanna
12.05 pm -1.00 pm	Panel presentations by CommonHealth study partners: *Building a Discourse on Women's Centred Maternal Health Care* *Fishbowl exercise*: *The study partners will be invited for a panel discussion.* Group I: Issues and concerns of women seeking MH care (Family/Community/FLWs/Health systems level) 45 mins **Partners:** 1. Shikhar Prashikshan Sansthan, Mirzapur, Uttar Pardesh 2. DEEPs, Dharmapuri, Tamil Nadu 3. Amchi Amchya Arogyasathi, Gadchiroli, Maharashtra 4. SAHAYOG, Odisha *Additional inputs from other partners if any*	Chair: Renu Khanna
1.00 pm -1.45pm	Lunch break	

1.45 pm -2.30 pm	Group II- Women's expectations (at Family/ Community/FLWs/Health systems' level) **Partners:** 1. Grameen Punarnirman Santhan, Azamgarh, Uttar Pradesh 2. Hashiya Socio-Legal Centre, Ranchi, Jharkhand 3. RUWSEC, Chengalpattu, Tamil Nadu 4. SAHAJ, Vadodara , Gujarat	Chair: Sanjeeta Gawri
2.30 pm- 3.00 pm	What is women-centred maternal health care: Findings from the ground *Open discussion*	Chair: Sharad Iyengar Presenter: Sundari Ravindran
3.00 pm - 3.50 pm	Panel of experts (presentation) *Panellists will share their expert comments -10 mins each* What are the challenges and women centred solutions with respect to: 1. Human resources for maternal health care 2. Technical Quality of care 3. Continuum of care /health systems 4. Addressing Social determinants of Maternal Health: Challenges beyond health systems	Chair: Alka Barua 1. Prakasamma 2. Radha Reddy 3. Sridhar Srikantiah 4. Anjali Radkar
3.50 pm – 4.00 pm	Tea break	

4.00 pm -5.15 pm	Group work: thematic groups and presentations *(The objective of this session is to deliberate and discuss in groups the below given thematic topics keeping in mind the intersectional and equity perspective and come up with position and recommendations for women centric MH care. The participants will be divided in 4 thematic groups as per expertise and interest.*	Chair/Rapporteur
	Group 1: Human resources for maternal health care	Shilpa Karvande / Poornima Nair
	Group 2: Technical Quality of care	Arun Gadre /Jennifer Liang
	Group 3: Continuum of care /health systems	Sarika Chaturvedi / Paridhi Jha
	Group 4: Addressing Social determinants of Maternal Health: Challenges beyond health systems	Sandhya Gautam / Jayashree Satpute
5.15 pm – 5.30 pm	Reflections of the day and way forward	Nilangi Sardeshpande
Day 2: 16th March 2024 **Building a discourse on women centred Maternal Health care**		
10.00 am – 10.15 am	Recap of Day 1	Bhuvaneswari Sunil
10.15 am -11.15 am	• Plenary presentations by groups (10 mins each, total 40 mins) • Discussion (*The discussion should highlight women centred perspective, intersectionality and equity)*	Rapporteurs of the groups Chair: Priya John

11.15 am -11.30 am	Tea break	
11.30 am – 12.30 pm	Developing a position on women centred care *Participatory exercise*	Facilitator: Sundari Ravindran
12.30 pm – 1.00 pm	Discussion on strategies and relevant actions for follow up At the various levels (community, state and national)	Swati Shinde
1.00 pm -1.30 pm	Summary and wrap up	Sanjeeta Gawri
1.30 pm -2.30 pm	Lunch	

About SAHAJ

Since its inception in 1984, **Society for Health Alternatives - SAHAJ** has focussed on comprehensive development of children, adolescents, young persons and women especially from 30 bastis from urban Vadodara. Additionally, through its partner organisations, SAHAJ has been working in Anand, Dahod and Mahisagar districts of Gujarat for Adolescent/Youth Rights, Reproductive Health and Community Development; and in the state of Punjab and Assam for localising SDGs 2030.

About CommonHealth

CommonHealth - Coalition for Reproductive Health and Safe Abortion, constituted in 2006, is a rights-based, multi-state coalition of organisations and individuals that advocates for increased access to sexual and reproductive health care and services to improve health conditions of women and marginalized communities in India. Within sexual and reproductive health and rights, CommonHealth concentrates its efforts largely on maternal health and safe abortion. The coalition draws its membership from diverse disciplines, thematic areas and geographies within the country.

Sahaj

towards alternatives in health and development

CommonHealth