Two-Day National Round Table Discussion on 'The Need to Stimulate Community Action and Accountability in Reproductive Health'

March 22-23, 2018

Vishwa Yuwak Kendra

New Delhi

ACRONYMS

ADM	Additional Magistrate Judge
ADMO	Assistant District Medical Officer
ANC	Antenatal Check-up
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
BMGF	Bill and Melinda Gates Foundation
BMO	Block Medical Officer
CAG	Comptroller and Auditor General
CBO	Civil Based Organizations
CDMO	Chief District Medical Officer
CDPO	Child Development Program Officers
CEDAW	Convention on the Elimination of All forms of Discrimination against Women
CHC	Community Health Centre
CHSJ	Centre for Health and Social Justice
COPASAH	Community of Practitioners on Accountability and Social Action in Health
CP	Community Participation
CRC	Child Rights Convention
CSO	Civil Society Organization
DFID	Department for International Development
DH	District Hospital
DLHS	District Level Health Survey Data

FGM	Female Genital Mutilation
FP/FP2020	Family Planning
FPS	Family Planning Services
Gok	Govt. of Karnataka
Govt.	Government
HRLN	Human Rights Law Network
ICPD	International Conference on Population Development
IGMSY	Indira Gandhi Matritva Sahayog Yojana
IUCD	Intrauterine Contraceptive Device
JMS	Jagrutha Mahila Sangathan
ICCPR	International Covenant on Civil and Political Rights
ID	Institutional Delivery
IMR	Infant Mortality Rate
INGO	International Non-Governmental Organizations
JMS	Jagrutha Mahila Sangathan
KJC	Karnataka Janarogya Chaluvali
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MO	Medical Officer
MSAM	Mahila Swasthaya Adhikar Manch
NAMHHR	National Alliance for Maternal Health and Human Rights
NFHS-3	National Family Health Survey 2005–2006
NFI	National Foundation of India
NGO	Non-Governmental Organization

NHRC	National Human Rights Commission
NRHM	National Rural Health Mission
OB/GYN	Obstetrician/Gynaecologist
OBV	Obstetric Violence
PHC	Primary Health Centre
PMMVY	Pradhan Mantri Matritva Vandana Yojana
PMNCH	Partnership on Maternal Neonatal and Child Health
PPIUCD	Postpartum Intrauterine Contraceptive Device
PRA	Participatory Rural Appraisal
QoC	Quality of Care
RH	Reproductive Health
SA	Social Accountability
SDG	Sustainable Development Goal
SHRC	State Human Rights Commission
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive and Health Rights
SC	Scheduled Caste
ST	Scheduled Tribe
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UoI	Union of India
UP	Uttar Pradesh
UPR	Universal Periodic Review
USAID	United States Agency for International Development

WHO   World Health Organization

WRA   White Ribbon Alliance

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The Need to Stimulate Community Action and Accountability in Reproductive Health

Round-table discussion organized by COPASAH
22-23th March 2018
Vishwa Yuvak Kendra, New Delhi

I.   Introduction

COPASAH organized a two-day round table discussion on 'The Need to Stimulate Community Action and Accountability in Reproductive Health' on the 22nd and 23rd March, 2018 at Vishwa Yuvak Kendra, New Delhi. It is a part of the ongoing initiative of COPASAH to push the agenda of social accountability practices around the issue of reproductive sexual health in different contexts. The main purpose of this round-table was to act as a preparation ground for the upcoming COPASAH symposium to be held in 2019. The round-table brought together 20-plus activists, researchers, human rights experts, developmental agencies, academicians from different regions of South Asia, Latin America, Africa and India working in the field of reproductive health and rights.

II.   Background

Maternal Health and subsequently Family Planning have emerged as important agendas of global health programming over the past two decades. In the years leading to the Millennium Development Goals, reduction of Maternal Deaths became a key indicator of improvements both of population level health as well as health systems. Multiple systems for promoting safe childbirth, as well as monitoring progress were established through mechanisms like the Partnership on Maternal Neonatal and Child Health (PMNCH) headquartered in WHO, Maternal Health Task force headquartered in Harvard University, the Countdown to 2015, the WHO Commission on Information and Accountability (CoIA) on Women and Children's Health and the UN sponsored movement Every Woman Every Child. In 2012, the United Nations' Office of the High Commissioner for Human Rights (OHCHR), also issued a technical guidance on the application of a human rights-based approach to the implementation of policies and programmes for the reduction of preventable maternal mortality and morbidity and subsequently conducted a review of it has been applied, in 2014. Similarly, access to contraception has received a boost through the Family Planning 2020 partnership which aims to expand access to family planning information, services, and supplies to an additional 120 million women and girls in 69 of the world's poorest countries by 2020. In the SDG paradigm maternal health remains an important target along with family planning, within the Goal 3 on health and well-being. Universal Access to Health Care

and sexual and reproductive health services in particular find prominence in both Goal 2 and Goal 5, suggesting that they are indeed important priorities in the global health and development discourse.

Ironically however, despite the tremendous interest, and visibility that issues such as maternal health and family planning have received in the last 15 years, reproductive health programming in this time has been remarkably top-down, driven by global goals and targets, rather than community needs. In case of maternal health, the push to institutionalize deliveries has resulted in the subjecting of women to poor quality services, and undignified treatment. In case of family planning, since the establishment of the FP 2020 initiative by donors like BMGF and DFID, globally many more countries have up-scaled their family planning programmes. The issue of coercion, and poor quality has been consistently highlighted in the past and were key to the discussions of ICPD (International Conference on Population and Development 1994). The FP programmes in India and Peru (under Fujimori) have been internationally decried. In the last ten years stories of forced sterilization have re-emerged as an issue in Eastern Europe (with Roma communities) as well as Africa around PLHIVs. With the renewed emphasis on Family Planning programming the issues of quality and coercion have become important once again and it is necessary to draw attention to social accountability as a key mechanism to guard against any form of coercion, disrespect and poor quality which form a continuum. Simultaneously, the growth of the private sector has given rise to new concerns around the rise of un-indicated procedures like C-sections and hysterectomies. Very often, the policies as designed, are not suitable for large swathes of populations, who have little say in how they should be tailored to their needs. In the domain of reproductive health especially, this takes on great significance because on the one hand, reproductive health is an intensely contested domain, with social control of women's bodies being the point of struggle, On the other hand, women have been typically seen as passive recipients of medical reproductive health interventions (sometimes against their will), and their capacity to negotiate with services is also poor owing to their relative marginalization and disempowerment. It is in this light that access to contraception, quality maternal health services, access to abortion services and so on have been central struggles of the feminist movement. Social norms that hinder the realization of reproductive rights are context dependent and the "prescription" of largely technical solutions, without adequate involvement of communities is counter-productive. Freedman critiques the current approach of "isomorphic mimicry" in global health policymaking and emphasizes on the need to look inwards towards its citizens rather than copy each other's policies and approaches. In terms of solutions she calls for more grounded research, increased South to South learning and robust social accountability measures to be put in place.

At the present time, the approach of both the SDGs and FP2020, is based on the Government partnering with International agencies, philanthropies, business and large social service NGOs to delivery services. A large number of international agencies, bilateral donors and private philanthropies are providing funds and other support to governments to

achieve the set targets. Many INGOs, Universities and in-country organizations are involved in a multitude of activities to bring about changes. It is a positive development that the idea of accountability within the global health discourse is being acknowledged, within the overall framework of evidence-based practice. However, there is much greater emphasis on 'fixing' the inputs – e.g. human resources and technological options and so on, and the importance of involving the citizens or the communities who experience the services is still not universally seen as important. The idea and practice of both "community participation" and "social accountability", even as it generates great interest in the global health discourse, views communities, especially women, instrumentally, rather than as political agents of change. Further, community participation itself is not without pitfalls and must engage with gender power imbalances within communities, especially in the case of an issue like reproductive health which is deeply contested and challenges patriarchal interests.

Rationale for this hub:

If the SDGs have to reach the last mile and include the most marginalized, a more comprehensive approach to development must not ignore the stake that women themselves have in the designing, delivering and monitoring of reproductive health programs. At this time, the idea of involving citizens as the main stakeholders of this process is not being considered and consequently, the thrust on community engagement and ownership is not well articulated. COPASAH's Maternal and Reproductive Health Hub looks to fill this gap by engaging more vigorously in promoting the practice of community action and social accountability in the field of reproductive health, which engages with power imbalances within communities and between communities and health systems, to advance an understanding of accountability that center-stages women's rights. It will do this through stimulating a conversation around the role of communities in reproductive health governance, especially around issues of autonomy and self-determination which are central to human rights and participation in governance.

Objectives of the Meeting:
This meeting will convene a group of experts from across the globe have been identified to be a part of this hub.

(1) Take stock of current knowledge and practice around community participation and accountability efforts in reproductive health globally, and in different regions.

(2) Draw learnings for the practice of accountability and community participation, from grassroots efforts that have attempted to strengthen bottom-up accountability in reproductive health through involving communities.

(3) Building on (1) and (2), propose future directions of work for the COPASAH RH hub around strengthening the practice of community participation and bottom-up accountability, building evidence on existing efforts and influencing global policy processes.

Outcomes:

(1) A documentation drawing lessons for strengthening practice, research and advocacy in advancing community-led bottom up accountability in reproductive health.

(2) A proposed future plan of action for the COPASAH RH Hub, based on priority areas identified

(3) Roles of different participants and how they would like to be involved in the future

(4) A plan for how the theme should be represented (in terms of content, mobilization and formats) at the COPASAH symposium in 2019

Methodology

The meeting intended to be participatory, drawing on participants' experiences. Each session began with inputs/provocations by the moderator and speakers, not longer than 10 minutes each. The floor will then be opened up for discussion and participation of others will be invited. At the end of each session, discussions and key learnings will be summarized by the moderator.

Day 1: Welcome, intro, intended outcomes of the meeting, going over the agenda:

Speaker: Sana Contractor, (Centre for Health and Social Justice/ Coordinator-COPASAH RH Hub) She began the opening session of the round table with a brief introduction about the institutional framework for COPASAH's work. COPASAH is a global network of community practitioners for accountability and social action in health. COPASAH has been here for a while and work largely in 3 continents of South Asia, South Africa and Latin America. It's only in the past few years that COPASAH started moving into thematic mode of working, where we do work on community participation and social accountability under three hubs which are Reproductive Health Hub, Private Sector Accountability Hub and the third one involves indigenous population for accountability in public health. She further announced that they will also be soon coming up with a symposium in 2019. She then went onto briefly introduce the objectives and agenda for the meeting and with this she set the stage for two days of engaged mutual learning.

Session I: Community Participation, Accountability and Reproductive Health- Laying the ground

Speakers: Abhijit Das, (Centre for Health and Social Justice, India); **Victoria Boydell,** (Population Council, Geneva); **Renu Khanna,** (SAHAJ/ COPASAH, India)

The first session of the round table outlined the key concerns in the current discourse around reproductive health, community participation and accountability. It traced the evolution of reproductive health policies and programmes, analysed them with a feminist perspective and discussed the impact that it has had on women's rights. It also looked at the emerging discourse and evidence on accountability in reproductive health and drew out areas where action is required in order to re-politicise "community participation."

Abhijit Das began talking about the importance of focusing on reproductive health by narrating his life history. He mentioned that he began his professional career as a doctor in rural Uttar Pradesh at a time when more than 45,000 women were dying. During the course of his work he was closely acquainted with maternal health and he found that although the situation was grave and the maternal health system was in shambles, the government's primary focus was Family Planning. Despite this, there was hope and optimism - ICPD with it Programme of Action was announced and it put obstetrics and gynaecology into reproductive health which led to a deeper understanding of social determinants that impacted women's maternal health status such as the power to influence, autonomy and the ability to seek care.

The 1990s was a time for new aspirations which led to a renewed visualisation of how health systems could be conceived and, in this visualisation, the centrality of women was focused upon. This set the standard and the bar was further raised in the 2000s when a new way of looking at health care became popular. Decentralisation, community engagement and rights were upheld and articulated in the public health standards. In 2005, the Millennium Summit was held in New York, where our Prime Minister learnt that India was performing worse than Bangladesh on maternal health indicators, the outcome of which was a greater emphasis on maternal health in the public health system.

Around that time, there was a global consensus that skilled birth attendance was a vital link that could improve maternal outcomes, but the way in which it eventually got interpreted in India and implemented was problematic. It led to the overnight de-legitimisation of home births and the relegation of traditional birth attendants to the margins of the health system. Further, the push for institutional deliveries was seen as the way in which skilled birth attendance could be ensured. This push however, ignored the fact that our health centres were poorly functioning and that we lacked both infrastructure as well as qualified health providers. Hence it was no surprise that this approach did not improve maternal health outcomes as the health system had too many weaknesses.

Globally, the discourse was moving towards a new kind of fundamentalism - one dominated by the presence of technical agencies, academicians and donors all of who began to dictate the discourse. Accountability became the buzz word that was being mouthed by several players - the PMNCHA and even the World Bank - all of whom had a different understanding of what constituted accountability. So, at a time when the government and the various technical agencies were in a overdrive to prove that the mantra of 100% institutional

deliveries was working, CHSJ and other civil society organisations conducted a study to understand what was actually happening when women opted for an institutional. The study sought to capture the experiences of these women and our findings of the lack of quality care and the ill-treatment that was meted out to women by health providers, was taken up by the White Ribbon Alliance and was termed as 'Disrespect and Abuse'.

The global trend has been supplanting models across different countries with scant respect for the contexts and local specificities. And in all this, women figured last, they were relegated to the margins and figured the last and the least in the discourse. The global interest now is on the provisioning of family planning services and it is essential to create a counter narrative by building grassroot evidence with the support of academicians to bring about a change in the lived reality of women in hospitals and homes.

Taking off from where Abhijit left, **Victoria Boydell** mentioned that she was associated with a USAID project that was examining evidence to see if social accountability could improve the provisioning of family planning services. She mentioned that after engaging in social accountability and developing report cards to grade the services they were able to improve service utilisation, delivery, provider knowledge and information, governance issues and ultimately health outcomes. Hence, she felt that there was very powerful evidence on why social accountability was important. She felt that the results of research on social accountability could be used to inform programming, especially if the research shifted its focus from exploring the 'how' to identifying 'what' or the factors responsible.

She highlighted that there was an increasing obsession with scaling up and costs incurred by such attempts. Scaling up could mean many things - expanding to the scope or direct replication in new geographies or mainstreaming into the health system or implementing in a wider accountability system. The threat of scaling up is the possibility of attempting the instrumentalisation of a political solution or resorting to technology - making a technological fix thus rendering them apolitical. However, the positive side of it is that there is a lot of interest in social accountability currently.

Renu Khanna mentioned that she had engaged in mapping the accountability initiatives for maternal health that were in India since 2010 and that her work was informed by the women's health movement, the protests to stop the introduction of harmful contraceptives that were dumped into India by the Western nations and the two-child norm and coercive population policies. She felt that there was a lot of work that had been done in India such as monitoring the quality of health care by various alliances such as the National Alliance for Maternal Health and Human Rights (NAMHHR), Public Health Movement, White Ribbon Alliance, Maternal Health Rights Campaign and Health Watch Forum. The documentation of maternal deaths by Common Health (Dead Women Talking) and by NAMHHR (Chronicles of Deaths Foretold), the series of maternal deaths in two blocks of Godda District (Jharkhand), work by Oxfam and the work done in Koppal District (Karnataka) through the Gender and Health Equity project. Several social accountability public hearings were held organised by

Jan Swasthya Abhiyan and NHRC and Oxfam. There was also the use of technology to promote accountability notably by the Video Volunteers and the Mera Swasthya Meri Aawaz campaign by SAHAYOG.

Litigation was also made use of by the Human Rights Law Network which filed a series of litigations on Reproductive Health rights violations, there were quasi-judicial efforts the National Human Rights Commission (NHRC), the Women's Commission and reports of the Comptroller and Auditor General (CAG) of India. Accountability was also ensure using institutional processes including CEDAW Shadow reports, MDG 5 CSO monitoring reports, UPR -III, position papers, etc. Budget accountability was being sought by the People's Budget Initiative and the Centre for Budget Governance Accountability. Policy advocacy using legislatives and elected representatives was being carried out by CLRA. Thus, it was evident that a lot of rich work using different methodologies and strategies was done moving away from verbal autopsies to social autopsies was done to capture the community perspective of why deaths were happening.

Hence, a whole culture of demanding accountability was spreading and the idea of citizenship was gaining ground - the fact that people have rights and can demand for these rights, especially the marginalised populations.

There were problems however, the foremost being that the advocacy was ad hoc and weak in that it failed to leverage each other strengths. Further there were limited spaces open to take learnings into policy and programmes and this has been shrinking rapidly. The present climate is one of completely rejecting CSO participation even in the mandated spaces, hence the need for civil society to synergise is ever greater. We are left with the question to ponder - where do we go with all this; if WHO is being dismantled and not allowed to function, then where does our accountability work go.

Discussion: Working in silos was acknowledged as a major challenge that faces us as civil society and the question was how we could bring people working at the community level together and how we could adopt different models and engage with communities.

It was also pointed out that while the global agenda might be made with good intentions, when it came down to the level of implementation, it was not always good. Citing the example of conditional cash transfer, it was mentioned that in many of our middle-income countries these were now being used as a tool for coercion. While it is true that the MDGs focus on the issue of rights and quality, the issue of access for the poorest of poor was neglected.

The current scenario is one in which there is state capture and the de-politicisation of public health globally. From 2008 onwards, there is an increasing professionalization of women's health and several international conferences are being held to discuss the issue. There is the example of WHO which is being funded by organisations that are not democratic such as USAID, hence the kind of accountability work that they would advocate for cannot be democratic and be representing the issue of the marginalised, although it is true that WHO is at least multicultural. Or take the example of The Lancet, which does not have anyone

from the Global South on its international advisory board. Further, an examination of the budgets show that a lot of work has been done by local and national NGO vis-à-vis the funding received by them, which is in contrast to the amount of funding received by international NGOs vis-à-vis the work done by them.

It was also pointed out that the people who were undertaking the review of accountability were not giving enough importance to documentation of the actual work that was being done to demand for accountability. The understanding of what constitutes accountability also varies, there is a World Bank's understanding of accountability - where social accountability is being reduced to just the monitoring of performance, but in our understanding social accountability is a political process that talks of changing power structures.

It was pointed out that we as researchers are also limiting ourselves to establishing the accountability of providers, we rarely talk of the accountability of policy makers or international organisations. Further, it was worth pondering where the nature of accountability changing and whether in countries like ours where the funding shapes the agendas, how do we demand for accountability. The understanding of accountability, it was felt, has changed, the language has changed and the conceptual frameworks are evolving and can be helpful in understanding our own work. Knowledge building can become an industry and it is important that practice should involve with knowledge building and it is important to articulate, which is where COPASAH comes it in and it is essential for us to acknowledge that for us accountability has political dimensions and it involves the politics of participation and knowledge making. Just because, the Global South is funded by international NGOs it does not mean that the solidarity among us should get affected; rather we should use our projects, funding and programmes to become effective and we should keep our whistle blowing function alive, so that we are aware at all time of what is going on. It was felt that there is enough steam in the social accountability process to keep it going and take it forward. Finally, in our work on accountability we should not forget the role that locally elected bodies have to play, especially as this is one of the ways in which to ensure sustainability and keep the work going.

Session II: Rights-based concerns around reproductive health and efforts to engage communities: Regional perspectives from South Asia, Latin America and Africa

Moderator: Jasodhara Dasgupta, National foundation of India (NFI), India; Wilson Imogan, Women's Health and action Resource Centre, Nigeria, Africa; Ariel Frisancho, CMMB, Latin America; Michelle Sadler, Universidad Adolfo Ibáñez, Chile, Latin America; Shireen Huq, Nariphokko, Bangladesh; Reena Shrestha, Beyond Beijing Committee, Nepal

Building on the first session, the contributors in this session focused their presentations on regional specificities and experiences around rights-based feminist reproductive health concerns and the practice of community participation and accountability.

AFRICA

Wilson Imogan began his presentation by pointing out that Nigeria is a new democracy and the issue of social accountability in the health sector is relatively new and therefore, extremely weak. The govt. has a very male centric approach to reproductive health issues at national and sub-national level. Women's rights are not mainstreamed at the national level and in terms of commitments to international declarations such as CEDAW etc. not much is done.

Imogan mentioned that their organization 'Women's Health and Action Resource Centre', works at the sub-national level and is still in the learning phase. They have conducted several studies on maternal deaths, reviews etc. and have all the documentation in place in the form of reports and queries etc. But they remain largely unaddressed because their organization believes in no shame, no name and no blame policy. Another problem that they found while working with the local govts. is that they have little regard for maternal health which further gets reflected in budget cuts, insufficient manpower and resources and quality of care comprised at various public health facilities.

Some of the positive changes that have come about in the region with efforts from CSOs/NGOs include community participation i.e., communities now take charge and ensure that women have access to health care services. Second, earlier having a woman to deliver nationally was expensive but now with advocacy around the issue there is free maternal care for women at govt. facilities. Lastly, Female Genital Mutilation (FGM) is very rampant in in the country, but with the passing of the law against FGMs it is now a criminal offence to cut a lady.

LATIN AMERICA

Ariel Frisancho talked about how the inequalities in health and education, along with ethnicity and rurality, affect women's ability to access modern contraceptives methods, emergency contraception, safe abortion, safe motherhood and delivery. He further enlists some of the dissonances and systemic challenges that they came across while working in the area of RH:

- **Universal Health Coverage = Universal health insurance:** but the way they are construed as having different meanings differently has led to a situation where people are not aware that they have an insurance and access to quality health services.

- **MDGs:** Donors are more focused on "value for money" and 'performance" metrics, dismissing quality and rights dimensions/cultural appropriateness (modern approach) and rural access (and some remote areas where accessibility is difficult).
- **Vertical Organizations:** Authoritarian practices (Mis-use of cash-conditioned transfers/ "Institutional Deliveries", etc.) Women are coerced to deliver in institutional services.
- **Underlying discrimination:** Non-significant electoral weight
- **Challenge for governance:** Lack of accountability culture- to whom should one report to?
- **Unequal power relations:** For instance, in some Latin American countries, the church has power over the use of contraception.
- **Corruption and economic interests:** Menace and prosecution of accountability initiatives
- **CP costs/Volunteers' crisis/co-option/partisan politics**

He further mentioned some of the initiatives made by them towards meaningful community participation to demand accountability. First, engaging in a dialogue and negotiation along with the communities to demand commitments of improved and better-quality health services from the providers. Which is a challenging task because of the different levels of constraint present at various levels of relationships. Thereafter, monitoring of commitments by contesting the proposals of the govt. with evidence from the field; and efforts to follow up on various issues in public health care. Third, work with media to create a momentum around the issues and to put pressure on the govt. and fourth, they also work to unite the level of citizen monitoring by forming citizen level coalitions.

Challenges and future course of plan: Ariel further shared that they really feel that results achieved are limited to certain segments of SRHR and there is a need to expand the scope. There is a need to cover the importance of maternal health, there is a need to question the links between MMR and universal health coverage. Another thing that they are going to work on is universal health coverage by finding ways to prevent private sector from taking advantage of people's ignorance. There is also an immediate need to regulate certain areas in public health such as C-section, which are being performed far more than what is accepted; there is a need to regulate unsafe deliveries and clandestine abortions specially in countries where abortion is not legal etc.

Building on the discussions put forth by Ariel in the context of Latin America, **Michelle Saddler** focused her discussion on some of the rights-based issues affecting the region including privatization in health, pervasive incentives, high number of teenage pregnancies, abuse, mistreatment, forced caesareans, forced place of birth, obstetric violence at child

birth in institutions, infanticide (if home birth) and over medicalization in childbirth etc. Inequalities in health affect women's access to quality health difficult.

Some of the dissonances identified: At policy level there is more focus on quantitative indicators (targets) and excessive control of risks ("just in case" obstetrics) and with no regard for women's needs to need quality care, "active transparency," and place of care/birth.

Recently, Venezuela passed a law against VAW and one of the forms of violence that was given recognition here was obstetric violence. While the same was never considered a violence in Latin America because it was so normal and natural.

Some of the initiatives made towards meaningful community participation to demand accountability:

- Evidence-based activism: Knowledge-based is the target of activism. Not only confrontational, but reformist, promoting epistemic change; Obstetric Violence and unnecesareans
- Credential knowledge and experiential knowledge are articulated instead of opposing forms of knowledge. Producing data on what is apparently not a problem and on methodologies that unveil naturalized conventions.
- Verbal abuse in hospitals reduced much faster
- User organizations are translating people's experiences into the language of science and medicine and vice-versa
- Exchange and appropriation of perspectives which leads to change

Some of the problems identified and learnings include:

- They learnt that a change in practice does not mean a change in paradigm.
- Not problem of bad health professionals; but a structural problem (much funding in training health professionals, but underlying culture of practice still there)
- Social cultural determinant of health are not independent variables but what shapes health systems/cultures
- Not bring culture into practice but understand that practice is cultured
- Structural violence, Power, Gender (Violence against women), Economic Incentives.

BANGLADESH

Shireen Huq focused her presentation on highlighting some of the rights-based concerns in Bangladesh. First issue is a lack of awareness among the majority of the population that they have a right to claim from the govt. health services, and among the bearers about their obligation to serve resulting in a non-functioning health system that compels poor people to seek services from the private sector, which are expensive, often inappropriate in terms of diagnostics recommended and drug prescribed and increased OOPE.

Another issue is of Violations: One very prominent violation in Bangladesh is in Family Planning Services (FPS) around the issue of coercion and abuse in sterilization. Bangladeshi women health activist lobbied against the govt. demanding them to withdraw compensation payment and which henceforth, resulted in a positive change. Similarly, with IUCD implant: There is a huge problem with the removal of implant. Here again the activists played an important role. Things are not 100 per cent perfect, but it certainly has improved on paper at least.

Health services in FP in Bangladesh were always fraught with issues of consent, money and increasing C-sections. As Bangladesh had started to follow the Latin American pathway of increasing C-sections. Which was happening on the part of both the providers as well as the women, where women were channelled into demanding and ending up in a C-section. Also, very disturbingly, this phenomenon is especially common among educated women from well of families, who have a clear preference for C-sections. What's all the more unfortunate is that there is no public education around the issue and about the potential harms of C-section etc. and also that there is a drain on the resources of public health sector because C-sections are costlier.

Third issue is that of corruption. There is no other sector as corrupt as the health sector in Bangladesh. Corruption ranges from procurement of drugs, supplies and equipment to highest levels of absentees among doctors in govt. services; to relieving of govt. resources to subsidize the private sector; to corruption induced by pharmaceutical companies, where doctors are increasingly prescribing third/fourth generation antibiotics, unnecessary diagnostics because they get commission from diagnostic labs etc.

Challenges identified:

Corruption is a major issue in Bangladesh but the activists are not able to make a dent because the corruption is not only in the health sector, it is actually starting with high up in the govt. and all the way down. There is an Anti-corruption commission which is non-functional and there is no ombudsman so, people are not able to file complaints against govt. servants. There is Inappropriate matching of resources and professionals. Certain issues that women health activists consider priority but are failing to get policy attention. One is the issue of maternal morbidity, something that a lot of women has suffered from and is not just fistula it is just a whole range of issues. So, that is not getting sufficient attention. Another issue that has come up is increasing number of still births and that is also not getting policy attention.

NEPAL

Reena Shrestha focused her presentation on rights-based issues concerning Nepal and on interventions and strategies used over the years to bring about positive outcomes in RH. First issue that Reena feels is majorly affecting Nepal right now is the issue of gender-based discrimination and more specifically in health where the health system and the society have

poor regard for women's health (more in rural areas than urban areas); Second, is the issue of unsafe abortions. Safe abortion became legal in Nepal in 2002 but despite the law many women still don't opt for abortion because of the stigma attached to the issue. In Nepal abortion is known as the 'killer of the child'; A third issue is the high rate of teenage pregnancies. In Nepal the legal age of marriage age is 20 years but adolescent boys and girls get married before attaining the legal age. Hence, the reason for many teenage pregnancies that put women in life threatening situations and serious complications during childbirth. A fourth issue affecting Nepal is issue of coerced of institution deliveries. Women have to deliver in institutions otherwise they don't get incentives, which is also a major reason behind increasing institutional deliveries.

CSOs in Nepal have been trying to work on reducing MMR by referring to some of the govt. schemes such as maternal incentive, introduced in 2005 and similar other schemes introduced in 2006 and 2012 have played a great role in reducing MMR in Nepal.

For the past few years Reena's organization has also been making various efforts at improving the situation around unsafe abortions such as by providing trainings and programs to nurses so that they can provide comprehensive abortion care, so that many women can avail services in rural areas from trained women and they don't have to get it done illegally from the private sector. Another major challenge that they are facing is with regards to the provision for indication of abortion i.e, if the pregnancies are a result of an incest/ rape. women in such situations should be able to avail the services anytime and anywhere but that is not happening right now.

In the discussions that followed after the presentations, **Akhila Vasan** pointed out that we really need to relocate accountability especially in the context of rising right-wing forces across the globe, where there is expert and corporate capture of policymaking by the private sector. Committees are headed by the private sector; medical professionals have become extremely professional and are performing predatory C-sections and hysterectomies. In response to another presentation she pointed out that *"it's time we play 'name and shame'. Otherwise we'll keep holding round table discussions year after year and reach nowhere".* Taking from where Akhila left, **Michelle Saddler** shared her reflections from the presentations *'Medicalization of childbirth is taking women's right to choose, we need to understand is this fear of consequences of vaginal birth or there is something else behind this.* Added to this, **Jasodhara Dasgupta**, summed up the by stating that it is 'a question of choice vs informed choice' is a fraught question. **Sana Contractor** questions *'why is there a reluctance in calling or accepting how things exactly are? If the quality of the care is poor, then it is. If it is unconsented, then it is.'* **Azra** pointed out few important issues. one, there are research gaps with regards to knowledge that is available, especially in our country, it lacks accounts of institutional violations and women's experiences of it. Second, she also raised the need to unpack some of the terms that were being used such as informed consent, accountability, quality of care, etc. **Abhijit Das** raised the issue of accountability in different locations there are health system aberration manifest difference.

We have to be smart in terms of understanding both the system and our response. Somehow at one point we contract to monitoring standards laid down we thought would be sophisticated enough to convert rights to standards then monitoring standards. But along the way systems mature and probably some standards get met and in the meeting of those standards process new kinds of aberrations emerge. So, Abhijit warns that it is here we need to be conscious of the paradigm that Michelle talked about and how do we consciously in our knowledge building be careful of such accountability and that requires the partnership of researchers and practitioners because there is a trap of public health conversation/language. So, probably we need to learnt to use it and subvert it.

Session III: Community participation and bottom up accountability Experiences from India to address reproductive health concerns

Moderator: Asha George, (School of Public Health, University of Western Cape, South Africa); **Speakers: Sandhya YK** (SAHAYOG); **Jayashree Satpute** (Nazdeek); **Sandhya Gautam** (NAMHHR); **Akhila Vasan/Teena Xavier** (KJC); **E.Premdas** (JMS)

Organizing women to demand reproductive rights in Uttar Pradesh

Sandhya YK mentioned a case study of MSAM women wherein SAHAYOG in partnership with other CBOs compiled cases of maternal deaths and denial of care across many districts in UP (from 2000 onwards) and documented some of the challenges faced by marginal communities in accessing quality care services such as informal fees; and unnecessary referrals without transfer and prescriptions; non-issuance death certificates in cases of maternal deaths; abuse during labour; and the issue of not providing information and obtaining consent with regards to the procedures done on them etc. All of these issues result in a number of preventable maternal deaths; and morbidities and significant expenditures as the poor are compelled to seek private health care.

An analysis of the study suggested factors responsible for the sorry state of affairs in the public health system in UP. Such as unequal power relations between health care providers and users, information asymmetry; and cultural impunity because of poor management of health services; lack of monitoring and supervision at the community/local level; and high level of corruption, lack proper redressal mechanisms where people can go and address their grievances etc., ultimately leading to an "accountability deficit".

After learning about the gaps in the system, SAHAYOG started building 'informed users'. For this they first conducted a campaign on 'Complete Citizens Total Rights, UP which culminated with the formation of a grassroots women's organization, Mahila Swasthiya Adhikar Manch, MSAM (A Women's Health Rights Forum that enables women to feel more empowered in their negotiations with providers and officials).

For bringing the community centre stage SAHAYOG provided technical support (to MSAM) by way of developing training modules, pictorial tools (pictures were used as majority women were illiterate and it made things easy to understand) and by conducting trainings. With the help of these pictorial tools women started monitoring the services and identified specific cases of denial of treatment in hospitals, functioning of the AWCs and budgets cuts etc. Thereafter, the collected data was used to engage in a dialogue with district health officials, where women demanded them to make improvements in the quality of services. Besides this SAHAYOG helps compile data into reports and create press briefs.

During their work with the communities SAHAYOG and CBOs learnt that women are not ignorant but in fact they are a credible source of real-time feedback about the quality of maternal health services. Amplifying their voices has helped bring out authentic grassroots evidence, which has been really powerful in demanding the health providers to take action. They also found out that there is now a culture of answerability as MSAM women are able to access health officials and contact them whenever required. But the gains are limited to MSAM women and non- MSAM women are still demanded informal fees for services. Moreover, there is always a possibility of backlash because many a times when MSAM women go with other women for deliveries, they are turned away with unnecessary referrals because the providers cannot procure informal payments from them. Therefore, SAHAYOG feels that they have not been able to bring about a change in the system.

Legal and social accountability to realize maternal health rights of tea garden workers in Assam

Jayashree Sapute also focused her presentation on a pilot study conducted by Nazdeek to bring about legal and SA intervention for demanding maternal health rights of the workers in Assam's tea plantation gardens. Sapute shared that when Nazdeek first started working in the tea garden plantations, they found that these areas had high maternal mortality, high Infant mortality, high cases of anaemia among both and men but there was no govt. data to refer and understand the reasons behind these numbers. So, Nazdeek's strategy was to first identify a local partner who had the vision to build legal capacities of their staff, to infuse rights-based perspective in their work and to build a legal cell within the organization. So, they partnered with an organization which was based close to the tea plantations, it was an all Adivasi organization named 'Pajhra'. Pajhra worked in different areas, in different villages and tea plantations in Assam. Nazdeek started training them on how to word the demands in a rights perspective, changing from charity language to rights language. During the conversations with local partners and people Nazdeek realized two crucial things, one, that they have to infuse these rights in labour rights and two, to find specific data to lead legal advocacy in order to get specific outcomes (targeted change).

The other barrier was the human rights discourse, i.e. how to use rights-based approach in advocacy at the local level with the local collector, BMO or CDPO etc. was another challenge. To pilot the work, they identified 20 women in two blocks, and started training

them on civic education and rights trainings. They asked women what are the issues, which are important to them and barriers? Some of the issues which came out were reproductive health, right to food, few others included pension and labour issues etc. They went into each subject in the trainings and identified specific issues such as in right to food entitlements, they found out that in ration cards the names of some of the family members were missing and because of which they were getting less ration. Another issue that came up was the absence of ultrasound machine at a CHC, and because of which the people had to get it done from outside or they would not get the test done because they didn't have the money to pay for it.

Further, they also did a geo of the location of the places to which the violations were connected to. For example, in a CHC money was asked by the cleaner, and in a district hospital after the delivery money was asked by a nurse for putting stitches etc. So, over a period of two years they managed to identified specific violations, geo located the facilities and collected solid data and sent complaints to the local officials. They also did media advocacy around the issues. They also managed to set up a grievance forum where paralegals would sit with BMOs and CDPOs at AWCs and then raise these grievances. The grievances would very specific, the data would be very specific for example, as to what grievance happened, where it happened, who was the victim, (they mostly kept the identity of the victim confidential) and who was the person who had asked for the money and therefore, the relief were also very specific and as a result they managed to get specific out comes.

After the pilot project in Assam they further replicated the same model in Delhi. In Delhi they clubbed health with sanitation in one of the slum areas where there were about 150 families and only five toilets for women and which were also in bad shape. They made complaints to the local officials and since the language was rights based they had no choice but respond positively. The toilets were repaired, white washed, seats were changed but there was one problem that did not change and was that the toilets were closed between 10 pm and 5 am. The officials informed us that it's a policy decision and the higher ups need to be approached for the same. Nazdeek then filed a petition and this petition was empowering in the sense that it was filed by the women from the community, it was their decision to move the court. As a result, the policy decision changed for the entire city.

The third petition that they filed was on IGMSY (Rs. 3000 in two instalments). Women who had enrolled for the scheme were denied IGMSY entitlements because it was replaced by PMMVY (Rs. 5000).

Challenges:

- Whenever they file cases on this scheme the most common response is we don't have budget, which is not true.

- The women they engage with are with are mostly illiterate and therefore, writing complaints is a challenge. Recently in Delhi and Assam complaints over the phone has been very empowering. The system that they Nazdeek uses right now is SMS based which they are planning to transition soon.
- Transition has been a challenge: Transfer of leadership to communities is sometimes a challenge. The idea is to keep the community monitoring system active irrespective of if Nazdeek is present or not. There is need to develop the community's capacity and a knowledge repository of its own has been a challenge.
- Livelihood issue is another important issue that Nazdeek plans to take up in future.

Negotiating accountability in family planning programs- NAMHHR

Sandhya Gautam focused her discussion on the issues around accountability in family planning and on some of the strategies used by NAMHHR in negotiating CP and SA in family planning programmes. She began, the main problem that we are facing right now is how the commitments made at international get translated at the local. The picture looks very rosy at the global level but as it reaches down at the local level the language changes. It becomes more target driven, coerced, female oriented. The approach completely it is seen more as a 'population control' measure rather than as 'family planning'. There is no concept of informed choices, no respect for women, quality of care is compromised, there are high rates of failures and complications etc. Therefore, it is a kind of forced implementation of the program.

NAMHHR uses various strategies for community-based monitoring and to negotiate for QoC in family planning such as evidence generation wherein systematic studies are conducted; women's experiences are documented and reviewed; camp watches are conducted to observe the conditions of the camps and to see if the guidelines are being followed; fact-findings are conducted to find out what happened, when and where etc.

Then the second step is sharing of experiences and results obtained at local, state, and national levels. It is done to bring together scattered experiences, to bring people together, to empower women and communities so that they can negotiate for better services. Then we have public hearings that also involve people, victims, service providers so that effective measures can be taken. Advocacy is another strategy where networks and alliances are built. NAMHHR works and networks with different groups, youth and men etc. Media also plays an important role in highlighting the violations. Similar approach was used in Madhya Pradesh, where the community participated in evidence generation. Check lists were prepared with very specific questions so that it is easy to understand for the community. The responses for the questions were as simple as red light for not good, yellow for okay and green for good etc. and following which a report card was prepared and shared with the service providers to help them work on the gaps.

The potential in using such a strategy is that it is participatory in nature. The community is directly involved in the process of the change, participates in enquiry and negotiation etc. But on the flip side there are limitations too. Such CP monitoring can be done only when clear parameters for quality of care are present and agreed to as issues of common concern by the govt. and the CSOs.

Blowing the lid on un-indicated hysterectomies in Karnataka- Karnataka Janarogya Chaluvali

Akhila Vasan mentioned about some of the fact-findings conducted by KJC in three districts of Gulbarga, Haveri and Chikamaglur. Where through RTI data, they found out about several hubs of unwarranted hysterectomies rackets run by an established network of doctors. In one of the detailed fact-findings that KJS conducted in Gulbarga they found that most of hysterectomies were conducted by private sector on extremely young women. In-depth interviews were done which informed the kind of violations these women were exposed to by "trained medical personnel". The fact-findings on the ground were supported by medical analysis by a panel of practising gynaecologists who independently arrived at what was wrong with each those medical records.

KJC used a range of strategies and actions to get responses from various commissions, committees and the state govt. It engaged with the popular mainstream media particularly television (Kannada television) in India in an active manner. In one of instance, because of a TV9 sting operation the Women's Commission took *Suo moto* cognisance and ordered an inquiry. KJS wrote extensively Kannada newspaper columns which helped form public opinions. Then there were a series of campaigns and protests that KJS lead on the ground which was extremely crucial in putting the pressure on district administration to order an inquiry.

KJC filed complaints with various forums and commissions such State Human Rights Commission (SHRC), Karnataka Medical Council (KMC), State SC/ST Commission, PS and Health Commissioner, Health and Family Welfare, Chief Secretary, Govt. of Karnataka (GoK) and Tanda Development Corporation etc. and then were two enquiry committees constituted, one by Department of Health and Family Welfare and the other one was conducted by Karnataka State Commission for Women.

They also worked with women on the ground and organized them and kind of formed coalitions on the ground. They had support from JMS, Dalit Women's Collective and Right to Food actually came and supported as they saw 'if these women can do it so can we.' So, these kinds of efforts were made to bring women together.

Status of Demands

1. **Compensation:** District formed a committee to estimate the number of women and the criteria for dispensing compensation but it's still dragging.
2. **Closure of hospitals:** six hospitals were closed for six months. But hospitals went to the court and got a stay order.
3. **FIR:** filed against one hospital under section 336
4. **Recommendations made to KMC:** to cancel the license of 6 doctors but no action has been taken in this regard.
5. **Karnataka govt. moved to amend:** Private Medical Establishments Act.

Some of the struggles that KJC faced since the struggle started, there has been a huge resistance from the private hospital lobby against KJS. There were pitched battles fought within the committees, inside the rooms on social media platforms- Facebook, Twitter, WhatsApp etc. and on the streets and in mainstream media and newspapers etc.

While all this happened, KJC managed to have few victories such for the first-time patients' rights put onto public discourse. Patients' Rights Charter was made justiciable; Many mass-based organizations, sangathans and representatives took it upon themselves to lead the movement; third, District Registration and Grievance Redressal Authority was set up; Fourth, there was huge legal and a regulatory vacuum around the democratic accountability of private hospitals but they have been able to create space for us to negotiate; and lastly, they managed to filed two petitions in the Karnataka High Court and impleaded in an ongoing PIL on hysterectomies in the Supreme Court

Dalit women's organizing around the health rights- Jagrutha Mahila Sangathan, Raichur

Background

E Premdas began his presentation by asking the participants 'What do they understand by caste and Dalit? Taking forward the presentation he began with explaining that caste is a way to sociological window to understand India. Caste is sociological category around which societies are organized in India. There is class- caste configuration in India. 'Dalits' are marginalized communities of India also known as outcastes. The term 'Dalit' is more a social word for movement. It was a social mobilization of Dalit women who are the ex-untouchable of India. Though untouchability is constitutionally banned in India but it is still socially practised in the society in different ways.

In this presentation, Premdas with the help of intervention stories traced the trajectory of Dalit women's organizing around the issue of RH. These stories tell how they came together, and that survival is the biggest struggle with regards to health care and where does maternal health come in reproductive health (RH) during the initial struggle, from where Sangharsh situation in 1919 etc.

First incident: A Dalit woman was stripped naked, paraded and beaten up on the accusation that she was responsible for a Dalit boy fell in love with an upper caste girl and eloped. She was hospitalized and was on the verge of dying. About 15 women from JMS went and stayed in her house for a day, showed solidarity and came back and called a Dalit women bandh, when all the Dalit women (around 1000 women) for the first time came out of their houses.

Second incident: Murders of Dalit women happened. Family gathered the courage and filed case, which was suicide from the husband's side and murder from the woman's side.

Another case: where Dalit women mobilized on gender-caste-based violence etc.

Actions and strategies:

In this whole thing JMS managed to put together a two-fold perspective one is called 'struggle for rights and dignities' and second was 'creative engagement for reconstruction or navnirman'

Second issue: was that the question is not only of 'rights' but also of 'rise'. JMS does a number of experiments in the health system. It engages with the primary health system, with the PHCs to see that system improves and accountability is built up not only in terms of rights but also in terms of entitlements (the services that should be available). That is why maternal health became the closest link that women found. So, this is the trajectory built over the period of 19-20 years.

Medical Officer denied social security (2003): So, the first interface with the health system happened in a slightly different way. KJS was trying to mobilize women to claim social security pension which was around Rs. 200 and for both disabled and old age women at that time. But the PHC Medical Officer (MO) who was authorized 35 to enlist women on the basis of their age, indiscriminately recorded everyone's age blindly and exploited each one of them by charging Rs. 400 then, which infuriated all of them and that lead to the beginning of a huge struggle. That is how the engagement with the PHCs began.

Women get to know PHCs: A yearlong campaign began called 'Come let's claim our spaces PHCs. KJS found that Auxiliary Nurse Midwives (ANMs) wouldn't visit Dalit settlement colonies because of the social stigma and so, none of the Dalit women would ever reached PHCs and none of them had ANC check-ups done. Groups of women from different villages mobilized and formal PHC was set up so that at least entering the PHCs.

Had similar experiences with Gram panchayats and with higher up authorities, police station that's how KJS introduced the entire public surveillance system, women's nutrition system, criminal system and right from the village to district from post of ADM etc. The whole idea was to introduce the system to the women but that was not enough.

Learnings:

Lack of knowledge: not issue among Dalit women/communities but lack of power was. They have power but how they realize that and how confidently they articulate that is important. This what has carried them forward them even today.

How to break the dependence on medicalization of health: Most of Dalits were defined as Dalit women agricultural labourers. Dalit because of in terms of caste, women because of patriarchy and gender and agricultural labourers in terms of class. So, they started engaging with this caste-class-patriarchy configuration. Herbal medicine was something that we thought to help the health workers to break the barriers.

Women active at PHCs: In a recent 2017-2018 campaign where KJC was quite instrumental and visited communities and conducted enquires with help from SAHAYOG's pictorial report cards. In 25 cases we found where women have spent Rs. 75,000 to private sector for child birth or for post-natal care, got trapped there. With an annual income of Rs. 45,00 is their annual income, how did they end up spending R. 75,000. They held a press conference and a huge rally that things are not getting followed up. A week ago, district health officers order came saying that doctors cannot charge so much.

Conceptual framework: how KJS looks at strategy and health: Looking back at our 19-20 years of work with the community, KJS found that for people's survival and dignity is more important and health is secondary. Only mobilizing them on health care or health issues is unsustainable.

He concluded his presentation by stating that bottom-up approach is a horizontally collective resistance and accountability is important to bridge the gap for addressing the structural constraints. Thus, 'Accountability is continuous process and not a finished product.'

Discussion and wrap up: The session concluded with a lively debate arounds issues of answerability, knowledge generation, and where should the buck stop? **Renu Khanna** raised the question of answerability. "*There is an understanding and appreciation for the fact that the person at the bottom of the hierarchy should not be held responsible because it's a systematic violation. My question is then whom should we name and blame, this needs to be unpacked*". Another issue that she raised was about human rights. She said she is in complete favour of quality control standards but she also feels that there should be standards to measure human rights and dignity. She further suggested that there is a need to reframe our quality standards and bring up UDHR into them. **Abhijit Das** shared his reflections on the challenges associated with knowledge making profession. "*He said the common strategy that we see in accountability is mobilization and data generation put together but that's not the real story argued Abhijit, real stories are much longer and complex like jigsaw narratives (example, KJC and JMS) that if a statistician is to pull them on a graph he would have a nightmare! By not putting out all the different layers we reflect only one part of the story and this is what we need be very careful about*", warned Abhijit**.**

Sandhya YK raised the concern about accountability in a scenario when govts. are rolling back schemes, she asked, then in such a situation who should be held responsible? **Akhila Vasan** raised her concerns about the idea of evidence generation being pitted against the ordinary citizen. She questions, "how many deaths the system requires to prove that deaths are happening."

Following the discussion was a **wrap up** session where the participants again shared some of their reflections around the issues of different angles in accountability, about holding religious leaders responsible who are narrowing the RH space. About how there is no understanding on cultural appropriates of health services available and on how the question of what is 'comfort' or 'risk' for women is never taken into consideration when certain perceptions of wellness or childbirth are rolled out without any understanding by practitioners. That is why it is important to first look into what's there and then built on it suggested one of the participants. Another participant pointed out that the issue of cultural appropriateness is contested because such categorization compromises on women's rights to standard universal care. Further it was also emphasized that QoC should not just contain materials about maternal deaths but it should also have material on preventing maternal deaths which would mean looking at nutrition and providing food security. That would also mean that we also need to look at other factors that are involved such as economic issues because it is never one issue that's responsible, it's always a range of issues. The concept of home-based deliveries (HBD) was also discussed in the context of how countries such as Nepal and Bangladesh unlike India are trying to introduce institutional deliveries (IDs) slowly and gradually but they are aware of the present status of facilities and hence, have not rolled back HBDs etc. which is an intelligent move.

Day 2: Session I: Linking Local Efforts with global Advocacy: Opportunities and Challenges

Moderator: Ariel Frisancho; Speakers: Azra (ARROW, Malaysia)**; Aparajita Gogoi** (WRAI/C3, India)

Azra and Aparajit in this session discussed the opportunities and challenges in linking local and global advocacy.

Azra spoke about connections, linking local and global advocacy and about the issues and challenges that come while working in different spaces. She began by talking about connections. She said when you talk about advocacy it is important to make the two-way connection i.e., local to global and global to local. Another important connection that she mentioned in terms of framing issues it has to be rights-based but it is also important to look at intersections. She explained you cannot talk about RH without relating it to the issues of economy and bodily integrity etc., and you also can't discuss maternal health without linking it with morbidity, safe abortion services and adolescent RH. It is critical to bring in broader frameworks. Another point she mentioned was in terms of Global spaces

and advocacy, and the local contexts where we work, where all of our countries are becoming increasingly conservatives and non-democratic views of the govts., are failing to meet the needs of the people, they have access and power over communities, so there is a need for a power analysis of the situation and contexts. conflict, post-conflict and post war situations and affected by climate change, and other factors that have the potential to affect the contexts in which RH rights can be achieved. Last point, even at the local and global level CSOs are not homogeneous union, as conservative CSOs are also part of the CSOs. So, the question that arises here is how can we function with women in such spaces?

Another critical issue that she discussed was about some specific spaces that we can potentially engage with in local and regional contexts. In relation to International Conference Population Development a critical agenda to keep in the forefront, it is being forgotten and marginalized. So, networks like these spaces can be used to push forward the agenda and that to generate evidence around issues and that can be done by developing a monitoring system where your own data processes can contribute to and lived expressions of women can be brought in. A lot of data out there is around the extent i.e., on how many women are dying etc. but we need to bring in lived realities and experiences of women on the ground.

ICPD also has a regional process which is Asia Pacific Population Conference (APPC), which is Asia focused, (other regions also have regional processes). It is important to see how we can engage in these spaces and how these (regional spaces) can contribute to the overall global process. ICPD is also coming up again for review ICPD plus 25 and SDG etc. so, again there are spaces to engage with better data and information from ground level experiences etc. It is also important to remember that spaces such as ICPD and SDG do not centre around accountability as perhaps are human rights processes are. Therefore, countries are under no obligation to report and can be selective in reporting, reflecting only the positives. But never the less these are important spaces given how much SDG process is in the forefront and how much attention it receives. Hence, this is why CSO space is also important, to remind the govts. that they are not doing well and to provide alternative reports CSOs that can help achieve accountability.

She also spoke of global strategy for women, children and adolescent health, 2016 and 2030 (information available online) and about the campaign 'Every Woman and Every Child. Movement'. There is a need for an accountability panel that tracks that monitors progress and reports annually and is another space to engage with. The framework pillars on International Human Rights Law as well as local human rights processes such as looking at courts and national human rights institutions (at the national level) and reveals how engagements can happen. There is a monitoring framework that draws on SDG framework and other frameworks that draw on SDG for entry points because they not necessarily capture all the points that we experience on the ground. Besides, WHO we should also be aware of other key agencies working on issue such as UN Women, UNFPA, UNICEF etc., who are also constantly trying to mobilize around the issue that we must be aware of, can also benefit from such data that we produce in the network.

She further lists some other potential spaces where we can engage. Other is a partnership around maternal new-born and child health, which is a partnership of CSOs across 77 countries and works with 10 constituencies, in terms of partner countries and donor foundations. It functions within WHO and draws from global strategy and works the context of MMR, new-born mortality, IMR and universal access to SRH and rights etc. FP2020, another process that draws on the global strategy and is also a national process and have representatives from the govts. and donors, UNFPA, CSOs etc. is another space in the context of contraception and rights-based access to RH. The Working Group on Health Human Rights of Women, Children, Adolescents is another group established by WHO, has a reporting process, and is based in the human rights council and has a clearer accountability mandate. Others are UN treaty bodies and based in Geneva and have regular reporting cycles including QPR. But, again there is strong opposition against these spaces and therefore, it is important that before jumping straight into any of these forums we must carefully look into who is engaging where and how can we continue to engage with these spaces and link local to global and how do we bring back decision from local to global and vice-versa. These spaces offer great opportunities for voices from the global south to be heard, to bringing experiences from local levels, and provides spaces to CSOs and holds the govts accountable.

She concluded the discussion by mentioning that there is definitely a need to explore the human rights agenda and explore and look for spaces where we can proactively bring our goals from the regional to global level up.

Aparajita Gogoi shared about the work White Ribbon's Alliance India has been doing to promote 'Respectful Maternity Care in India. She first began with a little bit of background on WRAI. WRA was founded in 1999 to promote maternal health. They first started their work with a study of data realised by the govt. that stated increasing number of maternal deaths in India which helped them mobilize around maternal health. WRA sits on most panels on women and children. WRA in India works on three specific focuses of policy advocacy, citizen and community engagement (do not call it SA anymore because it is contested), bringing in women's voices to the higher levels, circles and forums. In mid-2000 India launched a flagship program 'National Rural Health Mission', and they decided to shift our focus to community engagement and policy engagements and tested some of the tools of SA around public hearing, verbal autopsies, work with community, media and with political representatives and they found that they had perfected most of the tools but the challenge that we faced next was that govt. was leading accountability and the challenge then again was to where to go next.

They are at present focusing on two main issues of bringing voices of women at the global/national level on QoC. They have been conducting reviews, observations and studies and working with certain member of the parliament and legislative assembly on issues of dignity, abuse and obstetric violence in the last few years.

She mentioned about a local campaign that they started on 'Respectful Maternity Care' last year with no intention of making it global! The process started with a workshop around the issue of accountability, which was conducted because their organization asked to remove

the word accountability from their proposals for donors and during the discussions they felt that a good strategy for CSOs would be to bring in people themselves and conducted studies and looked into QoC work in India. They asked women and doctors about how they would define QoC, where doctors gave a clinical list of QoC indicator, the women clearly spelt out that for them QoC means respectful care, access to entitlements hygiene, clean bathrooms and food in the kitchen of the hospital etc. This how began the process of facilitating women's voices. They called the campaign on 'Our Health and Our Voices' and managed to reach out to 15,000 women and they wanted to bring the findings at the national level on the 11th of April. They convened meetings and campaigns with women where women voluntarily provided their addresses and numbers to reach them. Initially when they started the campaign it was unfunded the only money they had was enough to make entries, analyse the responses and present results. They started with an aim of 15000 but despite the financial crunch by the end of march they managed to get 1,50,000 cards from 24 states and UTs all across the country. but we could analyse only 1,14000 cards. The health minister gave them a date in April to meet the people. The analysis suggested two important things one that though the world had moved to QoC WRA realized that women were still struggling with availability and we looked into the details they surprised to see that women dignity and respect ranked first in QoC for women, other responses revealed 36 per cent women asked for access to services and entitlement, 20 per cent asked for access to health providers and 16 per cent asked for hygienic facilities. And second was in terms of respectful maternity care women asked for respectful behaviour from the provider, no discrimination based on caste-class, to not being forced to share their bed or stretcher and of course also on no harassment and no touching without consent when I am in labour etc.

Following which the challenge for WRA was how to translate the entire data gathered into what govt. can do. So, some of the messages they presented to the minister suggested monitoring entitlements, zero tolerance for abuse, to incorporate respectful care in QoC guidelines, another was inclusion of cleanliness of hospitals in Swachh Baharat Abhiyan etc.

Some of the positive outcomes of the campaign were that it caught everyone's attention. Three months back they were approached global leaders and who are now trying to adopt the campaign and putting in their efforts to make it global. Aparajita further shared some of the important global platforms where WRAI will again be participating such as Lancet Commission of Care, World Health Forum and will represent voices from various marginalized communities. Another platform that they plan to participant is 'Quality of Care' (recently started by WHO). Govt. of India is also organizing a PMNCH Partners Forum in India on the 10th of December, here also they are trying to find a place.

Some of the discussions that were held post Azra and Aparajita's presentations were around three main issues of the usage of jargons, on the need to broaden the scope of reproductive health, and the role of service providers. Some of the participants were of the view that we are getting too much trapped in the usage of terminologies which is leading to practice vs paradigm conflict. There is no sync between the language we use and outcomes we are aiming to achieve. For instance, there is a concept of Universal Health Coverage but in practice at the ground level there is no universal health coverage. Similarly, with regards to SA and advocacy where are we heading? It was suggested that there is a need to clearly

define what do we mean by SA, advocacy etc. For a longer vision it was recommended that we clearly spell out in a charter, step by step all the process required to achieve that vision, definitions, our needs and expectations. At present the entire discourse around SA is driven by the north and INGOs, there is a need to include and represent southern voices in such spaces and connect local to the global. Another issue that the participants raised was the issue of broadening the scope of RH. By focusing on just one issue (RH) we are breaking the solidarity on the ground, we should be more gender inclusive (to be included in the charter too). In terms of strategy, it was suggested that we need to move beyond interventions and get involved in the politics for politics has to be messy and noisy. A third issue that was discussed was about the role of service providers. It was pointed out that if we have to do advocacy and build alliances at the local level, and if we have to make the providers space more rights-based and non-judgemental, we really need to do service provider studies.

Session II: Group Work/ Plenary presentations: Moving forward

Moderators: Sandhya YK and Renu Khanna

The last session was group activity the focus of which to draw a future plan of action of COPASAH. All the participants were divided into 3 groups to discuss some of the key questions around the scope of COPASAH RH hub, COPSAH's engagement with Community Participation and AS around the domains of Practice, Documentation and Advocacy and lastly, how each individual participant would like contribute etc.

Group I: Practice: Wilson Imogan, E. Premdas, Sandhya Gautam, Baishali Chatterjee, Teena Xavier, Wilson Imogan

Group II: Documentation: Abhijit Das, Asha George, Sanam Monterio, Akhila Vasan, Masuma Mamdani, Victoria Boydell, Michelle Saddler and Sara Van Belle.

Group III: Advocacy: Renu Khanna, Shireen Huq, Reena Shrestha, Sandhya YK, _____

Plenary Session Moderators: Sandhya YK and Renu Khanna

1. **Is there a need to expand the Scope of the COPASAH RH hub?**

All the groups were of the view that the framework of the hub is limiting in scope and there is a need to include other important rights-based components such as intersectionality, abortion and hysterectomy. It was emphasised that the rational should be to stimulate a conversation around the role of the community through facilitating voice of the practitioners**.** The group also suggested few technical changes with regards to the concept note such as the need to include a vision note, a section on the creation of the hub and another on the socio-political-historical-cultural contexts of the issues etc. While it was suggested that it was important to expand the mandate of the hub, it was also pointed out that certain limitations for clarity of work should be there.

2. **How should COPASAH engage with SA and Community Participation in the following domains of Practice, Documentation and Advocacy**

<u>**Suggestions on Practice:**</u> The groups were of the view that weak chapters (such as Africa chapter) to be made more functional through upscaling of members by building networks, alliances and by organizing regional and country level annual meetings etc. There needs to be more focus on increasing cohesiveness / solidarity amongst the members for better exchanges. Opportunities to explore for linking collaborations with existing social accountability groups was recommended. Finally, to promote exchange of information, experiences, learning at all times.

<u>**Suggestions on Documentation:**</u> All the groups unanimously agreed that there are gaps in the existing knowledge. The existing literature is limited/similar more in the form of recipe books. We need to have more documentation of processes over time, backlash, risks, challenges, and experiences of how people/ communities (themselves as they have been part of the processes) managed them etc. For instance, the principles and approaches can be written/documented in a charter for better exchanges and adaption etc. Counter narratives to be also taken into account. Knowledge on practitioners and service providers also needs to be looked into and documented. As that will help them creatively reflective on their own practice.

The issue with regards to the need to identify, who is our documentation for and what kind can be done was raised. It was pointed out that Journals are not the only place, there are other alternative spaces such as blogs, commentaries, case studies, discussion groups/round tables, campaigns, protests, advocacy and regional/local media and journals which can be explored (example, KJC) etc. Social media such as twitter, Facebook, WhatsApp etc. can also be used as platforms of learning. Use of different methods was also recommended such as videos, pictures, graphics etc.

It was emphasized that the rational for all documentation (of practices) is that people should be able to benefit from them, they should be able to adapt them to local locations and pull out lesson which can be then shared.

The important role that students/universities and policy makers can play in knowledge building was also emphasized. The need to explore the role of students with practitioners, different universities can deliberately put up collaborations with policy makers, researchers, joint learning platforms, internships, setting up a round table etc was also pointed out. Finally, the need to build cross disciplinary alliances was also proposed for knowledge generation.

<u>**Suggestions on Advocacy:**</u> With regards to advocacy it was recommended that advocacy has to be systematic, planned and opportunistic. It will identify atypical spaces where we can mainstream our agenda. It will ensure the need to change the regional and global discourse around accountability and to identify barriers. It will ensure that accountability will include the voices of the affected people. Inclusion of this issue in the other hubs of COPASAH i.e., Corporate as well as Indigenous Hubs was also proposed. And lastly, with regards to doing

advocacy at various forums it was stressed that rather than blindly jumping into forums it is better to first identify avenues, analyse them and explore possibilities as to how and where we can engage for a meaningful representation etc.

Participants listed out some of the Forums, Avenues and Events where COPASAH should participate:
- ✓ there is one in Bangladesh, COPASAH should be there
- ✓ Engage with SDGs processes 3 & 5
- ✓ ICPD+25
- ✓ UHC2030
- ✓ All other human rights accountability spaces

What should be COPASAH's role: How to address the role dichotomy/tension?

During the discussions that ensued on the question differing opinions emerged. Some participants were of the view that COPASAH should start its own advocacy and should create a separate mechanism. A few others were of the view that it instead should strengthen the capacity of practitioners, as it's our history. It was also pointed out that if COPASAH becomes a global advocacy organisation, it would be a huge stress. Relationship building, matchmaking, taking the agenda forward is COPASAH's is de facto work and this should remain it's focus.

Another proposition was that it should engage in selective advocacy on issues where members think they can contribute. For this we would require specific objectives that are going to be shared with advocacy members, identified allies, spaces and processes.

The possibility of exploring an intersection with other hubs of COPASAH can also be relevant. For instance, a lot of women including indigenous women access the private sector for health services, here it becomes all the more important for the issue to be reflected in other hubs too. Similarly, if someone goes to WHO (or some other forum) to talk about indigenous health, that person should also bring up reproductive and sexual health. Health shouldn't be left out on the pretext that it is covered elsewhere. There is a need to analyse the linkages.

Another recommendation that was put forth was COPASAH as an entity or as individual should work with other groups and work with their own advocacy. Another view that was expressed was that COPASAH's work with existing advocacy groups such as ARROW should be further developed.

Another question that was addressed was with regards to local advocacy. Where it was said that many practitioners are experienced on the ground and hence, they can be involved in local to national advocacy and can be supported through relationship building to the appropriate advocacy organisation.

Next in line was discussed COPASAH's agenda and representation at various forums. It was decided that the focus of COPASAH should be first, helping the voices of marginalized

communities reach higher policy making levels and second, to change the discourse around accountability. As far as representation is concerned there are two ways of representing COPSAH. First, would be if someone goes to a global level not as COPASAH member then for that we carry along the existing material on COPASAH stand point and our best practices as an example. We can diffuse COPASAH while being present in our other capacities.

3. Within each group- How would individual participants like to contribute?

After much deliberation the participants decided that:

- **Ariel Frisancho:** Shall be responsible for making the advocacy strategy called COPASAH – Latin America experience
- **Azra Cader:** Mapping process, regional advocacy
- **Sara van Belle:** UHC2030, documentation
- **Sandhya YK:** SRHR gaps
- **Shireen Huq** would bring women narratives. She wouldn't write but speak about these
- **Baishali Chatterjee:** Will initiate the work with young women who will become a part of the process by sharing their experiences, learnings and challenges at the coming up 2019 symposium.
- **Wilson Imogan and E. Premdas:** Will take responsibility for West Africa hub, documentations

It was also decided that each member will go back to their organisation and take opportunities of collaboration with students; identify collective learning processes etc. Lastly, it was also suggested by some of the participants that very short and easy to understand, five to ten minutes presentations, case studies around the issue of qualitative practices around reproductive health, community participation and social accountability can also be put up on blogs and can really be of help to people interested or working in the field.

Annexes:

1. Agenda
2. Participant list

Participant List

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