Data-driven policy dialogue for gender equality and SDGs 3 and 5

SAHAJ Report on Assam Proceedings of the Three days Consultation on Policy Dialogue Planning for Gender Equality and SDGs 3 and 5 Assam State

Guwahati, 19th to 21st March 2018

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Introduction of participants and introduction to the project

Ms. Renu Khanna commenced the discussion by talking briefly about the objective of the consultation. The objectives were-

- To understand the field level SRHR and gender justice situation from the experiences of field level partners
- To review the current evidence about the implementation of selected SDG targets in the state of Assam
- To prepare policy dialogue plan for the state of Assam focusing on the selected targets
- To apprise government officials regarding the project activities and seek their inputs regarding Government initiatives about SDG 3 and SDG 5

She also talked briefly about SAHAJ and their area of work and requested the participants representing different organizations to introduce themselves. The participants introduced themselves and highlighted their organizations 'work.

The list of participants and the organizations is attached herewith as Annexure 1. The schedule followed during the three day consultation is given in Annexure 2.

Introduction to Sustainable Development Goals (SDGs) and SAHAJ

Dr. Nilangi Sardeshpande from SAHAJ gave a brief overview of the Sustainable Development Goals (SDGs) and the project. She told the participants about the Millennium Development Goals which were to have been achieved by 2015 and that SDGs is an extension of the MDGs, but with broad goals which have been derived by following the due consultative process.

Dr. Nilangi told the participants that Equal Measures is an international partnership of nine leading civil society and private sector organizations with a Secretariat hosted in the UK. She then explained that EM2030 works towards making sure women's movements and rights advocates have easy-to-use data and evidence to guide efforts to reach the Sustainable Development Goals (SDGs) by 2030.She added that the project is underway in six countries and India is one of them. A partner organization is selected in each country and SAHAJ is the India partnerof Equal Measures 2030.

In India, six states have been selected under the project, viz, Assam, Bihar, Punjab, Madhya Pradesh, Gujarat and Kerala. The objective of the project is to influence policy decisions and advocate for better implementation of programs/ schemes towards achieving the SDGs. For this reason, use of data in convincing the policy makers in taking appropriate decisions becomes important.

The selected targets for Goal 3 and Goal 5 under the project are-

Goal 3 Targets-

3.1- Reducing maternal mortality

3.7- Ensuring universal access to SRH services

Goal 5 Targets-

5.2Eliminating Violence against Women (VAW) in public and private spheres

5.3Eliminating harmful practices such as child, early and forced marriage and female genital mutilation

5.6 Ensuring universal access to SRH rights

Following are the activities undertaken as part of the project -

1) Preparing secondary data based reports for the states
2) Developing state specific policy dialogue plans
3) State level policy dialogues
4) Training State partners in using data / evidence for policy dialogue on SDGs
5) National policy dialogue meeting and policy dialogue

Ms. Lakshmi (the ant) suggested that the issue of domestic violence should also be included in the policy dialogue plan. Ms. Nilanju (NEN) mentioned that mental health issues also need to be discussed as a part of SRHR. On

receiving these inputs, Dr. Nilangi responded that most of the issues related to SRHR would be discussed and added in the Assam state report and policy dialogue plan. She emphasized that all these issues are inter-linked and they need to be understood holistically.

Ms. Enakshi (Institute of Development Action (IDeA)) added that most organizations working on development and rights based issues do not connect their work with the SDGs and there is a need for them to understand how their work in affecting the larger framework of SDGs.

Mr. Augustus (Diya Foundation) shared that his organization conducted a study in 4 districts of Assam on maternal health in which they discovered many issues related to maternal health service provision. Dr. Nilangi suggested that on the 2nd day of the consultation, participating organizations could share the studies or experiences related to the issues discussed during the consultation. These experiences would be valuable for the state report and will also feed into the policy dialogue plan for the state of Assam.

Introduction to CommonHealth

Dr. Nilangi told the participants that CommonHealth works in 20 states on the issues of maternal health, neo-natal health and safe abortion. She said that usually there is confusion among people between safe abortion and sex selection and most people lack the necessary information pertaining to that. Women are denied abortion (which is legal and necessary under various circumstances) because the providers confuse it with sex selection.

The activities that are undertaken by CommonHealth are-

- **Capacity building workshops-**
  - o Policy dialogue workshop in SRHR
  - o Workshops on gender, sex-selection and safe abortion
  - o Short courses on making pregnancy safer
- **Accountability for maternal health-**
  - o Fact finding on maternal health in Barwani
  - o Building community-involvement in accountability for maternal health- intervention in Gujarat
  - o Dead Women Talking report (in which 124 maternal death cases from across 31 districts in 10 states were reviewed and the reasons were studied in detail)

CommonHealth website was displayed for the participants and some of the points such as finding various studies, reports and SRH data for different states were explained. They were told that they can become members by paying a nominal fee.

Session 2:

Presentation on- SDGs for SRHR- Assam state report

SAHAJ team had prepared a report for the state of Assam based on some selected indicators related to the selected targets of SDG 3 and SDG 5 (Annexure 3). Ms. Rashmi Padhye (SAHAJ) presented data on some of these indicators. These data were collated from secondary sources such as National Family Health Survey (NFHS-4), Annual Health Survey (AHS), Census of India 2011, yearly data from NHSRC reports, Crime in India report by National Crime Records Bureau (NCRB) and many such sources.

The presentation included comparison for rural and urban areas in Assam. For the indicators from NFHS datasets, a comparison between NFHS-4 and NFHS-3 was shown.

The report was divided into several sections. These are-

Demographic indicators- Demographic indicators determine social issues to a greater extent. Thus, it becomes necessary to look at some of the important demographic indicators before looking at the women's health and gender related indicators.In Assam, a vast majority (86%) of the population of the state resides in rural areas. With regard to the sex ratioat birth, data showed that there are 794 female births for every 1000 male births in urban areas of Assam. This is an alarming situation and can be attributed to sex selective abortions.

Development related indicators- Data showed that only 4% households in rural areas had access to piped water at dwelling and 82.9% households in rural areas had access to improved sources of water. It was noted that women are the most affected ones by this issue of lack of access to improved water sources they generally fetch water for their household. Ms. Enakshi, added that many parts of Assam are inundated by floods every year which contaminates its water sources. Moreover, unsafe magnitude of arsenic can be found in ground water in most areas of Assam which can cause serious health problems for the communities. The data might not indicate the real

picture as what might seem to be an improved source of water in other parts of the country might actually be a highly contaminated source of water in Assam. To this, Dr. Sunil Kaul, (the ant) said that ground water in most parts of Assam is not fit for drinking.

With regards to sanitation it was observed that access to proper sanitation facilities showed improvement in 2015 with just 11.1% population in Assam with no sanitation facility. Dr. Sunil explained that this method of calculating access to sanitation facility/latrines counts all types and forms of latrines as sanitation facility. However, access to proper and usable latrines and the actual usage of the sanitation facilities would be much lower.

Education and women in workforce- Labor Force Participation Rate for women in Assam is 202 in rural and 216 in urban areas. This means that 20% and 21% of total women are available for work in rural and urban areas of Assam respectively. Of this, the number of women who actually find work will be even lower. Ms. Meghali Senapati, (Tata Institute of Social Sciences, Guwahati) added that the number of women in Assam and all over the world who are employed in white collar jobs is very low.

Although the literacy rate of women in Assam is better than the national average at 71.8%, the percentage of women with 10 years of education is just 22.5% in rural areas and 26.2 percent overall.

Economic profile- Per capita income of Assam at Rs. 54,618/- which is half the per-capita income of the country.

Public health infrastructure- 98% of villages in Assam have ASHAs and the ASHA to population ratio of the state stood at 1:918. There is a 21% shortfall in the number of Sub-centers and 37% shortfall in the number of Community Health Centers (CHCs) in the state. The number of Primary Health Centers (PHCs) in the state did not show any shortfall. Dr. Sunil added that data on public health institutions with 24*7 delivery services in Assam would be a good indicator to help reflect the state of health infrastructure in the state.

Session 3:

Presentation on- SDGs for SRHR- Assam state report (continued)

Health status of the population- Survey conducted by NSSO showed that 31 per 1000 population in rural areas and 47 per 1000 population in urban areas reported an ailment during the 15 days prior to the survey and hospitalization rate (during an year prior to the survey) in the state is 28 and 36 for rural and urban areas respectively. These numbers are lower than the national level. Dr. Sunil added that the number could be low because the people feel that most ailments are not major and might not need medical treatment and hence are under reported. He also said that the number of deliveries would be more than 20 per 1000 population and enquired if the data accounts that.

Ms. Rashmi said that the data by NSSO does not account hospitalization for deliveries and this data will have to be added separately. Dr. Sunil said that the cost for a C-section delivery at the civil hospital in the district of Bongaigaon is Rs. 20,000 and it would obviously be higher for a private hospital. Dr. Nilangi elucidated that the communities which have access to better healthcare services report more ailments and have a higher hospitalization rate. Ms. Enakshi added that data available in the public domain show that the cost of hospitalization in Assam is exorbitantly high, and more so in private hospitals in urban areas. Another participant, Mr. Agustus (BGSSS) sharedthat people don't trust the healthcare provided by the hospitals and thus they avoid going there for treatment.

Major surgeries per lakh population in a year in hospitals of Assam is at 145.5 where as it is 363 for the country. Dr. Sunil explained that the data have been taken from Health Management Information System (HMIS), a government data collection system. The data do not account for the patients from Assam who travel outside the state for treatment. It however reflects the number of patients from other states (mainly from other states of North East India) who come to Assam for treatment. Ms. Renu said that since the surgery rate in Assam is so low compared to the national rate, the health system in Assam might be much underserved. Dr. Sunil suggested that the low surgery rates could also mean that the hospitals in the state are not exploiting the patients and conducting bogus surgeries.

Nutrition among women- The proportion of women with BMI below normal is seen to reduce from 36.5% to 25.7% within a period of 10 years from NFHS-3 to NFHS-4. Dr. Sunil said that a lot of difference can be seen between the data in NFHS 3 and NFHS 4 and that the dramatic improvement in the data might not be a reflection of ground level realities in the whole state. He also informed the group that a study on nutritional indicators for the tea garden labor women has been carried out and could be a useful source of information. Nearly half of women in Assam were anemic during NFHS-4 though there is a drastic improvement from NFHS-3 to NFHS-4. Dr. Sunil said that while considering these data, one has to be very careful as there might be various methodological inconsistencies. He said that the sample size of rural and urban areas could be skewed in favor of urban areas and might pull of average up as urban areas have better health indicators. Ms. Rashmi added that although there might be some inconsistencies in such large scale studies, the fact that nearly half of all women in Assam are anemic is a cause for concern.

Assam and SDGs-Ms. Rashmi highlighted the fact that the Assam government is the first in the world to have a vision document for SDGs. A 7 years strategy and a 3 years action plan have been adopted by each and every government department of the state. For every goal, relevant government departments have been grouped and an attempt to create synergy has been made by the Assam government. She also added that budgetary allocations have been made for all the government departments for SDGs and Mr. Ravi Duggal will be analyzing it on the 3rd day of the consultation. SDG oriented outcome budget is available for the departments. Dr. Sunil said that the SDG related activities are being coordinated by the Center for SDG within the government. The future steps to be taken up by the Assam government to achieve the SDG targets were also highlighted. These include-

- Annual report on progress of core indicators
- Developing monitoring framework with periodic data updation and real time dashboard
- SDGs will be made 'people's movement'
- Preparing model SDG plans and implementing in different model areas including the deprived and vulnerable areas

Goal 3: Ensure healthy lives and promote well-being for all at all ages

Target 3.1: Reducing maternal mortality

Maternal mortality for Assam is the highest among the states in India at 300 maternal deaths per 1 lakh deliveries per year which is nearly double the national figure of 167. It was noted that one of the important services which can help in reduction of maternal deaths is that pregnant women should undergo at least 4 Antenatal Care visits, which has shown an improvement in NFHS 4 over NFHS 3. Dr. Sunil said that the improvement in ANCs can be seen after the implementation of the National Rural Health Mission which has helped in delivering ANC to rural women. The percentage of institutional delivery is also on the rise. At the same time, only 54% of women receive Post Natal Care (PNC) within 48 hours of delivery. Various participants added that the hospitals lack basic facilities and are so badly maintained that patients leave the hospitals early without completing the PNC follow-ups.

Describing the state of health services in Assam, Ms. Nandita Deka (Human Rights Law Network (HRLN)) said that the maternal health care services provided are very poor and women often die due to late arrival of ambulance during referrals to a hospital. Mr. Atual Kalita (Manab Kalyan) added that when a pregnant woman in labor pain is taken to the hospital at night, very often doctors are absent. The patients are told to wait till the morning for the doctor to arrive. He quipped that a doctor would thank the nurse if a pregnant lady in pain had come to the hospital the earlier night and she would give him a phone call informing him about it in the morning.

Ms. Meghali explained another phenomenon due to which families defer taking a pregnant woman in labor pain to a hospital at night. She elucidates that due to communal tensions in Assam, people of a certain community would not want to pass through areas dominated by another community at night to take a woman to the hospital. They prefer to wait till the morning to take the woman to the hospital even though it is an emergency. Mr Atul Kalita seconded the occurrence of this phenomenon and said that he has seen it in Darrang district. Mr Agustus described a harrowing incident in which a pregnant woman delivered the baby on the way to the hospital, so the family instead to taking her to the hospital for further care took her back. When she was brought back, she started to bleed and did not survive till morning. Explaining another reason for maternal deaths and complications among the vulnerable communities Ms. Enakshi said that pregnant women who belong to the tea tribe community continue to work in the tea gardens fearing loss of wage on which they depend for subsistence. To avoid this, Assam government has recently instituted an allowance for the pregnant women working in tea gardens to compensate for their loss during pregnancy.

Ms. Lakshmi described another painful incident of a 17 year old pregnant lady. She had not received any ANC during her pregnancy. In 2017, around the time of Diwali when she was 9 months pregnant, she experienced high fever for 3 days and so her family members took her to the PHC. They could not find the doctor there and did not receive any treatment. From the PHC she was referred to another hospital and at 11 pm the family gave a call to The ant. After receiving the call, Lakshmi took the

lady in the office vehicle to the hospital. By that time the lady had already lost her consciousness. The doctors at the hospital said that they can deliver the baby only if she regains her consciousness. Later, after regaining consciousness she gave birth to a baby who was still born. The doctors at the hospital referred her to a hospital in Barpeta district, after which the family called for an ambulance. By that time her condition had reached a critical state and she died before she could be taken to the referred hospital.

After hearing this harrowing tale, Ms. Renu said that the maternal death review reports should be made public by the government. She said that the group should demand the maternal death reviews to be made public. If negligence is seen on the part of the healthcare providers, the action to be taken by the administration should also be stated in the review. To this, Ms. Nandita added that her organization has been filing PILs on maternal deaths but the problem lies in finding out the exact cause of death as the hospitals point out various excuses for the deaths. She said that the medical histories are not recorded properly by the hospitals dealing with the concerned patient. She was of the opinion that ASHAs should be trained to follow-up on ANCs and deliveries so that the progression is tracked correctly and accountability is established in the system. She hoped that this might be useful in conducting thorough maternal death reviews.

After receiving vivid experiential inputs from the participants on various circumstances leading to maternal deaths, Ms. Rashmi continued with the presentation and shared data on ANC registrations done by pregnant women and the actual ANC check-ups.

Dr. Nilangi asked Ms. Meghali if collaboration could be explored between Common Health and TISS on the issues of maternal deaths in the state. She also asked Ms. Meghali for suggestions if they should be meeting any government official and if she knows of any relevant official whom they could approach. Ms. Meghali replied that collaboration could be explored between TISS which is an academic institution and Common Health. She also said that it would be productive to meet the chief secretary of Assam Government. Ms. Meghali asked if contraceptive pills which are easily available and widely used contribute of maternal mortality and if there are any researches on this area. Ms. Renu suggested that the final document produced after the consultation could be taken forward for the state and some of the students from TISS, Guwahati could take up researches on the issues of maternal deaths in Assam in collaboration with CommonHealth.

Taking the discussion forward, Ms. Sheetal Sharma (UN women) said that they have been working in areas dominated by the tea garden labourers where miscarriages during pregnancies are significantly high. She asked how this data could be gathered and used to reflect the state of maternal health. She further asked if ANCs could have a role in preventing such cases. She also raised the issue of teen pregnancies and need for sensitization on safe abortion.

After hearing about all these issues and the lack of bare minimum health facilities in the rural areas of Assam, Ms. Renu informed the participants that in Bihar the healthcare service delivery in rural areas is mainly provided by quacks known widely as ‘Bengali doctors’. They provide complicated ‘tertiary’ level health services at the primary level. To this, Ms. Jennifer (the ant) said that in the private hospitals in Assam, despite higher treatment charges compared to a government hospital, even a basic thing such as accurately measuring the weight of the baby during ANC is not done properly. In this situation, nothing much can be expected from a government hospital. Dr. Nilangi said that it is quite simple to provide ANC as it does not require any high end technology. The objective of an ANC is to ascertain if the baby and the mother are healthy, but in the course of nine months multiple ANCs still fail to ascertain if both are healthy which leads to complications during delivery and leads to maternal deaths.

Ms. Enakshi added that since ASHAs are crucial in primary healthcare delivery, their role needs to be explored further. If incentives are given to ASHAs, it can lead to improvement in quality of health services at the village level. Ms. Nandita added that the pregnant women usually have no idea about the results of the ANC as all the reports and data are kept by the ASHAs.

Moving on with the presentation, Ms. Rashmi highlighted that data showed a remarkable improvement in the rate of births assisted by skilled health personnel from NFHS-3 to NFHS-4. It was seen that the births assisted by skilled health personnel for urban areas is higher than the national rate. It was also highlighted that the rate of C-section deliveries in the urban areas of Assam is higher than the national rate.

Session 4:

Understanding the concept of sexual and reproductive health rights

Based on the demand from many of the participants, it was decided to include a session on understanding the concept of sexual and reproductive health rights (SRHR) before talking about SRHR related indicators.

Dr. Nilangi asked the participants what they think constitute Sexual and Reproductive Health (SRH). Some of the participants did not know the concept of Sexual and Reproductive Health Rights prior to the meeting although most of them have had vivid encounters related to deprivation of adequate maternal health in their communities. Mr. Proshik told that he had heard about the term SRHR for the first time in the consultation and said that one of the sexual and reproductive rights that a woman should have is the ability to decide whether to give birth to a baby or not.

Mr. Atul Kalita said reproductive health required that in order to deliver a healthy baby, the mother has to be both physically and mentally healthy. Ms. Nilanju added that reproductive health rights means for a woman to be able to decide- whether to give birth to a baby, when to give birth to a baby and where to deliver the baby. She said that safety of the mother should be of utmost importance in all these aspects of reproductive health rights.

Reproductive Rights- After listening to the participants' understanding on what constitutes SRHR, Ms. Renu explained the concept as of Reproductive Rights as being rights related to the reproductive system and reproduction where-

- A safe sex life is ensured with appropriate use of contraceptives, absence of violence, and safety from infections. Safety should be of prime importance from a stand point of pregnancy prevention.
- The ability of a woman to decide- if she wants to deliver a baby, when and how she wants to deliver her baby.
- Safety should be ensured during pregnancy, child birth and also the infant's safety should be ensured.
- She should have access to safe, effective, affordable and acceptable methods of FP.
- A lifecycle approach should be followed to ensure that both the mother and child are safe and healthy. Reproductive health needs start right at the time when a woman reaches her menarche and it is from that phase that reproductive health should be accessible to women. It is not an exclusive need of married and pregnant women, but all women (married or not) till they reach menopause and even beyond.

Ms. Renu outlined the earlier discussion with the participants on reproductive rights-

- To be able to decide on child birth. Dr. Sunil shared an example and shared how couples are pressurized by the society to have children right after marriage.
- Right to attain the highest standard of reproductive health
- The decision on child birth should be free of coercion or violence. She shared that a study was undertaken on the factors that contribute to mental health stress of the newlywed women, which showed that the thoughts related to timing of child birth and gender of the child are major stressors.

Reproductive Health - She explained that the following reproductive health services should be accessible through the primary health care system-

- Family planning, counseling, communication related to reproductive health should be provided to people. Information is very important and critical component to ensure good reproductive health. If necessary information is related to reproductive health is not provided to the people, it is a violation of reproductive health services.
- Provision of contraceptives, abortion services, services for reproductive tract infections, other gynecological problems are all part of reproductive health services.
- Prevention and treatment of infertility - counselling services provided to people on this issue
- The healthcare professional need to know the local language used for reproductive health related problems of women. Language barrier often leads to miscommunication between the patient and the health professional which results in ineffective treatment.

Reproductive justice- Ms. Renu explained about the concept of reproductive justice, which goes beyond reproductive health rights and seeks to address the reproductive health rights of the most vulnerable groups.

- **Women with disability-** it is a common notion that physically challenged women are asexual and sexually inactive and if they show any sexual behavior they are deemed hyper sexual. Since they are believed to be sexually inactive, physically challenged women are denied access to sexual health.
- **HIV/AIDS affects sex workers-** Another vulnerable group is that of sex workers for whom reproductive health services are not provided as they are never thought to be capable to bear children and take care of them.

Sexual health and rights-

- **Gender relations -** women are usually turned into sexual slaves which is a violation of sexual rights. Often it is conceived that sexual decisions are the prerogative of men and if the same decisions are taken by a woman then her character is questioned by the society.
- Relationships should not be based on discrimination and should involve emotional, mental and social wellbeing
- There are sexually diverse groups and they have the right to live with respect. Dr. Nilangi cited an instance where a female security personnel at a shopping mall refused to frisk a transgender woman which showed rampant discrimination against this group.
- Women, youth and LGBT community should have the right to take their own decisions regarding their sexuality. Ms. Renu added that when a child with ambiguous sexual and reproductive organs is born, the doctor usually advise the parents to undertake a sex change surgery on the child ignoring the possibility that the child may have different sexual experience in the future and this decision should be taken by him/her.
- Sexual intercourse can also be about sexual pleasure, and not only for reproduction. Contraceptives are available for the same reason.
- Comprehensive sexuality education should be provided not only to adolescents but also to all women and men of every age. Ms. Renu noted that sexuality is a taboo topic and people don't discuss about it openly.
- The right to privacy and confidentiality from the service providers should be maintained on cases related to sexual health.

Dr. Sunil told the participants that every PHC is supposed to have an ARSH (Adolescent Reproductive Sexual Health) clinic. Ms. Jennifer asked the participants if they know why the ARSH clinics are important in relation to the current discussions on sexual and maternal health. She further explained that since sexual and reproductive health starts from adolescence, it is very important to cater to children in this age group. Ms. Renu added that sexuality education among adolescents is so poor that such important issues are not addressed at all.

Session 1:

Presentation on- SDGs for SRHR- Assam state report (continued)

SDG 3 Target 3.7- Ensuring universal access to SRHR services

In the opening session of the 2nd day of the consultation meeting, Ms. Rashmi continued with the presentation on state of SDG indicators related to SRHR for the state of Assam.

Access to information about SRHR- Only 9.4% women in Assam had comprehensive knowledge relating to HIV/AIDS according to NFHS-4. . 44.8% of women of 15-24 years of age used hygienic methods of protection during menstrual period. In rural areas, the adoption of safe protection is 40% which means that more than half the women use unhygienic methods. Dr. Nilangi said that culturally menstruation among women needs to be accepted and discussed without any taboo. Societal restrictions and taboos hamper adoption of safe methods of protection during menstruation among women. Ms. Jennifer brought the perspective of the role of disaster in menstrual hygiene in Assam. She said that during floods, which are common in Assam, households have to live in relief camps which are over populated. These relief camps don't have spaces to dry clothes, so women wash their clothes and wear the wet clothes including the sanitary cloth, waiting for it to dry with the body warmth.

Ms. Renu suggested that very often than not, data collected on usage of safe methods of menstrual hygiene shows a better picture than it actually is. This is because the women say that they use safe methods to sound politically correct. Another problem with the numbers showing usage of safe methods of menstrual hygiene is that the women use sanitary pads continuously for 24 hours without changing it, which could lead to more harm than not using sanitary pads. Ms. Renu shared with the participants that SEWA- Rural had found out that women in their field area used a cloth named 'Falanin' during menstrual periods. She shared that the cloth has good absorption property and is red in color, which the women can wash, dry without any stigma and re-use. Ms. Enakshi shared that under a government scheme the adolescent girls now receive Rs. 600 to practice safe methods of protection during menstrual periods. But she said that the money provided would need to be productively used for it to show positive results.

Mr. Agustus informed the group that his organization BGSSS had distributed sanitary pads as well as sanitary cloth to the women. When they monitored the usage it was found that the women were using the sanitary cloth and had saved the sanitary pads. The feedback they received was that sanitary cloth is more comfortable and convenient for the rural women. They also found out that sanitary pads are difficult to dispose off because of the taboo associated with menstruation and so are not used by rural women. Dr. Nilangi said that this is one area where data definitely cannot provide a holistic picture and more community inputs should be gathered for deeper understanding.

Mr. Atul said that in order to hide the sanitary cloth from public eye, women wash and dry them in the backyards where there is no sunshine or on the back side of a cloth rack. This could lead to infection of the sanitary cloth and in turn lead to negative health implications for women.

Access to contraceptive services- Another set of indicators for access to SRHR are related to access to contraceptive services. The proportion of using modern methods of contraception had gone up since NFHS 3. The unmet need for family planning for Assam is 14% but since it is a reproductive health right, everyone should be receiving this service. Data related to sterilization, complication due to sterilization, deaths due to sterilization and abortion rates was also shared in the presentation.

Ms. Jennifer expressed her view that there might be an unmet need for sterilization as well. Whenever she goes to the villages she meets several women who enquire about sterilization services. She said that there might be a large unmet need for sterilization. She also added that the data which showed that there had been 103 cases of complication after sterilization is a case of under reporting. All the women who experience complication

don't necessarily report them in a hospital.

Dr. Nilangi shared that in other states when a woman goes to a hospital for abortion she is asked to undergo sterilization if she wants to get MTP service. She further added that copper-T is inserted after delivery without the woman's knowledge. Later when the woman realizes she cannot conceive a baby and goes to the doctor for checkup, at that time she comes to know that she had been implanted with copper-T. She asked if similar cases have been encountered in Assam.

Ms. Nandita said that HRLN conducted a study on sterilization in Kamrup (Rural) district of Assam where they found that women were not informed that copper-T was implanted after child birth. She cited a case where a woman who had undergone abortion was implanted with copper-T without her consent. Later when she experienced pain and went to the doctor for check-up, she was told about what happened. She also shared that women in rural areas think that sterilization leads to side effects and so they avoid being sterilized. She summed up that the phenomenon that Dr. Nilangi was talking about happens in Assam too.

Access to RTI/STI treatment- Data on STI clinics in the state was presented, to which Ms. Jennifer said that the HIV clinics in some areas of Assam are being operated well while that is not the case with other areas.

Access to abortion services- With regard to abortion services, Ms. Jennifer raised the issue of counseling. She said that usually no counseling services are provided by the health professionals to the women before abortion. Instead the doctors try to convince the patient not to undergo abortion. The health professionals try different tactics to influence women's decision to undergo abortion, one of which is to tell them that they might never be able to conceive again. Ms. Sheetal said that instead of a productive counseling, the health professionals brainwash their client. Ms. Nilanju of NEN weighed in and said that when a woman approaches a health service provider for abortion she should be provided with information about contraception in a non-judgmental manner so that such a situation does not arise in the future. She should be provided with the right information to help her make a decision rather than being influenced by someone else. With regard to counseling, Mr. Proshik shared his experience where his brother and sister in-law could not agree if they wanted to have a child. He said that he spoke to them and asked them to take the best decision keeping in mind his sister-in-law's ill-health, and not be influenced by other people. When they decided to undergo abortion, and went to the hospital, the doctor tried to convince them not to undergo abortion.

Goal 5: Achieve gender equality and empower all women and girls

Target 5.2: Eliminating Violence against Women (VAW) in public and private spheres

The indicators for Target 5.2 that were discussed were related to - violence against women, crimes against women and women's empowerment.

Violence and crime against women- Data on overall spousal violence and spousal violence at the time of pregnancy were presented.

With regard to cognizable crimes against women, data showed that Assam has the second highest crime rate in the country in 2016 with 131 instances of crime against 1 lakh women. Ms. Jennifer said that it is usually the students' union bodies that intervene instead of the law enforcement bodies in case of a domestic violence case. Most cases of domestic violence usually get addressed at the village level through community level bodies. Ms. Rashmi said that usually the families or villagers don't let the instances of domestic violence reach the law enforcement institutions as they think that it brings disrepute to the family and the village. Ms. Sheetal agreed to this and said that the number of domestic violence cases is under reported and the number of cases which are registered by the police is even lower. Ms. Enakshi said that the data provided by different departments and sources on domestic violence vary. She added that the number of cases which are followed up would be abysmally low. On the difficulty of obtaining reliable data on cases of domestic violence, Dr. Nilangi said that various factors influence the data collection such as- who has provided the information, how were the questions asked, who were present during the survey etc.

Women's empowerment- Three indicators on women empowerment were looked at for Assam, i.e., household decision making among married women, working women being paid in cash and property ownership of women. The data showed that over 50% women in Assam had property ownership which surprised the participants. Ms. Jennifer noted it and said that such a pattern of property ownership seems to be not true. Dr. Sunil said that this number might be because of the construction of houses under IAY which are constructed in the name of the women in the family.

Target 5.3: Eliminating harmful practices such as child, early and forced marriage and female genital mutilation

Child marriage-Under target 5.3 two indicators viz. women married before the age of 18 and women 15-19 years who were already pregnant were observed. The data showed that 30% of women in the age group of 20-24 years were married before the age of 18 years. 19% of women in the age group of 15-19 were pregnant at the time of data collection.

Ms. Nilanju said that there are women who get married before the age of 18 but stay with their parents till they turn 18, after which they move in with their husbands. She feels that this set of women might not have been captured in the survey. Ms. Jennifer said that in the past elopement of women had been culturally accepted in Assam, due to which a lot of women eloped and got married at a very early age. She explained that another reason for the high rate of women getting married early is the bad quality of education system, due to which a lot of students drop out early and as they reach adolescence they elope and get married. She added that elopement also helps the poor families save money on expenditures incurred during a wedding. Mr. Atul explained this phenomenon further and said that the families of the girl children tell them to elope and get married on their own as they will not be able to afford the wedding cost.

Session 2:

Legal issues related to SRHR

Dr. Nilangi made a presentation on the legal issues related to SRHR on the following topics -

- Child marriage in Assam
- Implementation of Prohibition of Child Marriage Act in Assam
- Maternal health in Tea estate garden workers
- Fact finding report of maternal health in Karbi Anglong
- Assam Public Health Act, 2010
- Sexual harassment at workplace
- Anti-witch Hunt Act
- POSCO Act, 2012
- Protection of Women from Domestic Violence Act, 2005

The discussion on the legal issues continued in the next session with the presentation by Ms. Nandita (HRLN).

Session 3:

sharing by NGOs working in Assam on Maternal Mortality

In this session the studies conducted by the participating organizations were shared.

the ant: Social autopsy conducted on maternal deaths for the 'Dead Women Talking' report (By Jennifer Liang)

Ms. Jennifer shared that in the year 2014, The ant along with 3 other grassroots organizations conducted social autopsies of maternal deaths, the findings from which contributed to the 'Dead Women Talking' report produced by SAHAJ. Four districts had been taken up for the study, in which a total of 14 maternal death cases were reviewed. The 'Dead Women Talking' report which it contributed to was shared and discussed with the government officials. She said that more organizations and academic institutions could do such studies and use them for policy dialogue. Ms. Jennifer said that the network of organizations in Assam is strong and a lot of organizations are working with women's groups which could be leveraged to conduct such studies and produce reports in the future. She said that IDeA, which is a programme of the ant can coordinate such studies and systematic studies could be done.

After sharing the gist of the study, Ms. Jennifer asked if Mr. Atul Kalita would want to share more on the study. He shared the cases of maternal deaths that they had come across-

- A nurse in a PHC had given birth to a girl child as her first child. Her in-laws pressurized her to conceive again. When she was pregnant with her second child, she secretly underwent a sex determination test and got to know that her second child too is a girl. She underwent abortion without letting anyone know and immediately reported to work as she did not want to raise any suspicion. After the abortion she missed taking certain medicines and started to bleed while she was at work. Her condition worsened and she did not survive. When the case was being followed up by Mr. Atul the husband inferred the cause of death to other reasons and not being related to her pregnancy.
- A pregnant woman worked as a labourer at a tea garden. Her husband had moved to another state for livelihood. She was anemic and when she delivered, the doctors said that she would require 5 units of blood. Since her husband was away and no one was available to provide blood, the ASHA herself provided 1 unit of blood to the patient. But her condition worsened and she was referred to the civil hospital. When she was taken to the civil hospital, she did not survive.
- A young girl had eloped when she was in 9th standard. She was 7 months pregnant when she developed complications and died. It was found out that since she was very young she did not know how to take care of herself or the baby. Moreover she did not receive the necessary reproductive health services, which caused her death.

Mr. Atul also shared that the prevalence of maternal mortality in Assam can be ascertained by the fact that a pregnant woman in Assam is allowed to eat whatever she feels like- this has a nutritional value during pregnancy but at the same time the family members are uncertain if she will survive the child birth and thus want to fulfill her wishes. He also shared that when a woman is to be taken to the hospital for delivery, her family members start to weep as they feel that there is a possibility she might not survive the child birth.

Diya Foundation: Women's experience with maternity care services in Assam (By Martin Rabha)

Mr. Martin shared the findings of the study that Diya Foundation had conducted in 5 districts of Assam on the experiences of women with maternity care services. The study included interviews of 92 women from the 5 districts covered. The findings of the study were as follows-

- Detention of patients- 69% of the respondents said that they were aware that the doctor would not deliver the baby if they don't pay for the health services.
- Denial of care- 27% of the respondents said that bare minimum care during childbirth was not provided to the patients. Mr. Martin cited a case where the woman who had delivered a baby was asked to clean her own room and prepare her own bed. She told the interviewer that during that time she felt that she was being treated like an animal.
- Discrimination- 7.6% of the respondents said that they felt discriminated based on their class, community or their appearance.
- Non- confidential care- 35% of the women said that the delivery did not take place at a private and safe place. They said that people could see the delivery taking place from the outside.
- Non-consented care- 16% of the women said that the doctors or nurses did not take consent from them while dealing with her and touching her private body parts.
- Undignified care- 35% of the respondents said that they were treated in an undignified manner by the health providers. One of the respondents had told the interviewer that when she had asked for water during childbirth at the hospital, she was scolded by the nurse and told that a hospital is not a restaurant. In another case a patient who had been taken to a hospital in Guwahati and was crying because of pain was hit by a doctor with a scissor and asked to keep quiet, which injured her.

Manab Kalyan: Cancer patient survey (Mr. Atul Kalita)

Mr. Atul shared that his organization had undertaken a cancer survey in the year 2014 during which they had found 3 women suffering from uterine cancer and 2 women suffering from breast cancer. The survey included 3000 households, in which 97 cancer patients were identified. One of the patients who was suffering from uterine cancer could not continue the treatment as her family could not afford the cost of treatment. Moreover they found that the women were not earning much money and so due to high costs the families would discontinue their treatment.

Ms. Renu said that research should be conducted to find out the reason for such common prevalence of cancer in Assam. She said that preventive care and early detection services for cancer should be demanded for Assam. Ms. Jennifer said that the Tata Trust is in the process of setting up a cancer treatment facility in each district of Assam and 16 districts would be covered in the 1st phase. Dr. Sunil added that the Guwahati Medical College Hospital has set up a center for free cancer treatment.

Human Rights Law Network: Reproductive Rights Initiative (Ms. Nandita Deka)

Ms. Nandita Deka presented the work being done by their Reproductive Rights Initiative in Assam. She explained that HRLN is an association of lawyers and activists who use laws to influence the implementation of policies for the betterment of society. She said that HRLN has been working on the issue of maternal mortality since 2015 and since then have been trying to address the main causes of maternal mortality. She gave an example of how they have been trying to address the issue of anemia among women by working to ensure nutrition to women through proper implementation of government policies. She highlighted that another problem they have identified which leads to maternal mortality is the shortage of blood banks. It is mandated that every district hospital should have a blood bank. She shared that HRLN had filed PILs in the districts of Udalguri and Baksa where no blood banks had been created. Right after the PIL was filed, the administration started constructing the blood banks. She emphasized that one does not need to be a lawyer to file a PIL in order to influence implementation of policies and that such tools can be used to identify and address loopholes in the government service delivery system.

Session 4:

Free listing of activities to be taken up and group work

A free listing activity was conducted where the participants suggested the various activities that would need to be taken up as a follow-up to the consultation meeting. The areas of work highlighted by the participants are as follows-

1. Women's health in tea garden areas need to be given emphasis
2. Women of households who had been displaced by flood
3. Inhabitants of char areas need to be given emphasis
4. Awareness regarding sexual and reproductive health entitlements needs to be raised
5. Menstrual and reproductive health of youth and adolescents need to be improved
6. Women's health issues- SRHR other than specified areas
7. Social pressure on women for child birth should be treated as a maternal health issue
8. Monitoring of health facilities for delivery services
9. Monitoring of ANC services in the community should be carried out
10. Gender and SRHR training should be provided to health providers
11. Diya Foundation report should be used for policy dialogue with the women's commission
12. Adequate IPHS standards in health facilities as rights (health providers are not willing to go to rural areas)
13. Safety of pregnant women at the health facility- Mr. Martin said that the safety of pregnant women at the health facilities is an issue. The doctors get carried away when they see beautiful women. In one instance a woman was raped after her delivery a baby. The ASHA worker could not find her after child birth and after continuous search she found her lying in a corner. He said that here had been 15 cases where adolescent girls who had gone for abortion were raped. Dr. Sunil added that safety of women in ambulances is also an issue.
14. Studies like maternal death review in conjunction with HRLN.
15. Status of SRHR among vulnerable groups such as adivasis, Bengali immigrants and population residing in char areas.

After the free listing of activities that the organizations could take up after the consultation to add more value to the report, the participants were divided into 3 different groups and then asked to come up with the activities which need priority. After the group work the groups came up with the following activities-

- Group1- Healthcare providers need more capacity building and training
- Group 2- Vulnerable groups should be focused such as women in tea gardens
- Group 3- Quality of ANC need to improve and causes of maternal death need to be studied.

Session 5:

Rights based monitoring of sexual and maternal health

Different components of the study were-

1. Sexual and reproductive pathways of women-

a. Documenting key events

b. Experiences of any violations of sexual and reproductive rights

2. Interface with healthcare services from providers and users (non-users) perspective

3. Policy and programme context

WHO principles

1. Non- discrimination
2. Availability
3. Accessibility
4. Quality
5. Acceptability
6. Informed decision making
7. Privacy and confidentiality
8. Participation
9. Accountability

Session 1:

Budget analysis with focus on SDGs for Assam

In the session, Mr. Ravi Duggal who is a renowned health economist explained to the participants how to analyse a budget with focus on resources being allocated towards departments and programmes which focus on SDGs.

He explained to the participants that in order to achieve the targets outlined by the SDGs, there is a need for services. The services could be from the government or from the private sector. In order to cover the cost of the services, the government has to allocate financial resources towards such services which focus on improving people's lives through budget allocations. So, resource allocation through budgets is very important for good service delivery which in turn results in good development indicators. He said that there is a link between the quality of services which are being provided at the local level and the budget allocations. Lack of budget allocation leads to poor delivery of services, and this is the reason it is important to be able to understand and analyse budgets.

In order to demonstrate how to analyse a budget he used the budget highlights of 2018-19 of the Assam government as an example. He noted that the budget made by the Assam government is very detailed and focuses on the SDGs. This shows a good intention from the government, even if at least on paper.

The goal wise budget has been consolidated and the budgeted amounts for the different goals can be seen, reflecting the priority of the government. Mr. Ravi pointed out that Goal 1 which deals with poverty alleviation has been allocated the largest amount of funds followed by Goal 3. Goal 5 which deals with women empowerment had been provided with less budget allocation of funds.

Then Mr. Ravi showed the ministry wise budget allocation for the financial year 2018-19. In this he also informed the participants that earlier budgets used to be bifurcated into plan and non-plan expenditure. But since the planning commission is now replaced by a new structure, the budget expenditures are now divided into committed and development expenditures. He noted that the budget for the ministry of women and child welfare is miniscule compared to other departments.

He then explained the process by which goal wise analysis of budget can be made. He took the example of maternal mortality and asked the participants to name government schemes and programs, which address maternal mortality. Schemes relating to ANM, Sub-centers, ASHA, NRHM outreach programme, ambulance service etc. which address maternal mortality were identified. He said that in order to understand the goal wise budget one needs to map out the services lined to that goal and then look at the programme budgets. He then considered the example of the Assam health budget for year 2017-18 and explained the budget allocations for different programmes.

Session 2:

Panel discussion on 'SDGs for Assam- partnering civil society for a people's movement'

Moderated by- Mr. Ravi Duggal

Panelists-

1. **Dr. R M Dubey, IFS (Retd.),**
   Sustainable Development Goals Cell, Govt. of Assam
2. **Ms. Supriya Khound,**
   Member, SDG Cell, Govt. of Assam
3. **Dr. Shridhar,**
   Health Officer, UNICEF
4. **Dr Zaman,**
   Maternal Health Lead, National Health Mission- Assam

Dr. Sunil initiated the panel discussion by introducing the panelists and highlighted that each of them have been involved passionately with issues related to women and public health and that their experiences would add a lot of value to the discussion.

Mr. Ravi Duggal took over the panel discussion as the moderator and asked the first question to Dr. R M Dubey who heads the SDG Cell within the Assam Government. He highlighted that Assam had taken a head start in making SDG part of the government machinery and creating an SDG cell. He asked Dr. Dubey about the experience so far in establishing SDG targets within the government departments.

Dr. Dubey said that the SDG Cell is staffed by just 3 or 4 people who have had experience working on development and it is them who helped him in getting a deeper understanding of SDGs as he was in a different department earlier. He emphasized the need for a vision before starting any initiative, and so the SDG cell worked on a vision for realizing SDGs for Assam and then followed it up by creating strategies and action plans to achieve the vision. On the factors which have helped SDGs to be given importance in the government functioning, Dr. Dubey said that the state leadership has been very supportive towards this initiative and so due to their support they have been able to make SDGs a part of the functions of every department. He added that the leadership in various governments have always been in favor of development work but it is the strategy and vision which helps in implementation of any well intentioned idea.

Mr. Ravi asked Dr. Dubey if the government departments had resisted the idea of working towards a goal or realizing the SDGs.

Dr. Dubey said that when they had started work on the SDGs in the state, the government departments were resistant to accept SDG related goals within their departments. He shared that the Chief Secretary of the government had told the department heads that if any department does not do any work which align to any of the SDGs, then there is no need for the department and it will be shut down. The departments gradually understood more about the SDGs and various consultations and trainings were held for them. Dr. Dubey added that now the budget expenditures of each department is tied to SDG targets.

Mr. Ravi asked Ms. Supriya Khound, who is associated with the SDG cell, regarding their collaboration with the civil society and how they plan to work with the grassroots organizations in the future.

Ms. Supriya said that the government departments did not have a good understanding of the SDGs in the beginning and that a knowledge gap did exist within the departments when they started out. She explained that each department had made their own strategy for a period of 7 years and action plan for 3 years as a first step. Thenthey held trainings and planning exercises for the departments, which, she admitted were not very participatory. But soon they realized and in the year 2017, 9 different conclaves were held through which they engaged the civil society, development organizations working in the grassroots and various experts. Through such conclaves, each department could take inputs from the civil society on their strategy papers. She added that localization is an important aspect that they want to include in every initiative the Cell takes up. To take SDG directed work to the grassroots, she said that 19 trainings have been organized at the district level since November 2017 which had been attended by block level officials and grassroots organizations. Ms. Supriya said that the 9 conclaves on SDGs organized for the government departments were helpful in bringing synergy within the government departments which in itself was a big step. The departments came together to work on specific goals and made plans to work in coordination with each other.

Mr. Ravi asked Dr. Shridhar to weigh in on how the processes taken up by the Assam government on SDGs have been beneficial in taking the development cause forward.

Dr. Shridhar started by saying that it is not an exaggeration that the Assam government is the first state in making SDG a part of the government machinery. He said that 2 other states- Maharashtra and Gujarat too have commenced work on SDGs, but Assam initiated it. He said that one of the achievements of the SDG related initiatives in the state is that the government departments have started to converge the work on SDGs. He added that the communities need to be engaged to make this effort impactful. On the need for convergence, he gave the example that a major cause of under-5 mortality is diarrhea which can be treated by the health department through providing ORS, which is curative. But in order to prevent diarrhea, safe and clean drinking water needs to reach the households, which can be provided by the public works department. He reinforced that it is because of these multi-faceted problems that convergence among the governments is necessary. This could be seen happening in the conclaves organised by the SDG cell. Another example which has induced the government departments double down on their efforts is the targets given in the SDGs. He said that the MMR in Assam is at 300 which are highest in the country but the target given in SDG is 70. So the health department has to reduce the MMR at 3 times the rate at which they are currently doing. To achieve this, the health department would need to put in 3 times efforts. He said that this gets the departments really thinking on their efforts.

Dr. Shridhar added that the initiative on SDGs by the Assam government has also induced fast budget approval for the National Health Mission. He told that

the budget for NHM for the states usually get approved by September or October, by which half the year is already past. He informed that for this financial year the budget has been approved in March and that the pace of planning has improved because of the focus on the SDGs. He also added that the GPDP planning at the district level have adopted the SDGs and grassroots level organizations are being involved in it.

Dr. Sunil said that his organization, the ant, had been invited to one the GPDP exercises and that it is a good initiative of planning with grassroots involvement. Ms. Nur Asma Ahmed from SESTA, added that they were part of GPDP exercises in 3 districts.

Dr. Dubey talked further on the implementation of SDGs at the grassroots level. He said that special plans have been prepared for 7 districts and that a research fellow would be assigned to each MLA to bring the grassroots issues to their notice for taking further action. He further said that the cell has developed 10 indicators in partnership with the State Institute of Rural Development which have been drawn from the SDGs. He said that these indicators would be used to assess the villages and only on qualification in all the indicators the village would be accepted as developed.

Mr. Ravi asked Dr. Zaman if the SDGs have helped the NHM in improving its performance.

Dr. Zaman started by saying that there is a stigma attached that Assam has the highest MMR of 300. But the data are for the year 2011 and that since then the situation has improved. He highlighted the challenges faced by his department and highlighted that the funds for NHM have been delayed every year and that when these funds reached them, 6 months of that year are already passed. However they are expecting the finances to reach them by April this year. On efforts for reducing MMR, he said that they are working with the NITI Aayog on measures to reduce MMR. He noted the role of teenage pregnancies resulting in maternal mortality. He said that although the department is making efforts to reduce the MMR, convergence with other departments to achieve this objective has been an area that needs to improve.

On the issue of MMR, Dr. Dubey said that the current estimate for MMR for Assam is around 200. He explained that the rate is high because certain pockets in some districts have very high MMRs and it is because of this that the state average shows to be very high. He gave the example of Dibrugarh, which is an economically wealthy district and yet is among the districts with high MMR in the state. He said that the tea tribe community who work in tea gardens have high MMR. So, every district needs to identify such issues in their district and the pockets which experience these issues and planning need to be done at district level rather than state wide homogenous plans.

Dr. Zaman said that there are enough provisions for maternal care and that all the services are free. Highlighting the challenges faced by the health department in bringing down the MMR, Dr. Zaman said that monitoring of the health facilities at the local level has been a challenge for the department. He said that the MMR can be brought down drastically by better monitoring at the grassroots level.

Dr. Shridhar added that 90% of the delivery cases can be taken care of at the PHC level if proper care is assured. He said a maximum of 15% of complicated cases arise related to child birth and there is enough infrastructure to address them at a regional level. But still there is overstretched demand for such facilities as people don't trust and use the local health facilities.

Mr. Ravi concluded the panel discussion and opened the floor for discussion and questions.

Dr. Nilangi said that the plans produced by the Assam government needs to be commended, but she added that there is a fear that the good reports and plans might not translate on the ground. She asked what would be the plans to ensure that. She also asked what the role for civil society would be in this regard and how the discussion and this exercise could be taken forward.

Dr. Sunil said that the convergence that is happening at the moment is welcome, but there is a need for deeper level of convergence as the issues are complicated and need multi stakeholder approach. He asked what role can be played by the NGOs in monitoring the health facilities so that the SDGs can be achieved.

Mr. Proshik highlighted two issues to the panel that the health facilities at the local level are not functioning and at the same time the regional medical centers such as the Dibrugarh medical college are over stretched and respectful treatment of the patients is not done. He said that there is a need for better monitoring on the ground.

Mr. Joel Rodriguez from NESRC shared his experience of working with the tea plantation workers in Tinsukia and the lack of basic nutritional and health services on the ground.

Ms. Enakshi pointed at the geographically induced vulnerability across the North Eastern states. She highlighted that some of the north eastern states have gone into a PPP model in healthcare. She asked if there is a way in which the government can partner with the private sector and NGOs to deliver local health services and run better institutions.

On hearing about the concerns raised by the participants Dr. Dubey said that the government is aware about the issues on the ground and is trying to solve the problems. On the lack of access to good healthcare by the tea garden labourers he said that mobile health vans have been sanctioned which visit the tea gardens every week.

He said that SDGs have provided the government with ambitious goals and that they are trying hard to improve the situation in the near term. On the issue of monitoring, he said that NRHM has a robust MIS which could be capitalized for better monitoring. However, he said that there are many aspects which cannot be monitored online and so surveys have to be conducted on the ground to assess the quality of the health care services being provided. On NGO partnership for grassroots monitoring he said that there are various areas within government departments where roles for NGOs have been defined. To this, Dr. Sunil said that NGOs are not looking for projects or funds but to help monitor the system better and provided a scope, NGOs will be able to raise their own funds to carry out such tasks.

Dr. Shridhar started by responding to Mr. Joel that the on the ground the situation is not such that nothing is working and at the same time it is not true that all government services are working. It is most often in the middle where some aspects of the machinery are working and some aspects don't function. He said that the questions have been raised in two areas- role of CSOs in health care and monitoring of the healthcare services. With regard to role of CSOs he said that they have to come up with the gaps as well as the solutions and present it to the concerned authorities. He emphasized that if the proposals are action oriented, the administration will not ignore the proposals. On the monitoring front he gave the example of an app called Mera Hospital where people can share feedback on local hospitals which is monitored by the health minister. Mr. Ravi concluded the panel discussion by saying that there are spaces where the CSOs can participate actively such as the Gram Panchayat Development Plans (GPDPs). He noted that the budgets being spent on various services need to be doubled in order to see any significant improvement in SDGs and this can happen only if healthcare becomes a political issue.

Ms. Enakshi gave the vote of thanks to the panelists.

Session 3:

Future activities to be taken up by participant organizations

In this session, the activities that the participating organizations plan to take up for the consultation exercise to go forward, were discussed. Dr. Nilangi informed the participants that a workshop on data analysis will be conducted for the benefit of the participants in the coming months. She urged the participants to collaborate and share their knowledge for the exercise to be productive. Dr. Nilangi informed the participant organizations that the session would be dedicated to decide on possible activities that the organizations could take up and that they need not go out of the way to take up activities which are not aligned with their work. She said that the organizations could do work around two broad areas of- awareness generation among their target groups and additional data collection related to issues covered under the consultation meeting.

An exercise was then conducted where the organizations put forth the activities that they plan to take up in the coming months, through which a table of activities was constructed (Annexure 4).

The meeting ended with vote of thanks.

Conclusion

The consultation met its objectives of review of current evidence about the implementation of selected SDG targets in the state of Assam and understanding the field level situation from the experiences of field level partners. The government officials were apprised about the project activities during a session on last day of the consultation. In this session, the participants also understood the processes initiated by the SDG cell in the state. A draft of activities that will be completed in the next few months by different local groups was prepared at the end of the consultation. This will help in preparing the policy dialogue plan and taking the process ahead in Assam with civil society participation. It was decided that the Assam state report will be a combined effort by SAHAJ and CSOs in Assam. This report will comprise of two sections- 1. A quantitative state level picture (prepared by SAHAJ team), and 2. Small studies, surveys or case studies pertaining to certain vulnerable groups in the state or some specific pockets of the state (prepared by the CSOs working in the state).

Annexures 1 List of Participants

Sr. No.	Name of the participants	Organization
1	Jennifer Liang	the ant
2	Martin Rabua	Diya Foundation
3	Niyar Gogoi	Pathikrit
4	Augustus Chermako	Boingaigaon Gana Seva Society (BGSSS)
5	Sheetal Sharma	UN Women
6	Nilanju Dutta	NEN
7	Laxmi Chetri	the ant
8	Usha Lakra	NEN
9	Nur Asma Ahmed	SESTA
10	Ravi Duggal	IBP, India
11	Sonma Burman	UBSSB
12	Bapi Sarkar	
13	Enakshi Dutta	IDeA
14	Utpal Bora	PUPS
15	Sunil Kaul	the ant
16	Priti Chakrabarty	Sanathan Unnayan Sanstha
17	Nandita Deka	HRLN, Assam
18	Soni Daimari	Gramin Bikash
19	Proshik Das	Jeevan Shiksha
20	Ronald Basumatary	IDeA
21	Renu Khanna	SAHAJ
22	Rashmi Padhye	SAHAJ
23	Nilangi Sardeshpande	SAHAJ
24	Meghali Senapati	TISS, Guwahati
25	Kankan Das	Diya Foundation
26	Atul Kalita	Manab Kalyan
27	Joel Rodrigues	NESRC
28	Netaji Basumatary	IGSSS

Programme Schedule

Timings	Particulars	Presentation by
Day 1: Monday 19th March 2018		
10.00 AM- 12.30 PM	Introduction of participants, introduction to the project and SAHAJ, introduction to CommonHealth	Renu Khanna and Nilangi Sardeshpande
12.30 PM- 1.30 PM	Presentation on- SDGs for SRHR- Assam state report	Rashmi Padhye
1.30 PM- 2.30 PM Lunch		
2.30 PM- 4.00 PM	Presentation on- SDGs for SRHR- Assam state report (continued)	Rashmi Padhye
4.00 PM- 4.15 PM Tea break		
4.15 PM- 5.30 PM	Understanding sexual and reproductive health rights	Renu Khanna
Day 2 : Tuesday 20th March 2018		
9.30 AM- 11.15 AM	Presentation on- SDGs for SRHR- Assam state report (continued)	Rashmi Padhye
11.15 AM- 11.30 AM Tea break		
11.30 AM- 1.00 PM	Legal issues related to SRH	Nilangi Sardeshpande
1.00 PM- 2.00 PM Lunch		
2.30 PM- 4.00 PM	Free listing of activities to be taken up and group work	Moderated by- Jennifer Liang
4.00 PM- 4.15 PM Tea break		
4.15 PM- 5.30 PM	Rights based monitoring of sexual and maternal health	Nilangi Sardeshpande
Day 3 : Wednesday 21st March 2018		
9.30 AM- 10.30 AM	Budget analysis with focus on SDGs for Assam	Ravi Duggal
10.30 AM- 12.30 PM	Panel discussion on 'SDGs for Assam- partnering civil society for a people's movement'	Panellists- Dr. R M Dubey, IFS (Retd.), Sustainable Development Goals Cell, Govt. of Assam Ms. Supriya Khound, member, SDG Cell, Govt. of Assam Dr. Shridhar, Health officer, UNICEF Dr Zaman, Maternal Health Lead, National Health Mission- Assam
12.30 PM- 2.00 PM	Future activities to be taken up by participant organizations	Moderated by- Nilangi Sardeshpande

Slide 1

SDGs for SRHR

Assam state report

MARCH 19, 2018

Slide 2

Demographic indicators

Total population	3,12,05,576	Census of India, 2011
Rural population (%)	86	
Population density (persons per Sq. Km.)	398	
Household size	4.6	AHS, 2012-13

Slide 3

Sex ratios

Assam	Total	Rural	Urban	Source
Sex ratio (Total population)	958	960	946	Census of India, 2011
Child (0-6 years) sex ratio	962	964	944	
Sex ratio at birth	929	945	794	NFHS 4, 2015-16
	922			HMIS- NHSRC, 2015-16
India				
Sex ratio at birth	919	927	899	NFHS 4, 2015-16
	922			HMIS- NHSRC, 2015-16

Slide 4

Development related indicators

	Total	Rural	Urban
HHDs with access to piped water into their dwelling, yard or plot (%)	9.0	4.0	31
HHDs with improved drinking-water source (%)	83.8	82.9	89.1
HHDs with clean fuel for cooking (%)	25.1	15.6	76.5
HHDs using solid fuel for cooking (%)	74.2	84.1	20.6

NFHS-4, 2015-16

Slide 5

Development related indicators

HHDs reporting no latrine (%)	35.1	Census of India, 2011
No sanitation facility (Total) (%)	11.1	NFHS 4, 2015-16
No sanitation facility (Rural) (%)	12.9	
No sanitation facility (Urban) (%)	1.0	
HHDs using improved sanitation facility (%)	47.7	
Coverage of IHHL (%)	82.1	Ministry of drinking water and Sanitation, GoI

Slide 6

Women's education

	Total	Rural	Urban	
Female literacy rate (Ages 7 years and above) (%)	66.3	63.0	84.9	Census of India, 2011
Labour force participation rate (Female) (%)	22.5	23.7	14.9	
Literate women (15-49 years) (%)	71.8	69.2	87.0	NFHS 4, 2015-16
Women with 10 or more years of education (15-49 yrs) (%)	26.2	22.5	47.4	

Slide 7

Economic profile

Per capita income (in Rs.)	54,618	Press Information Bureau, GoI, MoSPI, 2017
GSDP (in Lakh Crores) (2017-18)	2.6	Economic Survey of India, 2016-17
Percentage of working age (15-59 years) to total population	62.8	Census of India, 2011

Slide 8

Health infrastructure: Village level

Percentage of villages having ASHAs	98	Update on ASHA programme, July 2013, NHM reports
Density of ASHAs (Number of ASHAs selected/Total Rural Population)	1/918	

Slide 9

Health infrastructure: Facility level

Shortfall in Subcentres (%)	21
Shortfall in PHCs (%)	0
Shortfall in CHCs (%)	37
Shortfall in health worker (male) at subcentres	1230
Number of Subcentres without both ANM and health worker (male)	40

Rural Health Statistics, 2014-15

Slide 10

Stories from the field

Status of rural health infrastructure of Assam,

Dr. Pranjal Protim Buragohain

An attempt to analyze the status of health of different districts of Assam and the existing health care infrastructure of the state.

The health status among rural population- not satisfactory. Need for appropriate measure to improve the health status by providing quality health care services along with other determinants such as food security, safe drinking water, housing, toilet and electricity.

Status of Health Infrastructure in Assam,

Sibani Basumatari

Health infrastructure in Assam is far from satisfactory- Result of varying contributions of socio-economic factors.

Slide 11

Health status of the population

		Rural	Urban
Number of ailments reported per thousand persons (PAP) during the last 15 days	Assam	31	47
	India	89	118
No. per 1000 of persons hospitalized	Assam	28	36
	India	44	49

NSSO 2014-71st Round

Slide 12

Health status of the population

OPD per 1000 population	Assam	849
	India	1033
IPD per 1000 population	Assam	34.0
	India	48.5
Major surgeries per lakh population	Assam	145.5
	India	363.0

HMIS- NHSRC, 2015-16

Slide 13

Nutrition and women

	NFHS-4			NFHS-3
	Total	Rural	Urban	Total
Women with BMI below normal (%)	25.7	27.0	17.9	36.5
Overweight or obese women (%)	13.2	10.9	26.1	7.8
Anemia among Pregnant women (age 15-49 years) (%)	44.8	45.7	37.9	72.0
Anemia among all women (age 15-49 years) (%)	46.0	46.3	44.2	69.3

Slide 14

Assam and SDGs: up till now

- Formally adopted SDGs on 1st January 2016
- Vision 2030 document prepared in July 2016
- Seven year strategy and three year action plan prepared
- Cross sectoral synergies and goal and department clustering
- SDG oriented outcome budget
- 59 core indicators are identified for monitoring the SDGs
- Establishment of Centre for Sustainable Development Goals (CSDGs)
- Constitution of a semi formal body- SDGs Strategy Support Group (SSSG)

Slide 15

Assam and SDGs: Future steps

- Annual report on progress of core indicators
- Developing monitoring framework with periodic data updation and real time dashboard
- SDGs will be made 'people's movement'
- Preparing model SDG plans and implementing in different model areas including the deprived and vulnerable areas

Slide 16

Goal 3:
Ensure healthy lives and promote well-being for all at all ages

Target 3.1:
Reducing maternal mortality

Slide 17

Assam State vision with regards to Goal 3

Considering all these aspects, the Government of Assam, aims that by 2030, the state will significantly reduce all child deaths, and deaths among mothers while giving births to the global minimum; achieve full immunisation for all children; ensure universal safe delivery for all mothers; reduce the prevalence of chronic illness among all section of people to at least to half of the present level; and augment healthcare facilities and physical and human infrastructure to the extent facilitating and ensuring universal access.

Slide 18

Maternal health

MMR– Assam 300 India 167 (SRS 2011-13)

	NFHS-4			NFHS-3
	Total	Rural	Urban	Total
Full ANC (%)	18.1	16.6	30.4	6.7
Four ANCs during pregnancy (%)	46.5	44.8	60.4	23.5
Institutional delivery (%)	70.6	68.2	92.9	22.4
PNC during 48 hrs. of delivery (%)	54.0	51.9	79.5	13.2

Slide 19

Maternal health

ANC registration against estimated pregnancies (%)	Assam	91.0
	India	94.0
ANC registration in first trimester against reported ANC registration (%)	Assam	81.0
	India	62.0
Women with 3 ANC Check up against reported ANC registration (%)	Assam	87.0
	India	79.0

HMIS- NHSRC- 2015-16

Slide 20

Maternal health

		NFHS -4			NFHS-3
		Total	Rural	Urban	Total
Births attended by skilled health personnel (%)	Assam	74.3	72.1	94.1	31
	India	81.4	78.0	90.0	46.6
C-section (Total) (%)	Assam	13.4	10.8	36.9	5.3
	India	17.2	12.9	28.3	8.5
C-section (Public) (%)		12.9	11.4	26.6	21.0
C-section (Private) (%)		53.3	48.3	65.6	26.7

Slide 21

Maternal health

Home deliveries against estimated deliveries (%)	Assam	12
	India	9
Institutional Deliveries against estimated deliveries (%)	Assam	73
	India	66
C-Section Deliveries (%)	Assam	18.5
	India	16.7
PNC Visits within 48 hrs of delivery against total deliveries	Assam	72.0
	India	71.0

HMIS- NHSRC- 2015-16

Slide 22

Stories from the field

'Safe', yet violent? Women's experiences with obstetric violence during hospital births in rural Northeast India

Chattopadhyay S, Mishra A, Jacob S

15 months of ethnographically informed fieldwork between 2015 and 2017 in rural Assam

Procedures done without anaesthesia, improper pelvic examinations, beating and verbal abuse during labour, with sometimes the shouting directed at accompanying relatives.

Slide 23

Goal 3:
Ensure healthy lives and promote well-being for all at all ages

Target 3.7:
Ensuring universal access to SRH services

Slide 24

Access to information about SRH

	NFHS-4			NFHS-3
	Total	Rural	Urban	Total
Women having comprehensive knowledge of HIV/AIDS (%)	9.4	8.0	16.0	8.2
Women age 15-24 years using hygienic methods of protection during menstrual period (%)	44.8	40.9	62.4	25.9

Slide 25

Stories from the field

Knowledge and Perception of Women towards Reproductive Health Problems: a Study of Bishnupriya Manipuri women of Silchar, Cachar District in Assam

Rajiya Shahani and Arpita Debnath

To identify the nature and types of reproductive health problems of women, to examine the socio- cultural factors influencing reproductive health and to find out the accessibility of health services for them.

Age as a determining factor for the use of sanitary pads. Awareness about contraceptives and HIV/AIDS is from television but no knowledge of RTI. For general health problems as well as delivery cases, they have to visit the private hospital which is far away. Only one subcentre under the study area, that too without any doctors.

Slide 26

Access to contraceptive services

	NFHS-4			NFHS-3
	Total	Rural	Urban	Total
Use of contraceptive method (currently married, 15–49 years) (%)	52.4	52.0	54.9	56.5
Use of modern contraceptive method (currently married, 15–49 years) (%)	37.0	36.8	38.4	27.0
Unmet Need- spacing (currently married, 15–49 years) (%)	5.8	5.9	4.9	3.6
Unmet Need- Total (currently married, 15–49 years) (%)	14.2	14.4	12.9	12.2

Slide 27

Access to contraceptive services

Total sterilisations reported- female	48024
Number of cases of complications following female sterilization	103
Number of failures following female sterilization	35
Deaths due to sterilisations- female	4
Abortion Rate against Estimated pregnancies	2.3

HMIS- NHSRC- 2015-16

Slide 28

Access to contraceptive services

	NFHS-4			NFHS-3
	Total	Rural	Urban	Total
Health workers ever talked to female non users about family planning (%)	17.2	17.6	14.8	4.1
Current users ever told about side effects of current methods (%)	55.1	55.0	55.8	44.3

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Access to RTI/STI treatment

No. of STI clinics	28
No. of STI episodes treated in 2013-14	116,271
No. of Mother-Baby Pairs Received Nevirapine in 2013-14	79

NACO State Fact Sheet 2013-14

Slide 30

Stories from the field

A Study on Reproductive Health Problems and Menstrual Hygiene Practices among Adolescent Girls Living in Slums of Guwahati city

Chinmayee Barthakur, Monjuri Barkataki

Out of 119 adolescent girls, 52.5% used sanitary pads during menstruation. 20.2%, 24.4% and 9.2% presented with symptoms for RTI, UTI and for both RTI and UTI combined. Girls reported problems like dysmenorrhoea, UTI symptoms, and excessive vaginal discharge.

Slide 31

Access to abortion services

- Total 23 Training Centers in the State to conduct training of service provider
- 317 Service providers trained at district level (MO MBBS) till Mar'2017.
- 46 % of delivery points from PHC upwards are providing MTP Services
- 11 Clinical Mentors identified in the state to provide technical support
- All the 27 districts have District Level Committee
- A "Model CAC Centre" at Assam Medical College & Hospitals, Dibrugarh is build which will be a model site for all NE States.

Slide 32

Stories from the field

Abortion Incidents, Still Birth And Reproductive Health Risk Of Deori And Mishing Women In The North East India

Dr. P. Hazarika, Nilutpal Chutia

Objective- Mapping of reproductive health risk of tribal women in Sivasagar, Dibrugarh, Dhemaji and Lakhimpur districts

Sample- 240 Ever married women in 15-49 years age group and that aborted and delivered still birth.

Findings- Incidence of abortion and still birth to tribal women- a common phenomenon, leading to worsening of RH.

Positive factors- Increase in health and population education and investment in such sectors

Negative factors- Poverty and inadequacy of knowledge about health

Slide 33

Goal 5: Achieve gender equality and empower all women and girls

Target 5.2: Eliminating Violence against Women (VAW) in public and private spheres

Slide 34

Assam State vision with regards to Goal 5

The Government of Assam in pursuance of the SDGs envisages removing all barriers related to economic participation of women in the state; to eliminate the gender differences in work participation; to enhance the scope and avenues of employment for women and to reduce the excess female unemployment rate by 2030. Further, it aims at halting all forms of violence and crimes against women in the next fifteen years.

Slide 35

Violence against Women

		NFHS-4			NFHS-3
		Total	Rural	Urban	Total
Ever-married women who have ever experienced spousal violence (%)	Assam	24.5	26.2	15.9	39.4
	India	28.8	31.4	23.6	37.2
Ever-married women who have experienced violence during any pregnancy (%)	Assam	2.1	2.1	1.8	NA
	India	3.3	2.5	3.9	

Slide 36

Crimes against Women

Rate of total cognizable crimes (IPC+SLL) against women (Crime per one lakh population)	131.3
Rank based on rate of total cognizable crimes (IPC+SLL) against women	2nd
Cruelty by Husband or his relatives (Sec. 498 A) (Crime rate)	58.7
Kidnapping & Abduction of Women (Crime rate)	33.6
Rape (Crime rate)	11.2

Crimes in India 2016, NCRB

Slide 37

Women's empowerment

		NFHS-4			NFHS-3
		Total	**Rural**	**Urban**	**Total**
Currently married women who usually participate in household decisions (%)	A	87.4	86.2	93.7	88.1
	I	84.0	83.0	85.8	76.5
Women who worked in the last 12 months who were paid in cash (%)	A	17.0	16.7	18.6	25.8
	I	24.6	25.4	23.2	28.6
Women owning a house and/or land (alone or jointly with others) (%)	A	52.3	53.7	45.9	NA
	I	38.4	40.1	35.2	NA

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Goal 5: Achieve gender equality and empower all women and girls

Target 5.3: Eliminating harmful practices such as child, early and forced marriage and female genital mutilation

Slide 39

Child marriage

Mean age at marriage (Female- in years)			21.5	Census of India, 2011
	Total	**Rural**	**Urban**	
Women (20-24 years) married before the age of 18 years (%)	30.8	31.9	24.3	NFHS 4, 2015-16
Percentage of women age 15-19 years who were already mothers or pregnant	13.6	14.4	8.1	

A table of proposed activities in Assam

NGO/CBO	District	Stakeholders	Message/issue	Activity
UBSSB	BAKSA	SHG Members	Maternal Health Entitlement	GD
NEN	Udalguri, Darrang, Golaghat, Dhemaji, Kokrajhar, Kamrup (Rural)	Survivors of domestic violence, Adolescent boys and girls, support group members and community women	DV as a public health issue Maternal health entitlements	Meetings Awareness campaigns Surveys Policy dialogue
UN Women			Policy dialogue for SRHR	
HRLN	Not specified			Compilation of relevant reports
SUS		Community		Survey on safe drinking water and sanitation
The ant	Chirang	Women/SHGs	Domestic violence/ use of contraceptives	Survey
SESTA	Chirang	Women/SHGs members	Maternal health entitlements	Survey/situational analysis
Diya Foundation	Ribhoi / Kamrup (Rural)	Community	Maternal Health	TBD
Grameen Bikas	Sonitpur	SHGs	Child marriage	Awareness building / survey
BGSS	Bongaigaon	Adivasi community	Maternal deaths review	Documentation
	(Kokrajhar, chirang, bongaigaon)		Infant mortality	
Patikrit	Sivsagar	Children	Infant and Maternal health	Situational analysis
Jeevan Shiksha	Dibrugarh	Tea garden community (children/ women)	Adolescent girls and menstrual hygene	TBD
IDEA			Process facilitation	Facilitate quantitative and qualitative studies/ identify vulnerable pockets/groups/ facilitate at state level