COPASAH Series on Social Accountability

CASE STUDY 4

Claiming Entitlements:
The Story of Women Leaders' Struggle for the Right to Health
in Uttar Pradesh, India

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COPASAH

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Foreword

The world today is becoming increasingly complex and relatively simpler development aspiration of poverty alleviation has become complicated with a whole range of concerns including economic issues income inequalities to social issues like inclusion and environmental issues like climate change which affect both the rich and the poor people and nations. Participation, transparency and accountability are being seen as common principles which help to navigate the process of coming to consensus solutions. COPASAH (Community of Practitioners on Accountability and Social Action in Health) is a collective of practitioners who have been applying these principles in the field of health governance in different places around the world. Health care is a contested area of governance and public policy action. In many countries, especially in the Global North, it is provided through state support, whereas in many countries in the Global South public services are in disarray and the private sector is flourishing, creating huge inequalities in access and health outcomes. 'Privatisation' and 'fee for service' are a common refrain from many development think tanks, while a case for 'universal health care' is put out by others.

While cost of care and nature of public or private provisioning continues to be matter of public debate, it is undeniable that there is a huge power asymmetry between people, especially poor people in distress and providers. This power asymmetry affects the ability of the poor to access services in their best interests. In many countries communities have themselves come together to negotiate better health care services from the state. In this Case Studies series we wish to highlight some of these organised efforts. These case studies describes the work of colleagues in COPASAH, outlining how they conceptualised, organised and implemented these processes, drawing upon the principles of participation, transparency and accountability.

We hope these Case Studies will serve as stories of hope and inspiration for other practitioners to adopt similar practices while we strive for better health outcomes and for health equity in our common march toward health for all.

About Authors

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Claiming entitlements: The story of women leaders' struggle for the right to health in Uttar Pradesh, India

This case study is part of a series of papers commissioned by the Community of Practitioners on Accountability and Social Action in Health (COPASAH).

Acknowledgement

This case study is a testimony to the enduring spirit and enthusiasm of the women leaders, without whom there would be no *Mahila Swasthya Adhikar Manch* and no story to tell. We have seen many of these women going through their struggle with a rare sense of dignity and sense of humour and they continue to be sources of immense inspiration for the editors. This case study has been a collaborative effort of many people and many organisations and we would like to thank all our colleagues and partners in this process. Thank you - Bindu, Rajdev, Sandhya, Rehana, Uma, Urmila, Nitu, Avdhesh and others from the field coordinating organisations for not only sharing your stories, but for supporting the women leaders and helping them in their journey. Colleagues from SAHAYOG, especially Y K Sandhya, deserve our thanks for helping put together all the necessary documentation and Tithi Sunita and Reena for being an admirable supporting cast. We would like to thank colleagues in CHSJ especially Nidhi for all the preliminary work and to Sarita and Lavanya for giving shape to this product. We would like to thank colleagues at COPASAH for giving us the opportunity to write this story of the women leaders of MSAM. Last but not the least, we would like to thank our reviewers Dr Rakhal Gaitonde (Training and Research Associate, SOCHARA, India) and Dr Amitrajit Saha, (Senior Adviser, HIV & Human Rights, UNDP Regional Service Centre-Eastern and Southern Africa) for their extremely valuable suggestions.

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Executive Summary

Storyline - This is the story of the leaders of a women's organisation, *Mahila Swasthya Adhikar Manch* (Women's Health Rights Forum) in the state of Uttar Pradesh in India. It recounts how a group of women from the extremely marginalised sections of society have become empowered and are monitoring their entitlements around health services and other services which are related to the social determinants of health. It describes the evolution of the group, its activities and some of the results of their advocacy action with a focus on their empowerment process. The women leaders of this group have been supporting the members of the community to claim their health rights through a process of periodic enquiries and engagement with health providers and managers at different levels. As women leaders have become more empowered, they have also entered into the local electoral process. This story of women's empowerment is closely inter-twined with that of a group of facilitating organisations, who have not only contributed to this process, but also gained in confidence and credibility to strengthen the overall call for greater state accountability at different levels. The case study also discusses how this process which has led to a series of gains for these marginalised women both at a personal level and in improving accountability processes at the local level; still remains incomplete in the context of their overall political empowerment and autonomy.

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Chapter 1

Introduction

"Over the last six years, MSAM leaders and members have increased their understanding of entitlements in health, nutrition and food security, livelihoods, political participation, social security and violence against women. The leaders have built capacities to monitor the services to the rural poor, as well as identify incidents of maternal death that involved denial of care. The women have shared their findings every year with district health officials and state policy actors, and built up an identity as health advocates."

Taking Charge – Vignettes

It was early in the morning on the 20th of May 2012, when a *Dalit* woman in labour was brought to the Primary Health Centre (PHC) at Baheri village in Mahua Block of Banda district in southern Uttar Pradesh. She was admitted but in the afternoon the ANM (Auxiliary Nurse Midwife) asked her family to take her back home since her delivery would take place the next day. The family were reluctant and were concerned that taking her back home and then bringing her again to the hospital would cost more money and there was also the risk of her delivering on the way. However, the ANM was firm and directed the sweeper to lock the PHC for the night while she prepared to leave even though an ANM is expected to live on the premises. The family had no option but to wait in the open veranda – there was no light or water in the PHC. Vimla, a leader of the local MSAM group was informed about this face off in the PHC. Immediately she mobilised other members of her group and rushed to the PHC. After getting the details from the family she called up the Chief Medical Officer (CMO) of the district and complained. The CMO assured her of immediate action and a team of health providers came to Baheri PHC within the next 2 hrs and the woman delivered comfortably in the PHC during the night.

Dangri a member of the women's group from Majhgai village, of Naugrah block, in Chandauli district had come to the Naugarh hospital for treatment. She was surprised to see a large number of young women with small infants huddled together in the hospital campus. On enquiring, she learnt that these women with their new born had been coming every day for the last four days to collect their Janani Surakhsa Yojana (JSY) incentive but were unable to get their cheques. Dangri told the women to come with her meet the local legislator. They went to his house but he was not there and the women were disappointed. Dangri Devi took the women with her to the Head Clerk's office. The Head Clerk got scared seeing the large number of women and called the Chief Medical Officer (CMO). The CMO told the clerk to immediately distribute the cheques to the women. That day 80 women got their JSY cheques and since then women of that area get their JSY cheques within a week of delivery and without any problems.

Sharda Devi, a Musahar[1] woman of Podra village, Atraulia block of Azamgrah district, had her delivery in the Community Health Centre (CHC) at Atraulia on 20th September 2011. As was the custom the staff nurse asked for payment for conducting her delivery and she was given Rupees 820 by Sharda Devi's family. When she returned to her village and her story was shared among the members of the women's group in the village, they became very upset because all delivery related services were supposed to be free. The leader of the group Saraswati Devi immediately called for a meeting and it was decided that they would go to the CHC and ask for an explanation. The very next day 30 women from the village, under the leadership of Saraswati Devi marched to the CHC with a written complaint. The Medical Superintendent was not present so they shared their grievance with the Health Education Officer. The Health Education Officer got the staff nurse to

1 Musahar – rat eaters – an untouchable caste.

apologise and return the money she had taken. However, the women were not satisfied and they insisted that their written complaint be accepted and forwarded to the Chief Medical Officer of the district.

Vimla, Dangri Devi and Saraswati Devi are community level leaders of MSAM (Mahila Swasthya Adhikar Manch or Women's Health Rights Forum). MSAM is a forum of poor rural women most of whom also belong to the more backward castes. It was formed at the end of an intensive grassroots campaign on women's rights to maternal health across Uttar Pradesh (UP) in early 2006. This campaign was initiated because poor women faced great difficulties in accessing essential maternal health services even though the government was providing incentives for institutional deliveries. In many cases the designated emergency obstetric care facility did not provide the essential life saving services. In other cases, women were harassed, abused and faced financial extortion from health care providers. The campaign allowed women across several districts not only to understand their common plight, but they also became aware of their entitlements under the existing government programmes.

Over the last six years, MSAM leaders and members have increased their understanding of entitlements in health, nutrition and food security, livelihoods, political participation, social security and violence against women. The leaders have built capacities to monitor the services to the rural poor, as well as identify incidents of maternal death that involved denial of care. The women have shared their findings every year with district health officials and state policy actors, and built up an identity as health advocates. Today, MSAM has a membership of around 12,000 women across 10 districts in Uttar Pradesh. The entire process has been facilitated and supported by a group of community based organisations (CBO), which has been led by SAHAYOG, women's health and human rights resource organisation based in Lucknow, Uttar Pradesh.

The Context

Uttar Pradesh (UP) is the most populous state in the country with a population of about 200 million. However, it is also considered among the more backward states with less than average socio-economic indicators. UP is located in the Indo-Gangetic plains, a very fertile region where agriculture is the mainstay of the economy. The predominantly agrarian society upholds traditional values with a feudal mindset, strong caste-based hierarchies and the status of women here is clearly subordinate. Over the last two decades the state has been going through political realignments in which the subordinate social groups have started asserting their political rights. This has led to the formation of new regional political parties[2] which have now come to power at the state. There are concerns that this political restructuring has led to some decline in the governance mechanisms in the state.

2 The two important political parties are Samajwadi Party which is led by Other Backward Class (OBC) leadership and the Bahujan Samaj Party which has Dalit (earlier the "untouchable" caste) leadership.

The health system in India was in decline with the reducing state support for health care since the early nineteen- nineties. It was re-energised by the National Rural Health Mission (NRHM), which was announced in 2005 by the national government. Improving maternal health was a key objective of the NRHM and the principal strategy for achieving this result was to provide financial incentives to rural women to go to hospitals for their delivery. This incentive-based scheme is known as the Janani Suraksha Yojana (JSY) and includes the payment of a sum of fourteen hundred rupees (roughly USD 30) to all women who deliver in a clinic or hospital. In addition, village level volunteers called ASHAs were appointed to motivate and support women to do so. In UP alone, over 125 thousand ASHAs have been appointed for 107 thousand villages.

The situation of maternal health was particularly distressing in Uttar Pradesh. At the beginning of the millennium, the maternal mortality ratio of UP was close to 700 maternal deaths for every 100,000 live birth, totalling over 30,000 maternal deaths each year. Thus, the NRHM objective of improving maternal health was particularly relevant for the women in the state. While over three quarters of all deliveries took place earlier in homes in rural UP, the sudden policy change to promote institutional deliveries meant that the health system in UP was ill-equipped to deal with the anticipated load of deliveries. Three years into NRHM in 2008, less than 50% of all Primary Health Centres were either equipped to or were performing the simple task of delivering babies. Less than 10% designated first referral units had the capacity to perform C-section operations and only 1.3% had blood available.

In addition to being inadequately prepared to deal with the situation, there were reports of corruption across the system and women's experiences as well as small scale studies indicated that women had to face abusive and disrespectful behaviour from both nurses and doctors. As has been mentioned earlier, the adverse experiences of women as they came to hospitals for their delivery, energised CBOs from different districts across the state to come together to deal with the situation. These CBOs along with SAHAYOG, a state-level resource organisation, implemented a state-wide campaign, which led to the formation of the *Mahila Swasthya Adhikar Manch* (MSAM).

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Chapter 2

The Story of Mahila Swasthya Adhikar Manch

"On 26th May 2006, women analysed their situation and decided to plan to fight for their rights. In UP as many as 40,000 women died due to complications during childbirth. This sorry state of affairs of maternal health resulted in the formation of Mahila Swathya Adhikar Manch. The realisation that there is need to work on the issue of health was there but women were not prepared to fight for the same at the society and household level. Maternal deaths were considered God's will. Therefore, a need was felt to do advocacy for explaining to the families and villagers about the fact that maternal deaths were happening due to lack of facilities and not due to any divine reasons."

THE GENESIS

Bindu Singh of *Gramya Sansthan,* one of the key facilitators of MSAM highlights this genesis through her story.

"Gramya Sansthan (a CBO) started working in Naugarh Block of Chandauli district in 1996. Naugarh *is primarily a forested tribal area, and the tribals face a lot of hardships in their day to day life. At that time there were no schools or primary health centres. The transport facilities were also poor. In 1999, the forest department started taking away land from the tribals. At that time Gramya Sanstha along with the tribals formed a group to save their land which was called, Mazdoor Kisan Morcha (Labourers and Farmers Platform). Both men and women participated in equal numbers but it was the women who came forward to fight for their rights. Fighting for land rights gave women the confidence to fight for other rights. This was also the time when 'HISAB'[3] campaign was started. This movement gave women an opportunity to understand their issues. The organisation also thought if women can take active role in fighting for their land and saving it, then they can fight for other issues, which are equally important and close to their day to day life.*

Around this time, SAHAYOG supported us to conduct Participatory Rural Appraisal (PRA) on the health issues in 5 villages of Naugarh block. This helped in understanding the situation around health. Once the understanding around the issue of health was developed by the organisation, it got involved with the '*Puri Nagrik, Pura Haq*'[4] campaign on the issues of health and violence. The idea was that although women are considered full citizens but they are not given all the facilities that they are entitled. A film was also made which was very effective.

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Rajdev Chaturvedi from *Grameen Punarnirman Santhan* (GPS) of Azamgarh district has a similar but slightly different story.

In the Atraulia block of Azamgarh district, the health facilities were in such a poor state that doctors refused to treat women who were very poor and shabbily dressed. The government doctors would treat the patients only after taking fees and patients had to purchase medicines from private medical shops. The ANMs (Auxiliary Nurse Midwives) were absent from the sub-centres; as a result the maternal and post maternal services were hardly available. Because of this, common people especially women were not able to access

3 HISAB – was a state-wide civil society campaign in 2001 asking the state Government to take note of Violence Against Women as a policy concern.

4 Puri Nagrik Pura Haq – Full Citizens Complete Rights – another state-wide civil society led campaign on women's rights

government health facilities and the people at GPS were helpless. The workers of GPS did not have any understanding of rights, that too in the area of health.

In August 2000, SAHAYOG organised a workshop on maternal health at Lucknow. This was followed by workshops on gender and women's health organised at Shajahanpur and Azamgarh, which helped in perspective building and realising the impact of gender disparity on women, especially their health rights. During this time, SAHAYOG did an evaluation study of community facilities in Azamgarh. The data generated from this study inspired GPS to take up the issue of women's health seriously. In 2002 the Rani Jaiswal case of failed sterilisation came into light. At a meeting organised by Healthwatch UP[5] it was decided that a study on the negative impact of forced sterilisations should be undertaken in Uttar Pradesh. GPS collected the maximum number of case studies, based on which a Public Interest Litigation (PIL) was filed in the Supreme Court.

*In the areas where GPS works, the people are very poor and it is not possible for them to afford private health care. Due to poverty, malnutrition and unemployment, the health status of pregnant women used to be very bad and they had to depend on private doctors, especially quacks/ "*jhola chhap*". Often, they had to take loans or sell their belongings. GPS also worked on economic issues promoting women's Self Help Groups (SHG) and started discussions with SHG members on social and health issues. GPS also helped women to write applications to various departments with their complaints. After the activists of GPS developed an understanding of gender and women's health, it became clear that women have a right to health and ensuring it is the responsibility of the government.*

SAHAYOG did an evaluation study of community facilities in Azamgarh. The data generated from this study inspired GPS to take up the issue of women's health seriously. In 2002 the Rani Jaiswal case of failed sterilisation came into light. At a meeting organised by Healthwatch UP it was decided that a study on the negative impact of forced sterilisations should be undertaken in Uttar Pradesh.

SAHAYOG's role has been central in mobilising and supporting MSAM, however from some distance. SAHAYOG is an NGO registered in Uttarakhand, which shifted its headquarters to Lucknow in 2000. Earlier it worked primarily at the community level in Almora district of erstwhile Uttar Pradesh, which subsequently became part of the new state of Uttarakhand. SAHAYOG transition from a primarily community based organisation in Almora, Uttarakhand to an exclusively intermediate level resource organisation in UP required SAHAYOG to develop a niche and a support or client group while at the same time keeping its focus on community driven participatory processes and women's reproductive health and rights. SAHAYOG was already mobilising interest among voluntary organizations and NGOs of UP on the issue of coercive population policy through the facilitation of a network – Healthwatch UP Bihar (HW). The adoption of the UP Population Policy by the state in 2000, provided an opportunity for this group to examine the intent and implementation of this policy. This process led to the organising of a state wide fact finding process, a public hearing, a study of family planning camps and the filing of a Public Interest Litigation in the Supreme Court of India. This collective process between 2000 and 2003 energised many health groups to become interested in health rights issues and an understanding of how poorly provided services and health rights violations manifest themselves as individual and family level calamities.

As a group working on women's health and rights, SAHAYOG also allied with other women's groups in the state to initiate a campaign on violence against women called –

5 Healthwatch UP – a reproductive health and rights advocacy network that had been initiated in the state in 1996 following India's commitment to the ICPD Programme of Action

HISAB or "Hinsa Sahna Bandh". This campaign, conducted in 2001, mobilised over 3500 women from across the districts to come and attend a Public Tribunal in Lucknow in September 2001. The HISAB process and event also generated a lot of energy and interest among groups for working together on women's issues. The HISAB campaign tradition was continued through a second campaign on women's rights within CEDAW in 2003, *Puri Nagrik Pura Huq* (Complete Citizens Total Rights), which had SAHAYOG in a convening role (along with other organisations). This campaign provided a platform for activists working on women's rights as well as health rights (HW activists) to come together on one platform, as maternal mortality was one of the key campaign issues, demanding immediate state action and accountability.

In 2006, SAHAYOG in partnership with Healthwatch and many other civil society groups began another state-wide campaign, '*puri Nagrik Pura Huq-2*' (Complete Citizens Total Rights-II campaign) to address policy makers, constructing preventable maternal mortality as lack of equal citizenship for women. Once again women demonstrated on the streets, and tried to focus media and policy attention on the problem. The campaign mobilised thousands of rural women across half the state through a signature campaign; and some of them presented their experiences to the Health Minister, and spoke before legislators. Some of SAHAYOG's work with these women and the campaign was presented through the Public Services Broadcasting Trust (PSBT) documentary film 'Mother Courageous.'[6]

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The campaign experiences led to a change in strategy, towards a longer term organisation directly representing the interests of women from marginalised groups, which could enhance poor women's participation and agency in the process of rights-claiming, and seek responsiveness from governance institutions. On 28 May 2006, the decision was taken by women leaders and civil society groups to form a grassroots women's organisation in Uttar Pradesh, called the Women's Health Rights Forum (MSAM or Mahila Swasthya Adhikar Manch). This was an opportune moment, as the NRHM provided a legitimised space for the active engagement of the MSAM rights holders as it promised concrete service guarantees and defined standards for health facilities (Indian Public Health Standards); and it had the mandate for decentralised planning and budgeting, citizen representation on oversight committees, as well as citizen monitoring.

MSAM TODAY: A FORUM OF EMPOWERED WOMEN LEADERS

Jhamman is a traditional birth attendant (TBA) from Attri village of Rajgarh block of Mirzapur district and is a single woman who belongs to the scheduled caste. She is a daily wage worker, involved in stone breaking in a stone mine, and feeds her family. She has never stepped out of her house except for work. One of the women that Jhamman had attended to in labour, later died because of the absence of emergency obstetric services. Jhamman was very concerned and got involved with Shikhar Prashikshan

6 http://www.psbt.org/screening/movie_review/182

Sansthan, one of the facilitating partners of MSAM. When Jhamman got the information and understood that health is a right and the government is responsible for providing facilities to women, she along with other women from her village, fought with the gram panchayat and the block development officer (BDO) for better health facilities and for an Anganwadi Centre. She even put forth her demands at the district level. Today after the struggle, her village has all the promised facilities. The ANM visits the village; there is an Anganwadi Centre. She has even spoken confidently on BBC radio. Today, the villagers have a lot of respect for Jhamman and other women from her village. (As recounted by Sandhya, Shikhar Prashikshan Sansthan)

Mehron is the leader of an MSAM group in Purkazi block in Muzzaffarnagar district. Her sister-in-law died during childbirth, because she did not seek services in time. Today she has been motivating Muslim women to go for institutional deliveries. She also gives advice to families of pregnant women. She can guide the women and families on the phone about the locations of the delivery rooms, emergency rooms in the hospital. She even speaks to the doctors on the phone and knows the name of the Chief Medical Superintendent and can also call him on phone. Earlier Mehron was very scared to go to the PHC, but now when a new doctor was appointed, she went and met him and introduced herself as an MSAM leader. Once, a nurse tried to ill-treat some Muslim women by not touching their money, and instead asked them to keep the money on the table. When Mehron came to know she immediately protested. The nurse apologised and requested them not to go to the media. (As recounted by Rehana, Astitiva)

Earlier Mehron was very scared to go to the PHC, but now when a new doctor was appointed, she went and met him and introduced herself as an MSAM leader. Once, a nurse tried to ill-treat some Muslim women by not touching their money, and instead asked them to keep the money on the table. When Mehron came to know she immediately protested.

Jhamman, and Mehron are among the empowered women leaders who form the core of MSAM. MSAM is an organisation of women's groups across several districts of Uttar Pradesh, which are facilitated by local NGOs that partner with SAHAYOG. These partner CBOs have formed women's groups around various local issues, as described above, and some groups are also small-savings groups (known popularly as Self-Help Groups or SHG). Since its formation in May 2006, MSAM has been established in twelve districts.

STRUCTURE AND COMPOSITION OF MSAM

Currently (March 2013), there are 12,114 women registered as members in 171 active village-level groups spread cross nine districts.[7] The focus of the empowerment process has been a team of five women leaders from each village which has a MSAM group. These five leaders are responsible for the five themes that are part of the MSAM charter – health services, livelihood, nutrition and food security, violence against women, and social security. The MSAM group members elect these five leaders every three years. The capacity building of these thematic leaders is done by SAHAYOG and the partner CBOs in each district.

The leaders were first elected in 2009 and the most recent round of elections in MSAM was conducted in November 2012. 868 MSAM women leaders were elected from these 170 groups. Of these leaders, 50% are from the Dalit community, 9% are tribal women, another 9% are Muslim women, 30% are Other Backward castes, and 2% are from the privileged castes. The women who are members of MSAM also belong to poor, Dalit and backward castes. These women are largely illiterate and many had earlier never spoken in front of their husbands or other members of their families.

7 The 171 MSAM groups are in 115 village panchayats spread across 16 development blocks in these nine districts (as on 15 March 2013)

When these women initially decided to be a part of MSAM, they had to face a lot of opposition and ridicule from their families. The men would say *"Now women will improve the system. There are only two leaders, Mayawati[8] and these women"*. In the beginning it was essential to bring change in the lives of the women before they could fight for their rights. Earlier, women would not come out of their houses but now they can speak with confidence before the Chief Medical Officer of the district (CMO), or senior government officials and media; they also have greater political awareness. Recently photographs of two women got published in "Sandes" , a magazine started by Uttar Pradesh (UP) Chief Minister, Akhilesh Yadav. These made villagers realize that MSAM women are capable of many achievements, and the women also felt motivated when their photographs were published.

In Bundelkhand area where Tarun Vikas Sansthan works, women do not even come in front of men, there is purdah system. But today these women are coming out of their houses and are also developing an understanding about their issues and rights. Initially, these women were very hesitant to speak in front of the gram panchayat. They were not sure about the reactions of the villagers. They thought they might get scolded by the upper caste people, since they were from the lower caste. But today they are able to put across their issues not only in front of the gram panchayat but also at the district and state level. Now the women have become very confident. They even tell the MLA that now that they have got him elected, what will he do for them? Women who could not speak in front of the ward member or gram panchayat are now confidently speaking in meetings in Lucknow, and that is a very big success. Earlier women from upper and lower castes did not interact with each other but now they do sit together for meetings and other programmes. (As recounted by Uma, Tarun Vikas Sansthan)

Once it was decided that the CBO partner organisations would work with SAHAYOG on the issue of health and MSAM was formed, some immediate issues were addressed. An issue taken up at the beginning was the widespread demand for informal payments by the Auxiliary Nurse Midwife (ANM) for any service she provided - immunisation, or for issuing birth certificates (both of which are supposed to be provided free of cost), and women being harassed for money at the hospital when they went for childbirth. The emphasis was to make each individual grievance a part of the larger social struggle of the right to health for poor women.

The women leaders of MSAM are now able to look beyond their personal interests; even when an issue does not affect them personally they are ready to fight for it for the sake of other women. If a woman lost her daughter-in-law during child birth, she feels other women should not suffer the same fate. "*I may have suffered but I don't want other women to suffer*". As a result of awareness-building and local activism, the MSAM women leaders are willing to take up the cause of other women, relatives or neighbours in the village who are facing a problem.

A Dalit woman from Mirzapur district, was told by the ANM after her delivery that she will get her cheque of JSY only if the ANM is given Rupees 700 out of the Rupees

8 Mayawati is an iconic female Dalit leader of the state of Uttar Pradesh. She was the Chief Minister of the province when MSAM was being constituted and empowered.

1400. The matter was discussed at the MSAM meeting and they complained about this at the CHC. When the health official (CMO) scolded the ANM she managed to get the official speak to some man on phone, saying that he belonged to the Dalit woman's family and the matter has been sorted out. When the MSAM came to know about this, they once again approached the health official and after a lot of follow up, the ANM who is from high caste, gave the Rupees 700 back to the Dalit woman. (Recounted by Sandhya, Shikhar Prashikshan Sansthan)

In Atraulia block of Azamgarh district, the ANM took 700 rupees for the delivery of a poor Dalit woman belonging to Musahar community. Next day at the MSAM, meeting the incident was shared and it was decided that some action will be taken. About 10 women from the network encircled the PHC and with the help of a worker from GPS wrote a complaint letter and tried to give it to the doctor who refused to take it. The women then approached another health official, and insisted that he receive their complaint letter. Later, the doctor and the ANM begged and pleaded these women not give the complaint and returned the Rupees 700. It is a big thing to get back money given as bribe. (As recounted by Rajdev Chaturvedi, Grameen Punarnirman Sansthan)

Ramrati is an MSAM group leader from Bhagelpur village, of Naugarh block from Chandoli district. She had taken some women to a female sterilisation camp organised in Naugharh in Chandoli district. Here the staff were asking for Rs 50/- (about USD 1) from each woman for injections. Ramrati told the health staff that they could not ask the women for money as she knew that the procedure was completely free of cost. She asked the health department staff to return the money and they refused. A while later the Chief Medical Officer of the district came for inspection and Ramrati immediately told him that the ANM was collecting money. By then Rs 50/- had been collected from around 50 women. The CMO ordered the staff to return the money that had been collected and all the money was returned to the women. (As recounted by Bindu, Gramya Sansthan)

The personal victories of women were essential for larger struggle and the movement. The personal empowerment gave women the confidence to fight for their rights. The smaller struggles gave women the motivation to fight for bigger battles. (Notes from meeting with MSAM facilitators).

Rajmati belongs to Musahar caste, from Attri village of Rajgarh block, Mirzapur district. Their caste is so suppressed and ill-treated that even men are not allowed to speak in front of others. Their village is in the forest and no ANM ever visited it. When these women understood about their health rights they spoke to the CMO and informed him about the situation. After this, the ANM started coming for immunisation but only once or twice a month. The women again approached the CMO. The CMO told the ANM that unless these women give a report saying that the ANM has been coming regularly for immunisation, she will not be given her salary. This is a big success for their community and for the women. (As recounted by Sandhya, Shikhar Prashikshan Sansthan)

CLAIMING RIGHTS, CHALLENGING POWER HIERARCHIES

The MSAM women came together in 2006 envisioning that they would be campaigning on health. However, within a few months they realised that food security, livelihoods, social security and freedom from violence were critically important for their health and well-being. Thus, they asked for information on these entitlements, and were eager to locally monitor how far the rural poor were actually benefitting. In this, they have gone beyond a narrow approach to health improvement by monitoring not only the quality of health services, but have adopted a wider "social determinants of health" approach that incorporates food security, livelihoods, social security and women's freedom from violence.

In Madanpatti Gram Panchayat of Azamgarh district, women got their job cards under the NREGA scheme and asked the Pradhan to give them work. The Pradhan refused to give them work saying that women work less than men. After giving an application for work they were given work for 1 day and then their work was stopped. The women told the Pradhan if there was no work for women then both men and women would not work. But the Pradhan refused to listen to the women and told them that women work less therefore they will not be given any work. Women decided they would complain about this to the Block Development Officer (BDO is the supervisor of this government programme). About 50 women hired 2 vehicles and went to Attraulia block office. Since the BDO was not present, the leader Kailasi Devi called him on the phone. The BDO scolded and abused her. Instead of feeling intimidated, the women went to the District Magistrate's (DM is the chief administrative functionary at the district level) office and informed him of the situation by a written complaint. They also told the DM that it was not right of the BDO to abuse them. The DM immediately asked the Community Development Officer (CDO – mid level bureaucrat) to intervene and the CDO asked the BDO to immediately attend to the women's complaint. After this 84 men and women were provided with work for 29 days. Women consider this to be big victory and feel that if they can approach the DM, nothing is impossible for them. (As recounted by Rajdev Chaturvedi, Grameen Purarnirman Sansthan)

The women told the Pradhan if there was no work for women then both men and women would not work.

The Pradhan of Golhanpurkatri village, of Rajgarh block in Mirzapur district, is from an upper caste community and was earlier very authoritarian. He had appointed his family members in all the panchayat committees and also in the Block Development Committee. Initially, when Shikhar Prashikshan Sansthan had begun mobilising women he had created a lot of problems for them and had threatened the workers and women with dire consequences. He was against women participating in meetings. But when the local MSAM started getting stronger, they started informing the government officials about the Pradhan and his activities. There was pressure on the Pradhan from the government authorities to mend his ways and the women also started getting more assertive. Today, women participate in all village meetings to raise their issues, and their issues are addressed. The Pradhan has also accepted the fact that MSAM members are very serious about their issues and he cannot continue with his nepotism. (As recounted by Sandhya, Shikhar Prashikshan Sansthan)

Pyari from Narmadapur village, of Naugarh block from Chandauli district, is a single Dalit woman. When she came to know that the District Magistrate (DM) was coming to her village to discuss the development plan with the villagers, she went where the meeting was taking place. During the meeting, Pyari asked the DM when the Primary Health Centre (PHC) which was dysfunctional, will start functioning properly. The DM told her he will look into the matter. Pyari asked him whether he would only look into the matter or do something about it. She informed the DM that since there was no lady doctor in the PHC the women were facing a lot of problems. The DM told her he will come every month to understand their problems and solve them. Pyari told him that she will also come every month. Nobody had told her to talk like this. It was quite inspiring to see how a poor and illiterate woman could speak with so much of confidence. (As recounted by Bindu, Gramya Sansthan)

The women leaders have realised that when pressure is put on government officials there are chances of both success and failure. Usually, if the senior officials like District Magistrate (DM) are sensitive and have an interest in addressing the situation then they will ensure that the work is done properly and the policies and programmes are implemented correctly. The DM can get work done from the CMO and other officials. Sometimes just one meeting or intervention is not enough, and the women have to invest time to follow-up their complaints, forgoing their daily wage work to ensure that their demands are heard.

However, sometimes things do not work out so positively: the women leaders and CBOs have been faced with officials who are insensitive to the reality of the poor, who refuse to recognise that even getting a simple certificate is a struggle for the marginalised groups, who are expected to pay kickbacks for every development benefit. The MSAM leaders have faced dismissal of their claims and complaints, and very real threat of backlash.

DEMANDING ACCOUNTABILITY – SYSTEMATIC ENQUIRY AND REPORTING EVERY YEAR

Before the formation of the MSAM, there was local information about denial of maternal health services to women, and cases of preventable maternal death or serious morbidity often caused by neglect. These would often be documented as cases of rights violation by the local CBO partner and taken up for action. District officials tended to dismiss their protests and complaints as being anecdotal and sensationalist, and often refused to believe that such poor quality health services were being provided. Once the MSAM was formed it was decided to change this strategy, and engage in systematic monitoring of the health services in a way that could generate reliable data.

The challenge was to do it in such a way that the rural women (with little or no literacy) could actually generate data themselves and be able to present their own findings.

The challenge was to do it in such a way that the rural women (with little or no literacy) could actually generate data themselves and be able to present their own findings. SAHAYOG and the partner CBOs gradually developed a methodology that combined

the adult learning theories and methods of Paulo Freire[9] and pictorial materials that could be used by learners who had never been to school.

In the first year (**2006**), MSAM women got to know about the National Rural Health Mission (NRHM) that had been launched and the appointment of ASHA workers as local community-selected activists. They brought together their experiences of how bribes were being demanded in exchange for a fraudulent "application form" for aspiring ASHA workers, and they pointed out that most ASHA workers selected were in fact from the family of the local power elites, including the village council head (gram *panchayat* pradhan). When they presented these experiences to the State Director General of Health and Family Welfare, a government order was promptly issued to check these practices.

The next year (**2007**), MSAM women began to observe how the maternity benefits under the conditional cash transfer scheme (called the Janani Suraksha Yojana) promised by the NRHM was actually being disbursed to pregnant women who came to hospitals for institutional deliveries during labour. The poor women who gave birth in hospitals/health centres were being compelled to pay a bribe to the health staff so that they would complete the paperwork needed for women to get their entitled JSY money. Sometimes the money was never disbursed, and sometimes women were turned away by the health staff when they could not pay the bribe well in advance. While the MSAM women raised these issues with state government officials in Uttar Pradesh, it turned out to be a widespread problem in many parts of the country, and the central government issued an order for the JSY money to be paid directly by cheques to the bank account of women beneficiaries so that no cash transactions would take place.

In **2008**, MSAM leaders learned about the Right to Information (RTI) Act (2005) and learned about how United Funds under the NRHM were provided to their village councils, their local health Sub-Centres and Primary Health Centres to improve the quality of the services and provide assistance to those most in need. MSAM women and CBOs in five districts tried to find out how the Untied Funds were being spent, and when replies were not forthcoming in four districts, they put in RTI applications demanding transparency. Finally after many repeat applications, it turned out that even the committees to decide on the use of the funds had not been set up! The CBOs and MSAM women shared this information with district officials who asked them to join the committees to promote appropriate use of these funds.

In **2009**, MSAM leaders collected information on a large number of cases of denial of services and maternal deaths from the various districts. This information and the testimonies from sufferers were documented by the CBOs and presented at two public hearings, one in Lucknow and one in Azamgarh. The seventeen testimonies tell a sad story of how women were turned away by health providers, or expected to pay informal fees for the services, and faced abusive treatment. Some nurses appeared to be using irrational practices (e.g., continuous fundal pressure, several

9 Paulo Freire, (1921 – 1997) was a Brazilian educator and one of the founders of critical pedagogy. He is best known for his influential work Pedagogy of the Oppressed.

intra-muscular oxytocin injections and so on), to get the women to deliver, and these practices also led to the deaths. One woman had died due to an unsafe abortion, and another maternal death had resulted from a pregnancy that the woman did not want, after an unsuccessful sterilisation operation. Some women developed post-partum complications that were untreated; there did not appear to be blood transfusion services available that could have saved their lives; many were forced to use the private sector during which they incurred unaffordable expenses. These testimonies were presented on two occasions before the media in Public Hearings; at one of these a representative of the State Human Rights Commission was present, which set up a committee[10] to look into this matter.

In **2010**, MSAM leaders learned about the IPHS standards (Indian Public Health Standards) that exist for every level of government healthcare facility. Using a picture tool, they reviewed the compliance to these standards in their local sub-centres, and came up with findings from 71 sub-centres across eleven districts of Uttar Pradesh. Although most of them had a building with a room or two, half did not have electricity or sanitation. Two-thirds did not have a machine for measuring blood pressure of pregnant women, and half did not have even a pair of gloves to examine women or a stove to boil instruments for sterilising. These findings were shared at the district dialogues and prompted some local improvements by the officials. In Banda, upon hearing the findings, the district project manager (DPM) expressed his support for MSAM women to be members of the village health and sanitation committees (VHSC).

In **2011**, MSAM women learned about the Integrated Child Development Services scheme (ICDS) of the Ministry of Women and Children, and the fact that supplementary nutrition was meant to be given to all pregnant and lactating women as well as all adolescent girls in their villages. This led them to carry out a small local survey using very simple methods to examine whether women were actually receiving this important support in 62 anganwadi centres spread across 41 *panchayat*s of seven districts. The women found that although all women had been listed by the nutrition worker (Anganwadi Worker), only in three districts were all of them actually receiving the supplementary nutrition rations. In one district almost two-thirds were not getting their supplementary rations, while in another district 25% of them were being left out. In addition the MSAM women also learned about the provisions within the Public Distribution Scheme that is meant to provide cheap rations to the poor, and began monitoring their local Public Distribution System (PDS)[11] shops.

MSAM women have, through applications to the authorities, succeeded in making -anganwadi centres open regularly and provide supplementary nutrition in 7 gram *panchayat*s of 5 districts. In Chitrakoot, a woman gram pradhan from MSAM has ended untouchability in the anganwadi centre. In 6 Gram Panchayats of 5 districts, the MSAM have ensured that ration shops display the price list of items, and sell items in the right

10 It is another matter that this Committee could never be activated since the concerned officials were constantly transferred

11 Public Distribution System (PDS) is an Indian food security system. Established by the Government of India and managed jointly with state governments in India, it distributes subsidised food and non-food items to India's poor through a network of Ration shops.

quantity at the right price; in Banda they prevented black-marketing by reporting it to the Food Security Inspector.

In early **2012**, MSAM leaders learned about the recently launched Janani Shishu Suraksha Karyakram (JSSK)[12] scheme meant to ensure that all maternal and infant health services were provided free in public hospitals, through a simple pictorial tool about the JSSK. This was then given to 150 MSAM women leaders to carry out a neighbourhood survey with those who had delivered in a public hospital within the last six months (after JSSK became operational). The neighbourhood survey collected 410 responses from 11 districts[13], in which women reported paying an average of Rs 1277/- for the supposedly 'free maternal health services'.

In late **August 2011**, SAHAYOG had received a letter from the government of Uttar Pradesh requesting involvement of development partners in the implementation, monitoring and feedback of the JSSK; therefore these findings were shared with the NRHM Mission Director and other officials and the media on 28 May 2012 at a state dialogue. The MSAM leaders in two districts of Uttar Pradesh have also been using a toll-free number linked to an integrated voice response system (IVRS) and web-based mapping software to report illicit fees being charged for maternal health care in Uttar Pradesh, India. The programme has been operational since January 2012 (http://meraswasthyameriaawaz.org/).

SOME MILESTONES OF MSAM'S GROWTH IN THE LAST SEVEN YEARS

YEAR	MILESTONES	OUTCOME
2006	• Formation of MSAM organisation across Uttar Pradesh (28 May) following large campaign on maternal health	• MSAM set up in 12 districts; in March 2013 over 12,000 women are active members across nine districts
	• Feedback on the ASHA selection process	• A government order issued that ASHA selection should not entail informal payments
2007	• Testimonies on bribes for receiving JSY payments	• Central government makes it mandatory to pay women by cheques
2008	• Monitoring utilisation of the Untied Fund at village, sub-centre and PHC through use of RTI	• Shared with local health officials (that even committees have not been set up)
2009	• Testimonies presented of 17 cases of maternal deaths or near-miss situations with denial of care	• Two public hearings in the presence of the media and other public figures and officials; State Human Rights Commission sets up a Committee
	• First round of MSAM elections	• MSAM leaders elected in teams of five, to address all five social determinants, in each village, block and district
2010	• IPHS standards of sub-centres	• Shared with local health officials, MSAM women asked to be part of VHSC

12 http://mohfw.nic.in/NRHM/Documents/MH/Guidelines%20for%20JSSK%20.pdf

13 228 Revenue villages from 19 blocks of these 11 districts of Uttar Pradesh

YEAR	MILESTONES	OUTCOME
	• Capacity building of MSAM leaders in *panchayat*i raj (local governance) system and local campaigning for *panchayat* elections	• A total of 477 MSAM members and leaders contested in the *panchayat* election; one third (162) among them won: 17 were elected as Pradhans (Village Chief) and 139 as ward members of *panchayat*s and 6 became members of the higher-level Block Development Committee
2011	• Monitoring Hon. Supreme Court orders for ICDS centres – nutrition for pregnant and lactating women; checking PDS shops	• Data on 62 ICDS centres obtained (seven districts); MSAM petitions have led to functioning ICDS centres in five districts; improved practices in PDS shops
	• Celebration of five years of MSAM (28 May) with leading women activists of Uttar Pradesh	• Launch of documentary film "Voices from the Ground" and the book documenting five years of MSAM "Our Story in Our Words" (Humari Kahani Humari Zubaani)
	• MSAM presents a Joint Women's Manifesto to all political parties of Uttar Pradesh ahead of state elections	• Collaboration established with other women's organisations in Uttar Pradesh state
2012	• Monitoring the JSSK scheme for free maternal health services to all through survey and (in two districts) toll-free helpline number launched	• Data on 410 women from 11 districts on the high incidence of corruption presented to NRHM Mission Director; toll-free number shows high incidence of persisting corruption in health facilities in two districts
	• Second round of MSAM elections	• 868 MSAM leaders, 98% of whom are from marginalised social groups, elected in teams of five, to address all five social determinants
2013	• Large scale MSAM training camp organised for 240 participants	• MSAM women march on streets of Lucknow on 8 March with other women's organisations

Chapter 3

Behind the Scenes

"Through a process of capacity-building, participatory rural appraisal and collective advocacy, the group consolidated its approach of empowering rural women to speak up for their rights to health."

SUPPORTING EMPOWERMENT AND ACCOUNTABILITY

As described in Part Two (Genesis section), SAHAYOG has been working in collaboration with a group[14] of district-level organisations who were mobilising rural women on various rights issues since 2000. Through a process of capacity-building, participatory rural appraisal and collective advocacy, the group consolidated its approach of empowering rural women to speak up for their rights to health. In early 2006, the group of organisations began a campaign called Puri Nagrik Pura Haq-2 (Complete Citizens, Total Rights – 2nd campaign) where thousands of rural women mobilised through a state-wide signature campaign, demonstrations and media events, to demand their rights to better health care. Rural women leaders called for accountability for the tens of thousands of maternal deaths in Uttar Pradesh in a meeting with the Health Minister as well as legislators in the State Assembly. However they were disappointed with the dismissive attitude of their elected representatives.

The campaign experiences led to a change in strategy, towards setting up a longer term grassroots organisation directly representing the interests of women from marginalised groups. On 28 May 2006, the decision was taken by rural women leaders and civil society groups to form a grassroots women's organisation in Uttar Pradesh, called the Women's Health Rights Forum **(MSAM for Mahila Swasthya Adhikar Manch)**. MSAM members are basically women from the villages where the partners organisations work, and since 2006 the organisation has been set up in 12 districts of Uttar Pradesh (Azamgarh, Banda, Bareilly, Chandauli, Chitrakoot, Gorakhpur, Jaunpur, Kushinagar, Mau, Mirzapur, Muzaffarnagar and Saharanpur). MSAM village groups have five women as elected leaders to work on the five thematic areas (health services, livelihood security, food security and nutrition, social security and violence against women). Leaders are also elected at block and district level, as part of a federated structure.

STEPS IN THE WORKING OF THE MSAM

PARTNERS	KEY ROLES	
Step One	• Identification of partner CBOs who work in districts on issues of women's rights; reaching marginalised groups of rural women (Dalits, tribal women, minorities, etc.)	• Continued interaction with heads of partner CBOs through review and planning meetings every quarter conducted by SAHAYOG; CBOs also jointly plan state-level advocacy on reproductive health and rights issues
Step Two	• CBOs form the local MSAM, with groups of women at the village-level federating into block-level and district-level	• District leaders of MSAM are part of the State MSAM Steering Committee that meets twice a year to review experiences and plan strategies

14 Members of the Healthwatch Forum UP, mainly women's rights organisations

PARTNERS	KEY ROLES	
Step Three	• Partner CBOs select staff as MSAM facilitators; SAHAYOG provides a small honorarium for the facilitator	• SAHAYOG builds capacities of the facilitator through workshops, provides the MSAM Facilitator Handbook (a manual in simple Hindi)
Step Four	• MSAM women's groups elect leaders in teams of five at every level, for the five thematic areas (health services, livelihoods, nutrition and food security, social security, violence against women)	• SAHAYOG conducts workshops and training camps to build the capacities of the MSAM women leaders, based on their thematic responsibility; equips them with simple pictorial information materials. • MSAM leaders use the information to claim entitlements at the local level from various functionaries
Step Five	• Every year an issue is selected for monitoring (usually based on the thematic workshops that year); and a simple tool developed that the non-literate women can use	• MSAM women leaders with support from the CBO head and the facilitator carry out the monitoring exercise, data is collated and presented to the relevant officials in a District Dialogue
Step Six	• Every year selected MSAM leaders come to the state capital (Lucknow) to share their experiences through the year	• SAHAYOG tries to ensure that the MSAM experiences reach the policy actors concerned (state officials, the media and other organisations)

Leadership elections for MSAM were first held in 2009 and then again in 2012. Currently there are 868 elected women leaders (as of 15 March 2013) who cover about 171 women's groups (at village or hamlet level) from 117 *gram panchayat*s (Village Councils) spread across 17 development blocks in eight districts.[15] SAHAYOG supports these women leaders by conducting thematic capacity-building so that they are empowered with information on entitlements, and can monitor how far these reach the local poor. SAHAYOG also supports the local CBOs with a small contribution towards salary and travel costs of a staff member for facilitating the MSAM meetings.

The MSAM women leaders and their facilitator are meant to have monthly meetings with other women in their groups at the hamlet and *Panchayat* level. Every two months the women leaders are supposed to meet at the block level, and every three months at the district level. For the last few years, the MSAM leaders meet every six months at the state level and discuss their issues for monitoring and advocacy. SAHAYOG and partner organisations organise regular capacity-building programmes for the MSAM women leaders, in such a way that non-literate or semi-literate women can also obtain information. Each year a thematic issue is taken up, on which pictorial material is created, and a training programme conducted; following which the MSAM women are engaged in local monitoring of services and entitlements.

The information gathered is collated into district reports and a state report each year. The district reports are shared in a formal interaction called a District Dialogue with district health officials, to which local media persons are also invited. The local NGOs have found that their advocacy with district officials can be stronger if they ally with

SAHAYOG and partner organisations organise regular capacity-building programmes for the MSAM women leaders, in such a way that non-literate or semi-literate women can also obtain information. Each year a thematic issue is taken up, on which pictorial material is created, and a training programme conducted; following which the MSAM women are engaged in local monitoring of services and entitlements.

15 The remaining districts are partially dormant and do not have newly elected leaders

other like-minded representatives of civil society and this kind of a collective district forum also supports and strengthens the credibility of the MSAM.

Every year on the 28th of May (Day of Action on Womens Health) the MSAM leaders come to Lucknow to share their findings before officials of the state health department in a public dialogue on maternal health, covered by the media. This iterative process of capacity-building, community-based monitoring, data presentation and advocacy with officials has led to impressive gains in the confidence and articulation of these MSAM women leaders.

When the MSAM leadership approaches government functionaries the pressure of collective is strengthened with the power of evidence. The data that is generated through systematic enquiry, and review of secondary data done by the facilitating organisations, holds up womens reality in front of the government authorities. The authorities cannot negate the facts and data coming out of these real-life case stories. Also, when women come in groups of 50 or 60 at the district level and ask for already mandated services, the officials also feel the pressure. MSAM has been raising issues related to the Public Distribution System, the Mahatma Gandhi National Rural Employment Guarantee Scheme (MNREGS)[16], JSY other schemes at the district level dialogues. The women also share their concerns and issues through the state level dialogue at the state capital in Lucknow, at least once a year. These dialogues have been attended by ministers and senior officials who can intervene in bringing changes at the policy or programmatic level.

16 Mahatma Gandhi Rural Employment Guarantee Scheme: The MGNREG Act 2005 provides enhancement of livelihood security, giving at least 100 days of guaranteed wage employment in every financial year to every household, whose adult members volunteer to do unskilled manual work.

Chapter 4

Reflections: Stepping Back to Review

"In some cases women who were earlier survivors of human rights violations have turned into very strong human rights activists"

GAINS

The story of MSAM now spans seven years, and as a popular Hindi couplet goes – as the story has moved on, more and more people have joined the movement. Today, this story is inspiring more women to join the village groups, and more villages to form MSAM groups and more CBOs to join as partner organisations in the movement. Clearly there are some gains which these women cherish and would like these to be part of their lives as well. In this section we will review this seven year period to identify obvious gains, painful challenges and also try to find lessons that this story has to tell us.

Increased personal empowerment among MSAM leaders – The various stories shared earlier clearly indicate tremendous levels of personal empowerment among women leaders. In some cases women who were earlier survivors of human rights violations have turned into very strong human rights activists and the most powerful story is perhaps that of Snehalata.

Snehlata delivered a baby girl in the PHC at Purkazi block of Muzaffarnagar district. The ANM mismanaged her delivery causing a vesico vaginal fistula (a rare but very disabling complication). When they went back and complained that urine appeared to be leaking from the birth canal, the couple was treated very badly by the PHC staff. Her husband Kanwaljit Singh and Snehlata went to many nursing homes, hospitals and even to a Medical College seeking her treatment, but in vain. In the process they ended up in deep debt after selling their livestock and meagre household belongings The second part of her story starts after her treatment (which was supported by Healthwatch and Humsafar- a women's crisis support centre in UP). Snehlata understood about her health rights and decided to join MSAM. As an MSAM leader she had once telephoned the CMO but he did not speak to her and cut her off. Along with other women, Snehlata then went to the PHC and told the doctors and the CMO that her name was Snehlata and she would like to discuss a few issues with them. She told them that there are lots of irregularities in the distribution of JSY cheques. Women were also ill-treated and abused when they came for deliveries. She told them that she could not speak in English and next time when she called they should attend to it. The CMO promised to take action and also to receive her calls. Although very strong from within, she is not able to express herself very well in front of others . (as recounted by Rehana, Astitva)

Collective awareness and struggle – While the MSAM members belong to the poor and deprived sections, and every day continues to be a struggle for food or livelihood, the nature of their struggles have changed. Now their struggles are no longer individual and isolated but rather that of the entire community, which they have realised they have to take up together in order to survive. This sense of solidarity and a collective understanding of their problems has been strengthened by the knowledge about their rights. Now they are ready to fight for these.

They know that if they do not struggle for their rights, no one else will do it for them. Each time the struggle leads to some results, they feel reinforced to continue with their claims.

Increased ability of women to negotiate with public functionaries – MSAM is a collective and this collective has emerged as a powerful mechanism for dialoguing with public functionaries and people in positions of power. The *panchayat* members and frontline workers like ANM, ASHA, AWW are now aware of the strength of MSAM and after initial resistance have more or less accepted them as a group that is not only very organized but also very serious about the issues it is working on. Thus MSAM members and leaders are now confident in taking up issues with these providers at the local level. For the issues that require the involvement of officials at a higher level, they do not hesitate to take up issues even at the district level.

Improvements in the delivery of public services – The periodic systemic enquiries conducted by MSAM and the presentation of their results, as well as the spontaneous interventions by MSAM leaders has led to many small changes and improvements in service delivery at the local level. The most noticeable change has been in the demands for informal payments leading to reduction of out of pocket expenses, which is a very significant gain for these poor women. Women from villages with MSAM groups do not need to pay for services at the sub centre or primary health centre, especially if they are accompanied by an MSAM leader. They do not need to pay for cleaning the labour room after delivery, which is often mandatory in the case of lower castes. Women also do not need to pay for the discharge of the mother and infant, and are also receiving their JSY payments in time.

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In addition to changes in health service delivery, MSAM interventions have also brought about some changes in delivery of some other public services as well. The *Anganwadi* (preschool centre operated through the Integrated Child Development Scheme) functions better and women in villages with MSAM groups receive their rations (for children and pregnant and lactating women) from the Anganwadi in time. Families from villages with MSAM groups also receive their full quota of subsidised rations from the Public Distribution System. Families of MSAM members are also able to get work under the Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA).

Increased social empowerment – The influence of MSAM leaders empowerment has spread beyond the women to the other families from the lower social groups in their villages. These families feel less insecure about their status and are less hesitant to discuss problems related to entitlements under different government schemes, and raise questions about irregularities in implementation of different schemes in public meetings.

Increase in the credibility of community based organisations associated with MSAM – Earlier not only were members of the community but even community based organisations were hesitant to speak to the CMO or senior officials. However, currently these organisations have gained a level of comfort and confidence in their ability to approach and deal with senior public authorities. At the same time there has also been an improvement in the relations between these CBOs and government functionaries. The government authorities are now assured about the credibility of these organisations and the seriousness of the issues that they raise.

"Earlier when I used to call the CMO I had to introduce myself. But now when I call he recognises me as he has saved my number. So this is a big change." Rajdev Chaturvedi, Grameen Punarnirman Sansthan.

The partners also feel "*...the media has started taking our programmes seriously. Earlier they would not show any interest but now not only do they give coverage but also ask about our views and opinions. In fact, once a woman had problems related to her pregnancy, so one of the media persons gave her my helpline number. So somewhere it is in their mind that we work on health and we are serious". Sandhya.*

"Hindustan newspaper reporters now routinely call me on Womens Day, World Health Day and ask for my opinion. Recently, they asked for a statement on reservation in promotions. They have my photograph which they also printed. This speaks of our credibility". Rajdev.

In some cases facilitating organisations are now being appointed as members in various district level committees. However there is a concern that this may simply be a token because their recommendations are never taken very seriously. Once the district officials asked GPS to make village level health plans and these plans were prepared and submitted on time. However, in the end the CMO did what he wanted to do and made the excuse that the plans were sent so late that it could not get incorporated in the state level plan.

Strengthening of SAHAYOG's recognition as a maternal health rights advocacy organisation at the state level: While the community based organisations that have been involved in mobilising and supporting MSAM groups have received some level of recognition at the district level, SAHAYOG has received recognition from the state government at the state level.

Jashodhara, Coordinator of SAHAYOG explains:

"This is because SAHAYOG has a very good grasp of grassroots reality. We give data from grassroots both to the media and to the government. This has helped in establishing our credibility. SAHAYOG has case stories which tell them where what is happening, the documents that are available, there is also MSAM; the list of names go with documents. I feel credibility is very important because you cannot always protest from outside. If there is credibility then government will want to talk to you and you can get you issues taken forward. SAHAYOG cannot do anything from Lucknow alone. They need the support of partners. For example Mr. Hari Om Dixit (a senior state level functionary) is seeing for the last 4-5 years that women do come from 14 to 15 districts for the meeting. He knows issues are taken up; reports are made and sent to the media. Whether he likes it or not that is a different thing."

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SAHAYOG is part of the "MNCHN[17] Partners Forum", a platform of development organisations in Uttar Pradesh, which are trying to work with the government or trying to influence the government programmes to becoming more effective. Most of the partners of the Partners Forum are large international NGOs and the overall

17 Maternal-newborn and child health and nutrition

approach of this platform is non-confrontational. Jashodhara explains that bringing MSAM women's experience into the Partners Forum was not easy at first.

"We have been insulted in the Partners Forum because we do not speak the language of government. We bring data that is totally opposite (to that of the other organisations), something that the government is uncomfortable about. But in the last one and a half years, I think that perception has also changed and people have started listening to us more carefully. Even in the Partners Forum we are getting space and respect."

Taking Lessons from the Local to the National and Global: While women of MSAM have been bringing their stories to the state, SAHAYOG and the CBOs involved in facilitating MSAM have also shared the story of MSAM and the struggles women face at different national and international platforms. The challenges that women have been facing in accessing maternal health services have been systematically documented and placed before different policy making bodies and policy players at the national level like the Planning Commission of India, and before officials of the National Rural Health Mission.

While women of MSAM have been bringing their stories to the state, SAHAYOG and the CBOs involved in facilitating MSAM have also shared the story of MSAM and the struggles women face at different national and international platforms.

SAHAYOG's own partnerships with other organisations and networks have also provided it with the opportunity to raise the issue of women's experience of institutional delivery in different international platforms. The stories of MSAM women's experience and their resolve to face their own challenges have been made into films, which have been shared through the national television and through international web based platforms. MSAM women's challenges and successes have also been documented and placed before international audiences through academic publications. This work has been very important in the context of the MDGs where MDG 5 is devoted to improvements in maternal health. The fact that the official Government of India story and the MSAM women's story have been substantially different has provided SAHAYOG further opportunities.

The MSAM story also highlights important dimensions of human rights in the context of health and this has also intrigued several international health and human rights experts who have involved SAHAYOG and its leadership to participate in international deliberations and committees. Two very important processes that MSAM experiences have been able to influence through SAHAYOG participation include the Report of High Level Expert Group on Universal Health Coverage in India issued by the Planning Commission, Government of India, and the Technical Guidelines for Implementing Policies and Programmes to Reduce Maternal Mortality and Morbidity in Accordance with Human -Rights Standards issued by the OHCHR along with WHO and UNFPA.

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CHALLENGES

The gains from the MSAM process seem very impressive and range from changes at the level of women's lives, changes in community processes related to the delivery of health care services for the poorest of the poor, up to utilising these experiences to influence large national and international processes. However at the same time there have been

significant challenges especially in the context of the political gains that have been made through these processes. Some of these are described below.

Inability to influence the overall community participation processes within NRHM: Community participation was seen as a key implementation strategy within the NRHM. Provisions had been made for a Village Health and Sanitation Committee (VHSC) at the village level, which would actively engage with the village health volunteer (ASHA) and also engage in local planning for which a sum of ten thousand rupees (about 200 dollars) had been provided as Untied Fund. In addition, all health facilities, for example the primary health centres and the community health centre had provisions for a patient welfare society or *Rogi Kalyan Samiti*, which was also empowered with considerable funds for decentralised and need based planning.

The MSAM leaders and partner organisations have put in a lot of effort to ensure that women who have their delivery receive their individual incentive under the JSY scheme, but their efforts to engage with other components of NRHM were not so successful. Some effort was made to understand and influence the planning and expenditure of the Untied Fund available with the VHSC. At places, women did raise the issue of the use of Untied Fund. However, this was not very successful. In most places the members of the VHSC did not know about their membership and the fund would be managed by the village pradhan (elected chief). In the face of women's questions the *pradhan* gave some benefits to individual women (members of MSAM), for example, the cost for a vehicle to take women in labour to the hospital, or gave their own vehicles, but they did not have a meeting and nor did they share how they will spend the money received through the Untied Fund. One of the reasons why the MSAM members did not persist in this was also due to difference in the composition of MSAM and that of the village in general. MSAM groups primarily represented the interests of the more socially backward families while the VHSNC was a more generalised group with participation of the more dominant group and the interests of the two groups were not necessarily the same.

The ability of CBOs who have been facilitating MSAM groups to influence other community participation processes at the facility or district level was also severely restricted by the overall lack of official support to the community participation component of NRHM in the state. The partners report that at the district level other than the ASHA Mentoring Group no other committee which requires civil society engagement is functioning. The MSAM partner organisations have tried to proactively engage with this process but it has been difficult because the membership lists and procedures were not very clearly understood at the district level. In those cases where they have been able to participate in these processes the officials have tried to subvert their participation.[18]

18 When the officials realised that MSAM partner organisations were raising difficult issues they started making it difficult for them to attend the meetings. Meetings were called at extremely short notice, venues rescheduled or scheduled after 5:30 pm making it difficult for the CBO members to participate. In some cases when these organisations tried to find out about meetings, they were informed that the meetings had already taken place.

Limited headway in negotiating the complex social and political contexts: MSAM members and leaders are from among the poorest and most marginal social groups. The regions to which most of the MSAM groups belong are also among the most backward regions in the state. Some of these areas are forested areas and here there are the twin challenges of dealing with the government forest department officials and the so called 'Naxalite'[19] threat. There are areas which have denuded plateaus and have quarries and mines. There are other illegal contractors and labour agents who exploit these poor women with the support of local politicians and petty officials. The caste-driven feudal backdrop of UP also provides an additional hurdle at the local level where communities are not easily mobilised across different socially marginalised groups. In Western UP, *khap panchayat*s (traditional village councils) provide an additional challenge to any effort which has the potential to improve women's status in society.

Within these diverse contexts, MSAM members have come together to face the common challenge of inadequate service delivery of maternal health and other issues. However, while political mobilization of MSAM groups was possible because of the absolute deprivation faced by women, the socio-political complexity of these regions poses a major challenge for the MSAM groups to affect more substantial changes over the circumstances which affecting their lives. And MSAM members who do not hesitate to raise their voices against the government functionaries find it difficult to fight a '*pradhan*' or other political forces of their own village.

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Engagement of MSAM leaders with the local self government process – small gains and large challenges: Participation in the MSAM processes has led to tremendous change in confidence and leadership among many MSAM members and leaders. Keeping this in view the facilitating CBOs encouraged many of these women to contest in the *Panchayat* elections that took place in 2010. A total of 477 MSAM members and leaders contested in the *Panchayat* election for different positions and over one third (162) among them won. Seventeen were elected as pradhans and 139 as ward members of *Panchayat*s and 6 became members of the block development committee (BDC).[20] This can be seen as a tremendous gain in terms of the political empowerment of these extremely marginalised women.

In Naraina block of Banda district, MSAM member Chandrakali got elected as gram pradhan. At her training in Lucknow, she was given a format proforma and trained on how to fill it. She first discussed with women about what kinds of work needed to be done, before discussing it with her husband. After becoming pradhan she went to inspect the school in her village. The teacher did not get up and greet her, which upset her and she informed him that her husband used to come but now she would come to the school. She asked the teacher for the registers and wanted to know how many students had come, how many teachers were present, and for how many students the mid-day meal had been cooked. She had heard that

19 Naxal or Naxalite are generic terms used to refer to various militant communist groups operating in different parts of India under different organisational envelopes.

20 BDC – or Block Development Council this is the second level of the 3 tier panchayati raj system. The first level is at the level of village – the gram panchyat, the second at the level of a cluster of villages, which forms the lowest level of community development planning is the block panchayat and the third or highest level is the district panchayat.

the teachers used to mark their attendance in the register and then leave the school and she wanted to be vigilant. (As recounted by Uma, Tarun Vikas Sansthan)

However, the results of this political empowerment have been very mixed. Initially these elected women remained very close to the facilitating CBOs and their peers of the MSAM and sought their help and guidance on various issues of *Panchayat* governance. However, as they became more familiar with the procedures of governance, they have distanced themselves from their earlier associates and seem to have become co-opted into the 'system'. The CBO functionaries said that '*they are now speaking the Panchayat Secretary's language*'. However, there is also recognition that if a *pradhan* who was earlier part of the MSAM leadership genuinely wants to do work which will benefit the community she represents, she is not be able to do that because the BDO and government officials do not support her. There is not much that MSAM groups can at the level of *Panchayat* deliberations and decision-making because of the deeply entrenched political vested interests.

Reflecting on this 'volte face' in the attitude of the MSAM leaders after they enter electoral politics, the CBO facilitators feel that this is not very surprising considering the nature of politics and deployment of development resources at the village level in Uttar Pradesh. Firstly, one needs to understand that the local self government processes are not independent of the local bureaucracy and in many cases the elected representatives are seen as subordinate to the bureaucracy. The BDO and the *Panchayat Secretary* 'guide', the *pradhan* on how they should be making decisions relating to different government schemes and programmes related to rural development leaving them with little autonomy.

The second issue that needs to be understood is how the *pradhan* becomes a part of the entrenched power dynamics which include upward linkages to strong caste-based cartels, which are affiliated to the larger political parties of the state. While these relationships constrain the local elected representatives from acting for the benefit of their MSAM groups, they are also based on and strengthen local caste kinship and feudal associations. Thus, being part of the 'MSAM leadership', these women are very vocal in their claims and mobilise to make demands against the state health functionaries. However, when they become elected representatives they not only lose their autonomy but become part of the local political processes and state development machinery, seamlessly becoming part of a corrupt system.

Challenges for SAHAYOG: SAHAYOG has been struggling with the issue of high maternal mortality in Uttar Pradesh for over a decade. In partnership with women's organisations of Uttar Pradesh, SAHAYOG has campaigned several times to draw the attention of the government to the unacceptably high number of maternal deaths in this state. The strategy of facilitating MSAM as an organisation of "the users of health services" was expected to strengthen demand for improved quality services at the local level, since there was not much response from the state government. Planning the capacity-building of the largely non-literate MSAM leaders, and developing the simplest possible tools for them to learn about and monitor their entitlements, has been an exciting learning process for SAHAYOG.

The strategy of facilitating MSAM as an organisation of "the users of health services" was expected to strengthen demand for improved quality services at the local level, since there was not much response from the state government.

Seven years on, SAHAYOG remains inspired by these poor non-literate women's struggles, and has a strong sense of achievement; yet some challenges remain.

The MSAM work is strongly based on voluntarism: the MSAM women leaders are volunteers, contributing time for workshops, monitoring and advocacy work, despite losing their day's wages as a result. The heads of the partner CBOs have always contributed time for the advocacy activities, capacity-building and data collection of the MSAM, although SAHAYOG has not been able to compensate them for it. This is because the ownership of MSAM is evenly distributed between SAHAYOG and the partner CBOs. But within the collaborative process of strengthening the MSAM, SAHAYOG has an added responsibility: to derive results and demonstrate success so that donors will continue to fund this intervention. This requires SAHAYOG to also hold the CBO partners to account and extract data and reports from them, which sometimes becomes awkward in this kind of non-hierarchical relationship.

The MSAM work is strongly based on voluntarism: the MSAM women leaders are volunteers, contributing time for workshops, monitoring and advocacy work, despite losing their day's wages as a result.

Seven years on, the onus of sustaining the process remains with SAHAYOG.[21] CBOs are unable to raise resources to sustain a cadre of facilitators for the MSAM, and expect SAHAYOG to mobilise funding for this. As funding cycles become shorter and shorter, and all interventions (preferably 'technical') are expected to immediately show predictable measurable results, this kind of a long-term process-oriented, capacity-building programme does not fit too many donor requirements. SAHAYOG is currently in a quandary on how to raise resources for continuing the process of capacity-building of these grassroots women leaders and providing some support for the CBO facilitators to continue their work. The NRHM provides funding for 'NGO Innovations' and SAHAYOG has earlier applied for this, but it appears that more, cut and dried work with short-term results is preferred by NRHM officials.

CLOSING THOUGHTS

The story of Mahila Swasthya Adhikar Manch and its leadership is the ongoing story of a group of extremely poor and marginalised women who came together through their shared experience of the poor maternal health services in the state of Uttar Pradesh in India. The group has made a large number of changes in the way local service providers, not only those related to the health system but also to other public services are providing services to these women. They have even been ambitious enough to participate in the local political processes. A critical review indicates that the changes that have been achieved are more in the realm of the 'practical and the group has not yet been able to affect' substantive changes in the political processes that affect their lives.

Mahila Swasthya Adhikar Manch has made a large number of changes in the way local service providers, not only those related to the health system but also to other public services are providing services to these women.

However, this would be a 'black and white' assessment of the situation, and hide the fact that these women, many of whom are also involved in livelihood struggles that take

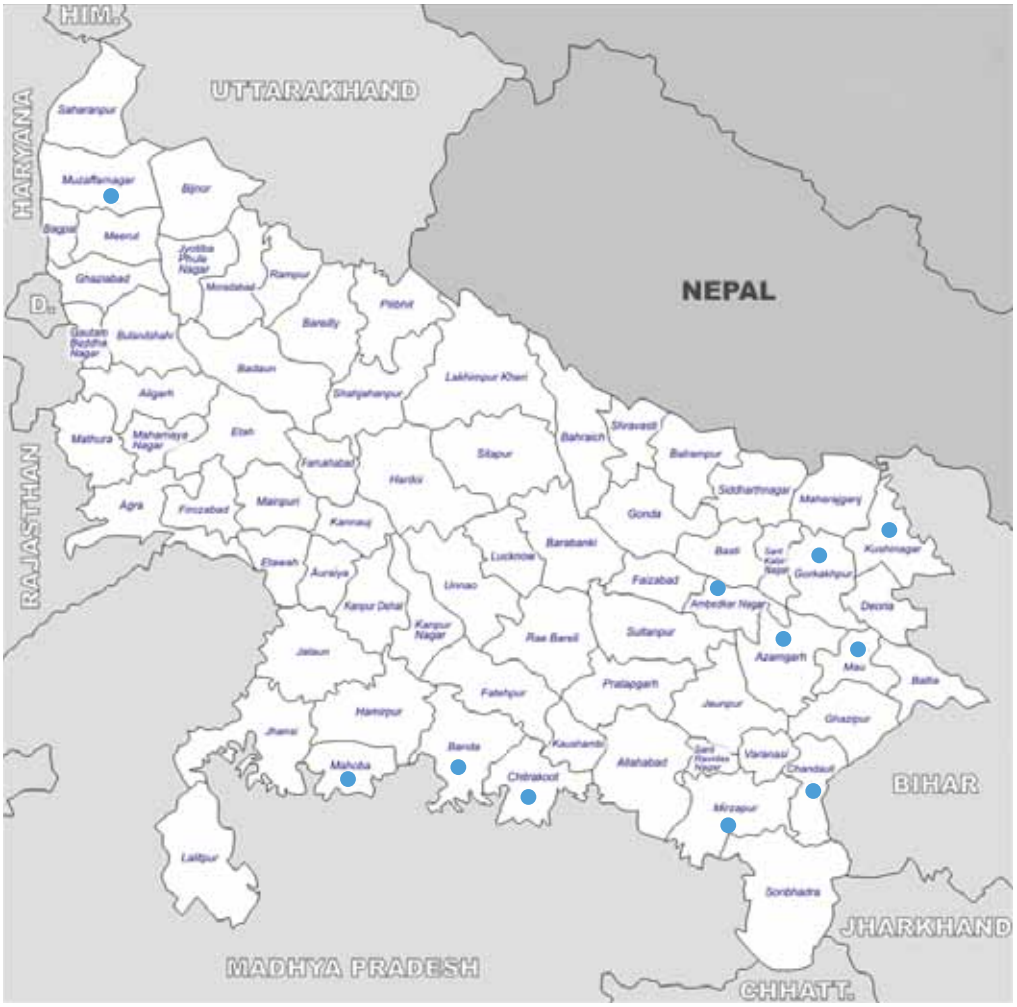
21 SAHAYOG has supported MSAM interventions through funding received from the ARROW-DANIDA grant that is mediated through the Danish Family Planning Association (2006-2013), the American Jewish World Services (2007-2012) and some part of the research project funds received from IDRC (Canada) and the MacArthur Foundation (in partnership with AMDD at the Columbia University, New York).

considerable time and energy, have taken tremendous steps in even 'aspiring' to affect the political processes. The future political struggle may not be in changing the system of power and affecting the distribution of development entitlements through participating in the leadership or decision making of the political processes, but to continue to engage with it critically, while remaining the ordinary 'citizen'.

Additionally, the period of six or seven years is an extremely short period to address social and political inequalities, which have resulted from centuries of social and economic oppression. Today, the life span of most externally-funded development projects is usually three or five years; however the time taken to challenge existing social hierarchies and transform them cannot be telescoped into such a short period. The Mahila Swasthya Adhikar Manch story shows how many changes can be obtained in the relatively short term, but also indicates that this process needs to be supported and facilitated for much longer.

Annexures

ANNEXURE 1:
MSAM PARTNERS AND DISTRICTS



List of current MSAM partner organisations with names of districts

1. Astitva Samajik Sansthan (Muzzaffarnagar)
2. Baba Ramkaran Das Grameen Vikas Samiti (Gorakhpur)
3. Ebteda Sansthan (Chitrakoot)
4. Grameen Punarnirman Sansthan (Azamgarh)
5. Gramya Sansthan (Chandauli)
6. Purvanchal Gramin Sewa Samiti (Kushinagar)
7. Shikhar Prashikshan Sansthan (Mirzapur)
8. Tarun Vikas Sansthan (Banda)
9. Bhagwan Manav Kalyan Samiti (Mau)

Older MSAM partners (not currently active)

10. Aanchal Gramin Vikas Samajik Sansthan (Saharanpur)
11. Assisi Health Centre, Suchetna (Bareilly)
12. Savitribai Phule Dalit Mahila Sangharsh Morcha (Jaunpur)

ANNEXURE 2:
GLOSSARY

Auxiliary Nurse Midwife (ANM) – She is the lowest functionary of the health department and the frontline health functionary.

Accredited Social Health Activist (ASHA) – A female community health volunteer who has introduced through the NRHM. Each village in the country has one ASHA.

Block – The lowest unit of development planning and implementation in the country. It consists of a number of villages. A number of blocks constitute a district.

CMO – Chief Medical Officer, the administrative head of the health department at the district level.

Community Based Organisations (CBO) – Indigenous development organisations which have emerged from community and led by members of the community.

Dalit – The extremely socially backward castes in India who were earlier considered untouchables. These communities prefer to be known as Dalits as this term indicates the historical oppression faced by the community.

Gram Panchayats – The lowest level of local government in rural India. It includes a village or a cluster of hamlets.

Janani Surakhsa Yojana (JSY) – Conditional Cash Transfer programme introduced by the government of India to promote institutional deliveries.

Khap Panchayats – Clan based village groups which act as upholders of traditional practices and norms. They have no constitutional validity but are extremely powerful in some parts of the north and west India.

Mahatma Gandhi Rural Employment Guarantee Scheme (MNREGS) – A scheme which promises 100 days of wage labour to all families who seek such employment. It is a legal commitment of the Government of India.

National Rural Health Mission (NRHM) – The overall public health programme for rural India. It is funded mostly through government of India (central) funds but the implementation is entrusted to the state government.

Pradhan – The elected village chief at the level of the gram *panchayat*

Primary Health Centre (PHC) – The lowest level of government health facility which has a trained medical officer and provisions for outpatient and in-patient services including labour room and emergency obstetric facilities.

Public Distribution System (PDS) – The government sponsored system for providing food grains and other essential items to the poor.

Public Interest Litigation (PIL) – A provision in the Indian judicial system which allows any individual or the court itself to file a suit in a court of law to protect public interest.

Rogi Kalyan Samiti (RKS) – Patient Welfare Committees constituted at the level of all public health facility PHC and upwards. These committees are provided some funds through the government (NRHM) for local planning.

Sub Centres – Health sub centres at the village level, covering a population of 5000. These sub centres are run by the ANM and are mostly expected to provide preventive and promotive health services.

Village Health and Sanitation Committee (VHSC) – Village level health committee which is supposed to be the fulcrum of community involvement around government schemes on health, nutrition and sanitation.

ANNEXURE 3:
A NOTE ON THE PREPARATION OF THIS CASE STUDY

This case study is the result of amalgamation of information from different sources and the effort of a number of persons. The story of the women of Mahila Swasthya Adhikar Manch has been documented carefully over the years both in film and in print and these documents have been very useful sources of information. SAHAYOG and its partner organisations who have been key agents in mobilizing and empowering the members and leaders of MSAM have been the primary contributors to this case study. A two day workshop was organised with some of the key facilitators from these organisations where they shared stories and their insights. They were also encouraged to write the stories of their own engagements in this process and supplemental case studies based on those reflections were prepared. Jashodhara Dasgupta, one of the co-editors of this document has been the principal architect in conceptualising and developing the MSAM experiment. Thus, most of the authors of the case study are also the key facilitators and this is their story of how they have seen and supported the process as it has unfolded. It is the women's story interpreted through their eyes. While this method may appear to compromise the objectivity of the document, it enriches it through detail and also highlights a continually learning and evolving internal process, which is the characteristic of all living and growing organisms.

Some of the documents consulted in the process of preparing this case study were:

- SAHAYOG Documents
- Puri Nagrik Pura Haq (Complete Citizens Total Rights) – June 2006 · Experiences with Janani Suraksha
- Yojana in Uttar Pradesh: Analysis of Case Studies by SAHAYOG and Partners – July 2007
- Haq aur Haqikat – Part 2 (Rights and Reality) – 2009
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- Mahila Swasthya Adhikar Manch Facilitators Booklet – May 2012
- Dasgupta J (2011), Ten years of negotiating rights around maternal health in Uttar Pradesh, India, BMC International Health and Human Rights 2011, 11(Suppl 3):S4 available at http://www.biomedcentral.com/1472-698X/11/S3/S4

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- Rehana – Astitwa Sansthan
- Sandhya – Shikhar Prashiksan Sansthan
- Sandhya Y K – SAHAYOG
- Uma – Tarun Vikas Sansthan

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