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The Emperor's New Clothes: feminist contests with global health knowledge

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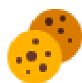
Texte intégral

Introduction

1 This paper is a reflection on fifteen years of working in Uttar Pradesh (UP), India, on the issue of maternal mortality among poor rural women, from the year 2000 to 2015. The work was done through SAHAYOG, a non-profit voluntary organisation, which I helped set up in 1992 and which I led from 2002 to 2014. SAHAYOG works with the mission of promoting gender equality and women's health using human rights frameworks, in partnership with community-based organisations (CBOs) working in poor rural communities across different districts of UP. SAHAYOG is also part of Healthwatch Forum Uttar Pradesh (HWF), an activist network set up in 1996, in the post-ICPD (United Nations 1994) years, to focus on reproductive rights and health rights issues in UP.

2 This paper describes the situation in UP, as well as the organisations SAHAYOG and HWF, and outlines the lessons learnt from our response to, and grounded documentation of, poor women's experiences. These are contrasted with official discourses about the prevention of maternal mortality, and the evident differences are analysed. The paper describes the subversive feminist strategy adopted by SAHAYOG and its partners, and concludes with a discussion on the importance of feminist contestations over expert diagnoses of problems that affect poor women.

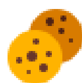
The situation in Uttar Pradesh



3 Uttar Pradesh, or UP, is a very large state in northern India, with three-fourths of its population living in rural areas and dependent on agriculture. Politics in this state have always hinged on divisions between various caste communities rather than on development issues. UP has the highest number of maternal deaths among the seven Indian states that together account for around 15% of global maternal deaths (Registrar General 2011[1]). The government's NFHS-3 data for 2005-06 indicate that only 22% of the few million childbirths in UP and 41% of 26 million childbirths in India[2] were taking place in institutions (IIPS 2007). The reason why a significant proportion of women preferred not to attend hospitals during labour is that the health centres in rural areas were extremely under-equipped. The District Level Facility Survey, 2007-08 (IIPS 2010) records that health centres and community hospitals in many Indian states like UP were also too under-staffed to handle any kind of pregnancy or childbirth complications – about one-third actually had an obstetrician and almost none were equipped to carry out a blood transfusion.

Description of SAHAYOG and HWF

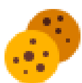
4 SAHAYOG is a voluntary non-profit organisation that was set up in 1992 in northern India, and works with the mission of "promoting gender equality and women's health using human rights frameworks through partnership-based advocacy". Over the last fifteen years (2000-2015), SAHAYOG has carried out interventions in health and rights of women and girls, with a focus on the state of Uttar Pradesh, although it has also anchored activities in other states and engaged in national policy advocacy. Working in close partnership with CBOs that worked directly with the rural poor, SAHAYOG facilitated a process of mobilisation, awareness raising, organisation building and leadership development among marginalised social groups, such as the women and girls from Dalit, tribal and minority communities. Through capacity building, SAHAYOG enabled these groups to carry out citizen monitoring (Das



and Dasgupta 2013; Dasgupta *et al.* 2015) in order to highlight the realities of service provision for the poor. Despite being a formally registered organisation that received funding to carry out development activities, SAHAYOG adapted several strategies from social movements and allied with them in order to carry out its mission. In this way, SAHAYOG carved out a feminist, "rights-based" identity distinct from most development organisations working on health within the broader umbrella of "civil society"[3].

5 Following the International Conference on Population and Development (ICPD) (United Nations Population Fund 1994), SAHAYOG and other civil society organisations came together on a platform called HealthWatch UP-Bihar (later re-named HealthWatch Forum UP or HWF) in 1996 to engage in citizen monitoring, in line with the commitments made by the Government of India during the Cairo ICPD. Since 2000, HWF has been documenting cases of violations of women's rights to reproductive health, and making these cases public through hearings, articles and media advocacy. Highlighting many such cases in a first public hearing in 2001 as a violation of commitments made under the ICPD Programme of Action, the HWF group took up the issue of poor quality of reproductive health services provided to women, especially for family planning, within "public interest litigation" in the Supreme Court of India (Supreme Court of India 2005).

6 Meanwhile, using the framework of legal obligations under the CEDAW[4] Treaty, the HWF group and its allies continued to document many more cases of maternal deaths and campaigned with the media and political parties of Uttar Pradesh on women's constitutional rights to survive pregnancy and childbirth. The HWF group participated in public hearings before the National Human Rights Commission (2004-05) and presented the case of a Dalit woman who was pushed out of the hospital during labour, leading to the childbirth (and infant death) outside the hospital gates. When the Government of India announced its

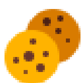


new National Rural Health Mission, the HWF group renewed its campaigning, and along with 200 rural women, formed the grassroots organisation of poor rural women Mahila Swasthya Adhikar Manch (MSAM or Women's Health Rights Forum) in May 2006. Increasing numbers of cases identified by MSAM women were presented at People's Tribunals to draw attention to severe violations of women's right to reproductive health (2009).

Understanding poor women's experiences with maternal health services

7 Between the years 2000 to 2015, SAHAYOG, in close collaboration with HWF partner CBOs, developed an understanding of poor rural women's experiences with maternal health services in many parts of UP state, which was quite at odds with the official version of the story. The partner CBOs themselves worked among poor rural women, usually belonging to marginalised social groups (Dalit, tribal and minority women), and had sustained interactions with them as well as a relationship of trust. The CBOs were trained by SAHAYOG to identify cases of human rights violations in the health sector, which they encountered during their interactions with these women. Using documentation tools within an ethical framework, SAHAYOG and the CBOs conducted interviews and community discussions to record these cases. Although the reach of SAHAYOG and its partners extended to only a small fraction of the 70-odd districts of the state of UP, there was a disturbing pattern in the cases that they were continuously documenting over the years, across different regions of the state. Some of the more memorable cases are described below.

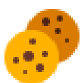
> The case of Mrs S. (2000): She had two sons and was perfectly healthy when she went to the local District Women's Hospital at the onset of labour for her third childbirth. There was a woman doctor who examined her when she was admitted, who gave her an injection,



and then left. The woman in labour developed rashes and went into distress; her husband went looking for the doctor but could not find anyone to help. Although she arrived well in time at the best equipped hospital in their small town, the woman finally lost her life before she could deliver the baby. The hospital took no responsibility for what happened.

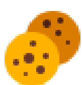
The case of N. (2004): In July 2004, a poor Dalit[5] woman, N., went to a Community Health Centre (CHC) when she was in labour with her first child. She was abused by the nurses and attendants as she could not pay the informal fees demanded, and thrown out of the hospital during advanced labour. She gave birth in the open, outside the gate, and the baby died within a short while. The local public created an uproar, and the incident was reported in the media. Upon reaching the scene, the HWF team discovered that a departmental inquiry team had left her with a large vaginal tear and rushed her to a tertiary hospital, but they refused to do a medico-legal examination and therefore delayed her admission for almost ten hours. It took persistent interventions by HWF activists working with lawyers, the media and the local legislator to enable the woman to access medical care for the severely infected vaginal tear, which required a month of hospitalisation to heal. Meanwhile her family made petitions to all concerned officials, but the health department refused to take any systemic action and colluded to conceal medical evidence. Despite a year-long media campaign and a human rights body taking up the case[6], the local police, in collusion with the perpetrators, put intense pressure on the very poor family, who were finally persuaded to withdraw their case for a small sum of money.

The case of R. (2008): In October 2008, a 26-year-old pregnant Dalit woman, R., travelled 17 kilometres through a forest, during labour, on the back of a bicycle to her hospital. During her first childbirth, she had been referred to a private hospital and incurred a lot of debt.



> They managed to reach the hospital around two in the afternoon, but by then there were no doctors around, only nurses on duty who told her husband to go buy three units of IV drip and three injections, which used up all the money they had. They took R. into the labour room and made the husband wait outside. Around 11 at night, the auxiliary nurse midwife came out and asked him to go buy one more bottle of glucose. Having no money left, he cycled back through the forest at midnight to borrow some money in the village, and managed to get Rs 9,000. When he returned with the money at dawn, he was greeted with the sight of a body covered with a sheet in the front yard. All the hospital staff had disappeared; there was no one to give him any explanation. While he sat by the body trying to comprehend what had happened, someone came up with an unexplained piece of paper for him to sign, which he refused.

8 These three examples are among a series of over a hundred cases of egregious rights violations identified and documented across UP by the activists of HWF over the years. Around 12 cases of women's adverse experiences with maternal health services were carefully documented in 2002-03, where half of the women had lost their lives being denied maternal care in institutions, being obliged to visit multiple providers in an attempt to seek care, or dying in hospitals despite having sought skilled care. Between 2005 and 2007, HWF partners collated another 23 cases that had similar experiences of maternal deaths and near-miss situations from six districts of UP (Dasgupta 2007). In 2009, testimonies of another 17 cases with a similar pattern were presented at two public hearings organised by HWF and SAHAYOG. As part of national research collaborations, SAHAYOG and partner CBOs in Uttar Pradesh documented in 2008-09 another 20 cases of poor women's experiences with the quality of maternity care; more recently, around 50 cases of maternal deaths were documented between 2013-15.

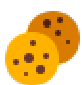


9 There was a disturbing similarity to the pattern in these cases, especially when families were from vulnerable socio-economic groups. When these pregnant women attempted to reach public hospitals for childbirth or in obstetric emergencies, they encountered healthcare providers who were not only under-equipped and unskilled but also quite unaccountable, and this pattern was repeated across peripheral as well as district hospitals. Doctors were hardly present and obstetric emergencies were not managed. Women and their families faced denial of treatment, misdiagnosis or wrong treatment, and in some cases actual harassment for large sums of money that poor families were unable to pay[7].

10 Even today we continue to document similar stories of women braving great odds to reach hospitals, facing over-worked, under-equipped and under-qualified healthcare providers, with the same sequence of staff either demanding money from the families or denying care to women in labour, with abuse and harassment, or irrational medical practices bordering on quackery. In desperation, families ricochet between primary hospitals to secondary and tertiary centres, often leaking out into the private nursing homes, where they incur catastrophic expenses, when they cannot receive adequate care. Elements of discrimination and social exclusion within the health system prevent poor and marginalised women from seeking effective redress for their grievances, which in turn fosters a sense of impunity among those who mistreat them.

The official discourse around maternity

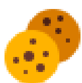
11 Compared to SAHAYOG and partner CBOs' findings, the government health system had an entirely different discourse around poor women's maternal health, which is unsurprising. When we began working in 2000, the standard refrain of doctors in public hospitals was that maternal deaths occurred because "women arrived too late to the hospital, usually after the traditional birth attendant (TBA) in the community had messed up the case". The



"Three Delays framework"[8] situated the problem with the family or the physical location of the community, and to some extent acknowledged that there may be "delays" in actually starting appropriate treatment at the hospital. Yet our understanding based on the women's experiences indicated that there may be denial of treatment in hospitals, harassment for money, or sometimes just lack of providers or capacity to manage the obstetric complication.

12 For decades the public health system in India has been on a downward slide as it has been systematically starved of resources: the government spends less than one-third of public health expenditure in India while close to two-thirds is out-of-pocket expenses (Parliament of India 2016). Within UP, public health spending is among the lowest in the country[9]. It is not unexpected that in many districts of UP there are not enough doctors in rural health centres, nurses have not received sufficient training in childbirth care or in managing complications, and there are not enough medicines or equipment or supplies. The District Level Household Survey (including the Facility Survey) showed that health centres are not accessible for a significant proportion of the population (IIPS 2010), owing to inadequate roads or public transportation facilities, especially for people who live in remote coastal areas or deep within forests, islands, deserts or mountains. Nonetheless, despite this under-served population and often dysfunctional health system, the Government of India (GOI) took a decision about the best way to bring down the high numbers of maternal deaths in 2005, while rolling out the National Rural Health Mission (NRHM, now called National Health Mission)[10].

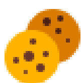
13 Understanding that the problem of maternal mortality affected mostly pregnant women who were possibly too ignorant or impoverished to reach a hospital "on time", the GOI announced a new scheme to encourage and support them and promote hospital childbirth. Within the "Mothers' Protection Scheme" called Janani Suraksha Yojana (JSY), the government offered a conditional cash transfer of Rs



1,400 (approximately 20 Euro) to all pregnant women who could reach a public health facility during labour. In a bid to improve the dilapidated condition of the health centres, untied funds were provided under NRHM to improve their facilities, new wards were constructed, and infrastructure was upgraded. The department also trained a few hundred thousand village women as health volunteers, i.e. Accredited Social Health Activists (ASHA workers), who would advise pregnant women to register with the public health system, and accompany them into hospitals during labour. The ASHA workers also received a small incentive payment for successfully ensuring hospital childbirth for all pregnant women in their village. Within a few years, in 2011, the GOI further announced that hospital treatment, medicines, tests, transportation and all other costs during maternity would be free and entirely cashless under the Janani Shishu Suraksha Karyakram (Mother and Child Protection Programme).

14 The JSY scheme was assiduously implemented in all the states with high maternal deaths, like UP, which also happened to be the states with poorly functioning health systems. However, that inconvenient truth was brushed under the carpet, while the machinery of the public health system began to promote this cash incentive everywhere. The government celebrated the rising numbers of "institutional childbirths" as the graph rose from 41% in 2004 to 78.7% in 2013 (MoWCD 2014). While handing out money to the JSY beneficiaries, their numbers were carefully counted. The number of JSY beneficiaries became a proxy for measuring "safe childbirth", and the government was convinced that maternal deaths had indeed gone down by getting women to go to public hospitals.

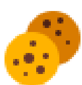
15 As for women who for some reason did not, could not or would not go to a hospital during labour (due to a lack of roads, transportation, money or time), the state policy decided to ignore them entirely and leave them to fend for themselves, so that "home-births" would receive no encouragement[11]. Women in many parts of rural UP receive the most rudimentary antenatal care, usually limited to iron



folic acid tablets (for anaemia) and tetanus toxoid shots; any manifestations of high-risk symptoms like high blood pressure, diabetes, poor weight gain, anaemia or any infectious diseases (such as TB or malaria, for example) do not get picked up by the health system. As for women who needed abortions or had miscarriages or incomplete abortions (one in every ten deaths of pregnant women), there was no plan to ensure accessible services were available for them, even though termination of pregnancy is legal under certain circumstances in India. If a woman actually reached a health centre during labour but they could not or would not treat her there, and she had to ricochet from one hospital to another, she would be blamed at the tertiary centre for "coming too late". In fact for most complications, women were forced to go into the rapacious and unregulated private sector if they wanted to avoid the inevitable referral to the medical college hospital (usually very distant from their villages), but then, these decisions too were blamed as being irrational. By shifting the onus onto the women and their families to "behave correctly" in order to access the supposedly life-saving maternity services on offer, the state absolved itself of responsibility, erasing the language of rights and accountability, and undermined its own constitutional obligations towards women's right to survive pregnancy.

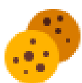
"But the Emperor has no clothes!"

16 With around 4 to 5 million births every year in the state of UP, the government was proceeding ahead at full steam to ensure "100% institutional childbirth". The activists of HWF could see this was a disaster waiting to happen, through our sustained process of documenting pregnant women's adverse experiences with the health system in the years preceding and following the NRHM. The cases we documented in the post-JSY scenario made us painfully aware that public health institutions still lacked trained providers, essential drugs and supplies for maternal care, accountability mechanisms and oversight. Flooding an ill-



equipped, poorly staffed, poorly motivated and poorly supervised public health system with tens of thousands more pregnant women would barely ensure safe and hygienic childbirths for women who had uncomplicated, normal deliveries. It seems incredible that the conditional cash transfer scheme for hospital childbirth did not anticipate that facilities would become over-crowded, and that the poorly skilled and underequipped staff would turn women away if there was the slightest perceived complication. The health system obviously did not have the institutional capacity to respond to a greatly increased demand for maternal health services. It was easy to guess that the women in critical condition, who actually needed specialised care, would be ignored in the stampede, or perhaps turned away or forced to seek care in the private sector, even if it was unaffordable.

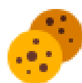
17 But our efforts to raise this question for 15 years with national policy actors and public officials in UP met with no response. SAHAYOG and HWF allies made repeated attempts to address various "duty bearers" about these human rights violations and their responsibilities in preventing them. Reports presented to the Government of India were always ignored, saying that "implementation of health programmes was a State subject". The numerous petitions to every health official in the case of N. (see above) met with no response, and accountability was not enforced: the department merely suspended from service the lowest-ranking nurse in that hospital. Reminders about obligations under international agreements or treaties such as the ICPD or the CEDAW cut no ice with any of the public officials in the state. The state human rights commission was unable to recognise that rights violations could occur beyond the civil-political sphere. Cases that did manage to reach the courts faced threats by the perpetrators and police, and impoverished families could not sustain the struggle during the long, drawn out process of justice in Indian courts. Within UP, campaigns with prolonged media coverage and dialogue with elected representatives and political parties



made no dent in their silence and their disregard for this critical issue faced by poorer women in their constituencies.

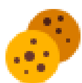
18 Across UP, in the massive effort to popularise the JSY, propel poor women into hospitals and count the beneficiaries, what was not counted was whether women's lives were actually being saved. The means had become the end. There was an implicit assumption that input was equal to output; if a birth took place in a public health institution, it meant that one more maternal death had been averted. The attractive simplicity of this equation vitiated the need for monitoring whether the other components of health system strengthening were actually leading to the desired results. What made it even easier was that maternal mortality ratios certainly seemed to be going down in UP, as large national assessments such as the Sample Registration Survey indicated (Registrar General of India 2013[12]), leading to general satisfaction among public officials. No one in the districts bothered to track the registered pregnancies to count the number of lives actually saved through provision of specialised services, for which these hospital-based deliveries were being promoted in the first place. No one measured the quality of emergency obstetric services or safe abortions available for women who desperately needed these, or the actual numbers of women dying. In fact, beyond some limited clinical audits carried out in hospitals, there was no rigorous effort to count the maternal deaths actually happening, review them to understand how they could have been prevented, or to make plans to improve the poor treatment and abusive behaviour encountered by women.

19 This ostrich-like happiness among policymakers in India and health officials in UP was largely encouraged and endorsed by international public health expertise. The high numbers of women dying during pregnancy were viewed as a critical problem that needed to be solved, but the technical expertise of obstetricians, public health researchers and development economists was sought to define the problem of maternal mortality. The global health thinking of the new



millennium had veered sharply away from the rights-based articulation of the various UN conferences of the 1990s such as the ICPD (United Nations 1994), the Fourth World Conference on Women in Beijing in 1995 and other statements on comprehensive reproductive and sexual health and rights by women's movements. When the international community pledged to achieve the Millennium Development Goals (MDG), maternal mortality reduction was retained as a goal, but it was not articulated from the comprehensive health and rights standpoint of the women's health movement. Instead the diagnosis of the problem was that poor women failed to access 'skilled attendance at childbirth' by giving birth at home, as they were too poor, ignorant or slow to access the modern services (Dasgupta 2016). If countries could increase access to "skilled attendance", then they were solving the problem of maternal mortality.

20 Within India, a proxy measure was to get pregnant women to reach hospitals, which was assumed would to be equivalent to having access to 'skilled attendance', although the 'skills' were in fact lacking. A "market-based" solution based on international development economics was to motivate poor women by offering them cash: a conditional cash transfer that would be a "demand-side stimulus" to get large numbers of women to go to hospitals. The international public health experts inexplicably ignored the "supply-side" at the outset of the JSY scheme, even though the dysfunctional public health facilities in poor areas had been well documented through Facility Surveys and other government studies (IIPS 2010; MoHFW 2012). This decrepit state of public health facilities continues in large parts of India (IIPS 2010) where even in the year 2015, 83% of all the Community Health Centres in India lacked a surgeon, and 76% lacked a gynaecologist (Sharma 2015). Yet the magical equivalence of "pregnant women in hospitals" with "maternal deaths averted" was accepted and appreciated by the international public health community, content with their assumption that institutional childbirth

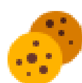


would result in skilled care by competent personnel in adequately equipped settings.

21 However, the dissent sounded by SAHAYOG and its allies has finally been vindicated by recent research indicating that despite the JSY scheme of the NRHM, maternal deaths have not decreased significantly in India. In fact it appears that "the pace of reduction has been slowing down in recent years"[13] (Joe *et al.* 2015). Other studies have concluded that poorer women are dying four times as much as richer women, even though the cash transfer was intended to remove financial barriers; in fact, there appears to be a "gross unavailability of free emergency obstetric care during the JSY programme" which has led to more deaths among the poorest women, while richer women have been able to purchase specialised care from the private sector (Randive *et al.* 2013; Randive *et al.* 2014).

Feminist subversion

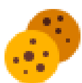
22 Faced with consistent denial of attention to poor women's perceptions of the problem, SAHAYOG and its partner CBOs of the HWF opted for a subversive strategy. The JSY scheme had conceived of women as ignorant "passive beneficiaries" who needed to be told how they could ensure their maternal survival. The dictated solution was for them to accept the conditional cash transfer and reach hospitals on time. The subversive strategy adopted was to mobilise poor rural women across different districts of UP and turn them into "active claimants" negotiating their rightful entitlements from the state (Dasgupta 2011; Dasgupta 2016). Over the last ten years (2006-16) over ten thousand women from socio-economically marginalised communities have come together within the Mahila Swasthya Adhikar Manch (MSAM or Women's Health Rights Forum), which has elected leaders in every village and district. SAHAYOG and its partner CBOs have built the capacities of the women leaders to be informed and aware about their rights and the state's constitutional obligations, including the reproductive health services mandated under the government policies. The



women members all have an MSAM identity badge and wear it when they visit hospitals or accompany other family members.

23 The MSAM women leaders develop skills to monitor the provisioning of services, track maternal deaths, or report harassment for informal payments. They are also equipped with tools simple enough for a semi-literate person to manage, which enable them to conduct systematic monitoring exercises of the health facilities and service provisions (Dasgupta 2011). This "citizen monitoring" conducted every year for the last ten years by the empowered "user community" generates data, which are then regularly presented by MSAM and the CBOs to the district health officials and hospital managers. These data, presented at non-adversarial "dialogue" sessions, are appreciated by officials as being authentic real-time feedback, and they feel answerable to this public demand to initiate some local corrective actions. This exercise has also led to increasing recognition of the MSAM organisation by public officials and local elected leaders. At health facilities, it has shifted the unequal power relations that had previously led to poor treatment and denial of care; now frontline providers are careful not to harass MSAM women or their family members when they come into health centres (Dasgupta *et al.* 2015).

24 As active claimants of their rights and entitlements, MSAM women also continue to identify incidents of rights violations in their community, such as outright denials by duty bearers, and take these up for investigation and direct activism. Their enhanced sense of agency, knowledge about what the government has promised to do, and access to district officials has strengthened their leadership in their communities (MSAM 2016). Simultaneously, the connection with the MSAM has also built the credibility of the local CBOs as well as SAHAYOG. The CBOs are increasingly invited to join committees and meetings by their district officials, which gives them access to spaces where their representation of the problem can be voiced[14]. SAHAYOG was also invited into policy spaces by the national

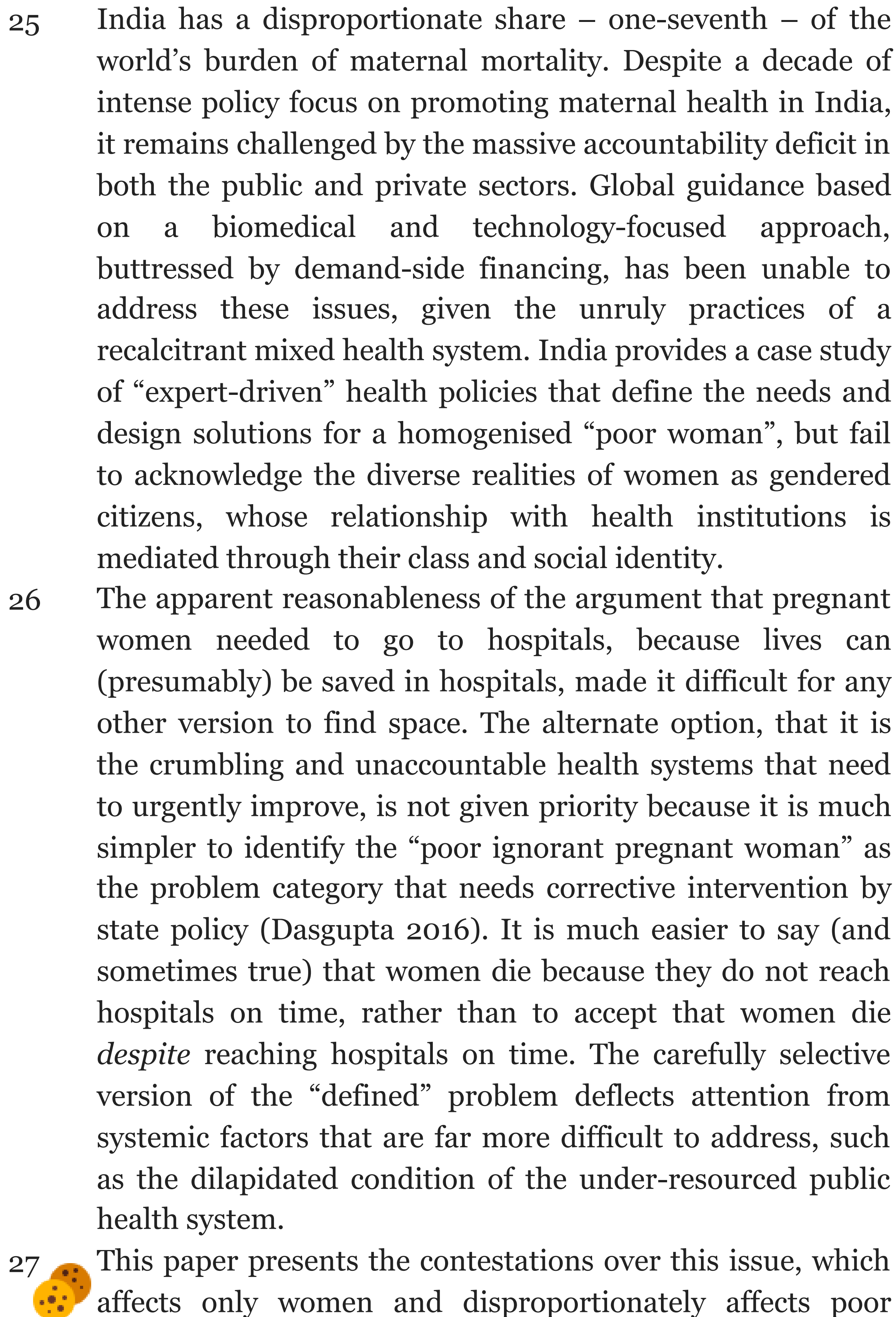


government[15], while within UP, SAHAYOG is on several health-related committees and actively engaged in collaboration with state officials of the National Health Mission.

Discussion and conclusion

25 India has a disproportionate share – one-seventh – of the world's burden of maternal mortality. Despite a decade of intense policy focus on promoting maternal health in India, it remains challenged by the massive accountability deficit in both the public and private sectors. Global guidance based on a biomedical and technology-focused approach, buttressed by demand-side financing, has been unable to address these issues, given the unruly practices of a recalcitrant mixed health system. India provides a case study of "expert-driven" health policies that define the needs and design solutions for a homogenised "poor woman", but fail to acknowledge the diverse realities of women as gendered citizens, whose relationship with health institutions is mediated through their class and social identity.

26 The apparent reasonableness of the argument that pregnant women needed to go to hospitals, because lives can (presumably) be saved in hospitals, made it difficult for any other version to find space. The alternate option, that it is the crumbling and unaccountable health systems that need to urgently improve, is not given priority because it is much simpler to identify the "poor ignorant pregnant woman" as the problem category that needs corrective intervention by state policy (Dasgupta 2016). It is much easier to say (and sometimes true) that women die because they do not reach hospitals on time, rather than to accept that women die *despite* reaching hospitals on time. The carefully selective version of the "defined" problem deflects attention from systemic factors that are far more difficult to address, such as the dilapidated condition of the under-resourced public health system.

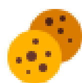


27 This paper presents the contestations over this issue, which affects only women and disproportionately affects poor

women or marginalised groups, but which has been entirely constructed by "expert" voices, international public health experts and economists. For 15 years, SAHAYOG and the allies of HWF struggled to represent the reality of poor pregnant women and their traumatic encounters with the inept health systems, using feminist approaches and documenting human rights violations in the health sector. However, the voices of those closest to the experiences of poor women in rural UP were not permitted to influence the discourse, since they represented a version that would completely undermine the policy solution supplied by experts. Therefore, the activists were consistently met with baffling silence in the policy arena.

28 Nonetheless, the contestation from feminist and rights-based civil society groups like SAHAYOG generated local insights that persisted in providing a contrary picture to the globally acclaimed results of the JSY. Using the critical approach of social movements, they have examined the realities where law and policies operate through the experiences of the actual users, and fed that research back into policy forums. The struggles of SAHAYOG and the HWF brought to light the idea that a problem that affects poor women the most cannot only be diagnosed from the "expert viewpoint" with no reference to the actual experiences and realities of those poor women. Solutions also need the participation of these women, who therefore need to be able to analyze the issues and have their voices heard at policy platforms.

29 This reflection of fifteen years of SAHAYOG's work reveals that it is important for feminist activists to be engaged in making and implementing policies by providing a different kind of expertise; merely opposing is not enough. They need to take active roles in policy forums or take on accountability functions. The access of SAHAYOG to certain policy spaces provided the opportunities to represent the experiences of poor marginalised women, which questioned the definition of the problem. Today, ten years later, these are now



substantiated by more scholarly analyses of maternal health data.

30 On the other hand, the struggles and victories of the MSAM reminds us that we should not completely "civilise" outrage, for their outrage fuelled the efforts of these disempowered groups to build their voice in negotiating their entitlements with the state, and finally led to a difference in the way these women were treated by the health system (MSAM 2016; Dasgupta 2016).

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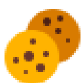

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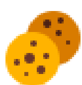

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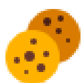

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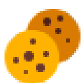

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Notes

1. Rajasthan, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Orissa and Assam, together account for about 12% of global maternal deaths – half of India's population and 62% of India's total maternal deaths (Registrar General and Census Commissioner 2011).

2. As estimated for the year 2004 in the report of the Registrar General (2006).

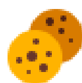
3. In India, the term "civil society" can encompass a wide range of meanings, including grassroots community groups, faith-based groups, voluntary organisations headed by social activists or professionals, international organisations, providers' associations, quasi-government institutions and corporate social responsibility entities.

4. Convention for Elimination of all forms of Discrimination Against Women (CEDAW)

5. Dalits are those from the "untouchable" caste; they are protected by laws, but continue to face social discrimination

6. The media coverage enabled the Uttar Pradesh Commission for Prevention of Atrocities on Scheduled Castes and Tribes to take *suo motu* cognizance of the incident, and this Commission recommended that N. be compensated for the death of her baby, and instituted criminal proceedings in court against the doctor on duty at the CHC.

7. In fact the data from the National Sample Survey Organisation (NSSO 71st Round in 2014) tells us that out-of-pocket expenses for poor families has not reduced, despite all government announcements about free services in maternity: they spent an average of Rs 5,544 (approximately Euro 75) per childbirth in rural areas, ranging from Rs 1,587 (in public hospitals) to Rs 14,778 (in private hospitals).



8. According to this framework, maternal deaths were caused by delays either in decision-making to seek care, delays in actually reaching care

and delays at the point of providing care. The general assumption was that women's lives could be saved if women reached institutions in time during labour, and if institutions had skilled medical personnel (Thaddeus and Maine 1994).

9. The per capita Public Health Expenditure for 2013-14 in UP state is Rs 455 or 6 Euro, which is the 3rd lowest among 35 states/Union Territories in the country.

10. Website page: http://nrhm.gov.in/nrhm-components/rmnch-a/maternal-health/background.html

11. Earlier programmes for training community women to be birth attendants for normal childbirth were discontinued, as the WHO changed its stance towards these, entirely discounting their role in birth companionship and management. The new formula was to get every pregnant woman into a hospital.

12. The IEG paper by Joe *et al.* (2015) indicates that the decline in maternal mortality rates may be related to reducing fertility over the years (Joe *et al.* 2015, 8).

13. Specifically, we examine the progress over three periods: 2001-06, 2004-09, and 2007-12. Here, the first period can be regarded as the pre-NRHM period; the second and third periods can be regarded as falling under Phase 1 of the NRHM (2005-12). We can expect some effect of the NRHM during the second period, but greater results in the third period. Interestingly, the all-India reduction in MMR for the three periods was 47 points, 42 points, and 34 points, respectively. This absolute view suggests that the pace of reduction has been slowing down in recent years (Joe *et al.* 2015, 5-10).

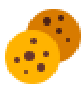
14. These include the Hospital Committees, Maternal Death Review Committees and District Health Society.

15. These include the Planning Commission's High-level Expert group on Universal Health Coverage, and a technical group on maternal mortality in the Ministry of Health and Family Welfare.

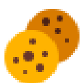
Auteur

Jashodhara Dasgupta

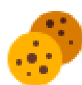
Jashodhara Dasgupta travaille en faveur des droits des femmes dans l'Uttar Pradesh, en Inde, depuis près de 30 ans et elle est



actuellement une militante et chercheure en politiques publiques pour le droit à la santé, avec un accent particulier sur la santé et les droits sexuels et reproductifs. En 1992, Jashodhara Dasgupta a co-fondé l'ONG indienne Sahayog dont elle dirige, depuis 12 ans, les activités en faveur de la santé des femmes et de l'égalité de genre en utilisant des cadres des droits humains. Jashodhara Dasgupta a siégé à divers comités universitaires et gouvernementaux sur la santé, y compris, récemment, la Commission Lancet-Université d'Oslo sur la gouvernance mondiale pour la santé. Depuis les cinq dernières années, elle dirige l'International Initiative on Maternal Mortality and Human Rights, un programme de la société civile.



Jashodhara Dasgupta has been working with issues of women's rights in Uttar Pradesh, India for almost 30 years and is currently a policy advocate and researcher on the right to health, with a specific focus on sexual and reproductive health and rights. She was one of the founders of the Indian NGO SAHAYOG in 1992, and for the last 12 years has been heading its work with women's health and gender equality using human rights frameworks. Jashodhara Dasgupta has served on various academic and government committees on health including most recently the Lancet-University of Oslo Commission on Global Governance for Health. She has been anchoring the civil society platform, International Initiative on Maternal Mortality and Human Rights for the last five years.



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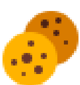

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