

MAHILA SWASTHYA ADHIKAR MANCH, UTTAR PRADESH, INDIA



AN EVALUATION OF THREE YEARS' EXPERIENCE
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EXECUTIVE SUMMARY

It has been three years since the grassroots organization of women leaders, the Mahila Swasthya Adhikar Manch (Women's Health Rights Forum) has been formed in Uttar Pradesh in 2006. This evaluation was meant to examine ***to what extent the formation of the Manch has been an effective strategy in promoting women's right to healthcare in Uttar Pradesh***, in terms of

- Building a consciousness of themselves as rights holders; being able to articulate or analyze the deprivation of essential maternal care as a rights issue
- Using their collective 'voice' as a strength in negotiating improvements in health services
 - a. To what extent they are able to involve local leaders/elected PRI representatives in monitoring and improving the quality of maternal health services available in their district?
 - b. To what extent have their efforts to convey local problems to health officials (PHC, CHC, CMO) or state-level officials (Minister, MLAs, Director etc) led to acknowledgement of gaps and improvement in service delivery?
 - c. To what extent has the local media been able to amplify their 'voice' in order to highlight the condition of health services?
- Effectiveness and relevance of the capacity building of poor rural women leaders, specifically in monitoring and advocacy:
 - a. To what extent the MSAM leaders are equipped with local data/information on cases regarding poor women's access to health and nutrition entitlements
 - b. What is their experience of using this information to leverage improvements in services?
 - c. What further skills or information would be useful?

During the course of the field visits to 3 different districts in Uttar Pradesh, the evaluator met with grassroots women of the Manch and several other key players. From these interactions, it seems clear that in the short period of 3 years, the Manch has been able to bring attention to the issue of maternal health care in Uttar Pradesh and also change attitudes towards this situation as being unacceptable.

The Manch leaders have received capacity building on the rights framework and also on their various entitlements related to health and programmes addressing its broader determinants. They have been able to articulate at various levels with both their local leadership and the health system the poor state of public health care services and the lack of accountability of both public and private health services. They have also been successful in some cases in negotiating for improvement in existing services. The Manch members have also taken this negotiation to a wider level where they have been able to act for their entitlements in programmes that address broader determinants of health.

Members of the Manch have also participated in gathering evidence for their advocacy through identification of cases of violation of health care rights and also through gathering information on health care entitlements like the use of untied funds and household expenditure on health care. They have also participated in dialogues and campaigns, at district and state level, on the poor state of maternal health care in Uttar Pradesh.

While women have thus been successful in negotiating for better health care at various levels, very often, their stance towards the system seemed confrontational.

SAHAYOG and the partner NGO work from a very strong rights perspective - while women of the Manch speak the language of rights, a deep understanding of the rights framework does not seem uniform beyond the leaders of the Manch.. Women also seemed to be unable to envision a larger systemic change in the future and strategize towards this.

While women viewed their collective strength as important in their struggle for maternal health care, they have faced struggles arising from gender and caste discrimination in the initial stages of such organization. The natural leaders among women in the community seem to be actively involved in the Manch; the challenge now is to involve other women in the community in the Manch.

Overall, the Manch has achieved more than what would be expected realistically in three years' time. The women's enthusiasm and earnestness in their quest to realize their rights amid extremely adverse circumstances was a privilege to witness.

For the future, this evaluation recommends the following –

- i. Organization building - the MSAM needs to consolidate as well as deepen its base. However the participation of women leaders needs to be re-evaluated in terms of financial sustainability, as many of them are poor daily-wage labourers
- ii. Capacity building – the MSAM women other than the leaders, have to develop a stronger understanding of the implications of a rights based approach, technical aspects of maternal health, the social determinants of health, as well as of the health system itself and its potential. SAHAYOG needs to develop a definitive training module for this. The local media also needs further inputs to ensure that they develop a 'health systems' approach to problem solving
- iii. Use available spaces – the MSAM needs to develop a strategy for intervening in the Panchayati Raj process, including standing for elections and participating pro-actively in the Gram Sabha. The MSAM can also use opportunities for citizen participation within the NRHM framework
- iv. Second line leadership – both SAHAYOG and the partner organizations need to develop a policy to attract and develop capable staff on a longer term basis
- v. Technical capacity – Given that staff are not medically trained, there needs to be a strategy in place to ensure that case documentation, for example, is accurately conducted

CHAPTER ONE – BACKGROUND AND METHODOLOGY

Maternal Health in Uttar Pradesh

India is the largest single contributor to maternal deaths in the world with a maternal mortality ratio (MMR) figure of 254 for the period 2004-06 (Registrar General of India, 2009). Uttar Pradesh state in northern India has one of the highest maternal mortality figures even within India - its MMR for the corresponding period is 440 (Registrar General of India, 2009). Uttar Pradesh also fares poorly compared to the rest of India in other health indicators like infant mortality rate.

The Government of India through its flagship programme, National Rural Health Mission, has been attempting to bring in systemic changes to improve the maternal health care situation in the country. The Janani Suraksha Yojana provides cash assistance for women delivering in institutions. However, the institutions seem ill equipped to provide safe obstetric services. The District Level Household and Facility Survey 3, 2007 -08, documents large gaps in the health system infrastructure of Uttar Pradesh - only 37% of ANMs live in the sub-centre quarters, only 45% of Primary Health Centres function on a 24 hour basis, only 30% of Community Health Centres have an obstetrician gynecologist, less than 6% of First Referral Units have offer caesarean sections and only 15 of FRUs have blood storage facilities. All of these fall severely short when compared to the Indian Public Health Standards proposed by the Government of India and could severely compromise the provision of basic and emergency obstetric care.

The maternal mortality situation of Uttar Pradesh has been analyzed in a recent report by Human Rights Watch. This report clearly documents several health system factors as contributing to the high maternal mortality. These include barriers to emergency care, poor referral practices, gaps in continuity of care, and improper demands for payment as a condition for delivery of healthcare services. In addition, a lack of accountability in monitoring deaths, identifying flaws and instituting systemic changes was also highlighted. Also, no grievance redressal mechanism exists to help women who have been denied services by the health care system (Human Rights Watch: No tally of the Anguish - Accountability in maternal health care in India, 2009).

About SAHAYOG

SAHAYOG is a voluntary organization working on women's health issues from a rights based framework since 1992. According to documents provided by SAHAYOG, currently its work focuses on the following areas.

- Women's rights to maternal health services
- Young people's reproductive and sexual rights and health
- Work with men on gender issues, masculinity and ending gender based violence
- Work on gender equality and women's human rights

The key strategies of SAHAYOG include –

- Facilitating issue-based partnerships
- Providing capacity-building and field support
- Conducting studies and documentation, as well as information dissemination activities
- Policy advocacy through networks; campaigns and engagement with the media.

SAHAYOG has been working on maternal health issues since 1999. Initially this work was with community based organizations and involved developing their capacities in the rights based framework. From 2003 onwards, SAHAYOG has been systematically documenting cases of denial of maternal health services as rights violations. In 2003, SAHAYOG was part of the campaign for Right to Health Services by women's organizations called the *Puri Nagarik Pura Haq* (Complete Citizens Total Rights) campaign. Since 2004, SAHAYOG has been holding annual dialogues between civil society groups and state officials to provide space for voicing the realities of women's lives. In addition, SAHAYOG was also involved in directly working with rural women leaders in building their capacity in monitoring and advocacy. In 2006, SAHAYOG along with other community based organizations and grassroots women of Uttar Pradesh ran a campaign called *Puri Nagarik Pura Haq 2006*. This campaign lasting for almost 3 months focused attention in the issue of maternal mortality as a rights violation.

MAHILA SWASTHYA ADHIKAR MANCH (MSAM meaning Women's Health Rights Forum)

The *Mahila Swasthya Adhikar Manch* was formed in 2006 following the *Puri Nagarik Pura Haq* campaign. After this high profile campaign that created a lot of energy and brought a lot of attention to the issue of maternal mortality in Uttar Pradesh, it was felt by the participating organizations and the grassroots women themselves that a more sustained form of demand-side pressure was needed to be kept up at the health system. Thus the MSAM was constituted as a forum that would provide space for grassroots women to exercise such pressure. It was felt that such a forum would help women in collectively raising their voice for maternal health care as a rights issue; it was also felt that this would give women a more "direct" voice that would be independent of mediation through NGOs.

SAHAYOG, through partnership with selected district level NGOs undertook to build the capacities of the Manch members in understanding maternal health care as a rights issue and also in monitoring of health and allied services and in advocacy. SAHAYOG also provided the partner NGOs with some minimal financial support through grants from DANIDA - ARROW through the WHRAP project and supplementary grants from AJWS. The state level NGO network, Healthwatch Forum provided space and support for state level advocacy activities of the Manch. It also provided support for raising media attention around the issue at state level and for dialogue with policy makers.

Thus, in summary, the Manch was intended to organize women from marginalized communities, build a consciousness of themselves as rights holders, and enhance their capacity to articulate or analyze the deprivation of essential maternal care as a rights issue. The assumption was that their community based monitoring of health services combined with advocacy activities at local, district and state levels would lead to increased accountability from the health system leading to better performance. (See Logic Framework - Annexure 1)

Current outreach of the Manch and interventions

The Manch is currently active in 11 districts of Uttar Pradesh with over 8000 members. SAHAYOG works with a partner organization in each of these 11 districts listed in the table.

Partner organizations since 2003	Partners who joined in 2006	Partners who joined in 2008
<ul style="list-style-type: none"> • Shikhar Prashikshan Sansthan, Mirzapur • GRAMYA, Chandauli • Purvanchal Gramin Sewa Samiti (PGSS), Kushinagar • Baba Ramkaran Das Gramin Sewa Samiti (BRDGSS), Gorakhpur • Gramin Punarnirman Sansthan (GPS) Azamgarh 	<ul style="list-style-type: none"> • ASTITVA, Muzaffarnagar • Tarun Vikas Sansthan, Banda 	<ul style="list-style-type: none"> • EBTEA, Chitrakoot • AANCHAL Gramin Vikas Samajik Sansthan, Saharanpur • Suchetna Assisi Health Centre, Bareilly • ASHA Ashram, Hardoi

According to documents received from SAHAYOG, the present interventions with the Manch include the following.

- Working closely with the selected MSAM leaders through the local intermediary CBO in order to expand the MSAM in each district
- Capacity building of the MSAM leaders through community-level workshops as well as opportunities to participate in state or national-level advocacy events
- Local monitoring by MSAM leaders of quality of maternal health and nutrition services, including aspects such as availability, affordability and access
- Surveillance to identify local maternal deaths (or denial of health services) for fact-finding by MSAM leaders and the CBO
- Ensuring regular quarterly meetings of the MSAM in each district for decentralized problem identification, choice of strategies and activity planning
- Supporting the MSAM through a district forum comprising of other NGOs, lawyers, journalists, academicians and other civil society members
- District level advocacy activities planned by local MSAM members to focus public attention on maternal health issues
- State-level advocacy event on 28 May each year (International Day of Action on Women's Health) with participation of the MSAM women

Methodology of the Evaluation

Since the Manch has completed three years of existence, an evaluation was sought in order to identify **what have been effective strategies and what are the lessons learnt**. The scope of the evaluation was the interventions with the Manch from July 2006 to July 2009, focusing mainly on the oldest 5 districts and to a lesser extent on the newer 6 districts. According to the Terms of Reference provided to the evaluator, the aims and objectives of the evaluation were as follows:

The evaluation will examine ***to what extent the formation of the Manch has been an effective strategy in promoting women's right to healthcare in Uttar Pradesh***, in terms of

- Building a consciousness of themselves as rights holders; being able to articulate or analyze the deprivation of essential maternal care as a rights issue
- Using their collective 'voice' as a strength in negotiating improvements in health services

- d. To what extent they are able to involve local leaders/elected PRI representatives in monitoring and improving the quality of maternal health services available in their district?
 - e. To what extent have their efforts to convey local problems to health officials (PHC, CHC, CMO) or state-level officials (Minister, MLAs, Director etc) led to acknowledgement of gaps and improvement in service delivery?
 - f. To what extent has the local media been able to amplify their 'voice' in order to highlight the condition of health services?
- Effectiveness and relevance of the capacity building of poor rural women leaders, specifically in monitoring and advocacy:
- d. To what extent the MSAM leaders are equipped with local data/information on cases regarding poor women's access to health and nutrition entitlements
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 - f. What further skills or information would be useful?

This evaluation of the MSAM was carried out in December 2009, 3 years after the MSAM was formed. After a review of some of the available documents regarding the formation and activities of the MSAM, an initial tentative design of the evaluation was shared with the SAHAYOG team. Following this, the evaluator travelled to Uttar Pradesh. The first day there was spent at Lucknow with the SAHAYOG team, in understanding the programme through detailed discussions and clarifications. The evaluation plan was further modified at this point with inputs from the team at SAHAYOG. Following this, the evaluator, accompanied by one member from the SAHAYOG team, travelled within 3 districts in Uttar Pradesh where MSAM has been active since 2006. At the various sites, the evaluator met women leaders and members of MSAM, staff of district level partner NGOs, local Panchayat leaders, personnel at various levels of the public health care system including ASHA, ANM and medical officers. [A list of the people met at the various sites is listed in Annexure 2.] Unstructured interviews with all of these respondents were based on a guide drawn up earlier. Approximately, one and a half to two days were spent in the field in each district. Following the field visits, half a day was spent in a debriefing with the team at SAHAYOG. In addition, the evaluator was provided with copies of relevant documents, module for training grassroots women, report of evaluation of SAHAYOG's media advocacy, and CDs of 2 films made by SAHAYOG on the maternal health care situation in Uttar Pradesh.

Limitations

- One of the limitations of this methodology was inadequate time. Two days or less at each site was insufficient to understand more than 3 years of work - however, in view of distances and travel time between districts, this was what could be realistically achieved. Also, the evaluator falling sick to a gastroenteritis episode during the travel compromised some meetings in one of the districts.
- Out of the 11 districts that the Manch is active in, the evaluator could visit only three - the findings are thus extrapolated to the other districts and the evaluator has relied on the SAHAYOG team's judgement for assessing representativeness of the findings.
- Also, the evaluator travelled around in the last 10 days of December 2009 - the Christmas holidays saw some health officials on leave; some of them could hence not be met.

CHAPTER TWO - FINDINGS

The findings from the evaluation are presented below under the headings of the objectives mentioned in the Terms of Reference of the evaluation. In addition, certain other issues that the evaluator either purposely looked at or that came up during the evaluation are presented under the heading "Other issues".

OBJECTIVE 1: Women's consciousness of themselves as rights holders; articulation and analysis of the deprivation of essential maternal care as a rights issue

SAHAYOG has been very consciously working with the perspective of women being rights holders and the state being the duty bearer as far as maternal health care is concerned. The conceptual pathway of MSAM leading to better maternal health care is through women organizing their collective voice to demand better services as a right. Thus, it was important to understand how much women had internalized this rights framework and were able to articulate it for negotiating with various stakeholders. This aspect was mainly addressed through various questions to members and leaders of MSAM during interactions with them.

While narrating their various activities as members of MSAM, women very often used the word *adhikar* and *haq* (right) and that they had to get their rights. Some women used the words *adhikar hanan* (violation of rights) as the motivation for their joining the Manch.

hamare adhikar hame mile (we should get our rights) - MSAM member, Thithila, Kushinagar

adhikar hanan ho rahe the - uske liye ladne ke liye (rights were being violated, we had to fight against it) - MSAM leader, Dhadha bujurg village, Kushinagar

But when specifically asked why they thought this was a right, only some of them could articulate it clearly. Many seemed to think of the state as a benevolent state that launched welfare measures - these did not reach the poor and they were entitled to get its benefits.

yojana ka labh garibon ko milna chahiye (the poor should get benefit of programmes) - MSAM member, Thithila, Kushinagar

In one district, when asked whether the state had a responsibility to implement welfare programmes, leaders of MSAM said that the state had a responsibility for the citizens' welfare and should provide health care services. They also said that they paid taxes and hence had a right ask the government to fulfill its duty. But beyond the leaders, not all the MSAM women could answer why the state was responsible for running welfare programmes and could not articulate this as a right of the citizen.

This understanding was delved into further in the same district with women leaders of the Manch who seemed to have a good appreciation of the rights framework - a case study of the state handing over running of a PHC to a women's group was brought up for discussion and women were asked what they thought about it and what they would do if they were faced with such a situation.

Initially, the women said they would be able to run the centre much better than the government and would therefore take it over. When the facilitator from the partner NGO asked what would happen if the government started handing over all such centres, and also if they were handed over to corporate groups, they felt it would be good as corporate groups would run it better. The facilitator then explained to them that private players would not be accountable to the community and that their motive would be profit making. Following this, when asked again whether they should take over the PHC if offered a chance, the women said yes.

Thus, while all women speak the language of rights and rights violation, this seems to be more at a rhetorical level. Compared to the women members, MSAM leaders seem to have a better appreciation of the rights framework and are also able to articulate it better - this is possibly because as leaders, they have greater opportunities of interacting with partner NGOs, SAHAYOG and other stakeholders at state and district level. When challenged with situations where such a rights-based framework had to be applied in order to strategize, for example with privatization, women seemed to have some difficulty.

OBJECTIVE 2: Use of collective voice in negotiating improvements in health services

At the time of formation of MSAM, it was expected that the organization of grassroots women into a formal forum would enable them to negotiate with various stakeholders to bring about more accountability and better performance from the health system. The evaluation was expected to look at women's interactions with local leaders of the Panchayat, officials of the health system and the media to understand whether they had been able to use the collective voice of the Manch to negotiate for improvements in health care. This objective was analyzed based on interactions with MSAM women. In the various districts attempts were made to meet with local leaders, health and other officials to get their perspective on how effective the MSAM efforts had been.

Negotiating with local leadership -

In all the areas visited, the women had approached the *Panchayat Pradhan* (head of the elected village council) for support at some time or the other. While in some areas, women had approached him regarding Job-cards for work under the National Rural Employment Guarantee Act, in some, the issue was regarding informal payments at the Public Distribution System shop. Women also said they attended the Gram Sabha now which they hadn't done earlier. In one village, a woman demonstrated how they would hide behind each other a few years ago if they ever attended any meeting, for fear of being asked a question. She said now they sit ahead of the men-folk in the village, and men ask any questions they want answered through the women, as they feel women's questions are better received.

Most women said they received *sahyog* (cooperation) from the *Pradhan*. Some said the *Pradhan* now respected them. In some areas, women said they were now consulted by the *Pradhan* in important issues related to women.

Abhi Pradhan hamen mante hain (The Pradhan now respects us) - MSAM member and ASHA, Baldihan, Kushinagar

Some also narrated instances where the *Pradhan* had initially not been supportive, but

changed after seeing their various actions and their results.

In some areas, this interaction with the local leader had turned confrontational when women challenged existing power hierarchies. In one area where women had exposed corruption in the PDS, the *Pradhan* had abused them and asked them to take back a petition applied for under RTI. In another area, a *Pradhan* had tried to intervene on behalf of an erring ANM for out-of-court settlement in the case of a maternal death. But the women from MSAM had confronted him, and compelled him to stop supporting the ANM.

In the course of travel through 3 districts, the evaluator also interviewed four *Panchayat Pradhans* in various villages. All of them felt that women's knowledge (*jaankaari*) and awareness (*jagrookta*) has definitely increased over the years. Two of them were not aware of the Mahila Swasthya Adhikar Manch by name, but knew that women were organizing over various issues. One of the *Pradhans* disclosed that women had met him regarding expenditure of the 'Untied Fund' given to the Village Health and Sanitation Committee (VHSC) and because of pressure from them, he had then used the money for fogging the village against mosquitoes.

Two of the *Pradhans* met were women. While one of them seemed to be extremely active and shared with us all the welfare measures she had undertaken as the *Pradhan*, the other woman *Pradhan* in another district was not aware of anything happening in her *Panchayat* and seemed content to let her husband handle the affairs of the *Panchayat*.

Impact on local perceptions

It also seemed that women had largely been effective in changing community perceptions of maternal death being one's fate. One partner NGO staff shared that earlier a maternal death was seen as an auspicious event as a woman pre-deceasing her husband was considered fortunate. Now, a maternal death is considered unacceptable.

pehle kehte the laddu lokti gayi hai, ab nahi kehte. (Earlier they used to say she has gone distributing sweets, not any more) - Uma Kushwaha, Tarun Vikas Sansthan, Banda

Similarly, according to this respondent, physical abuse of the woman in labour by the ANM was earlier accepted as normal, but this attitude has now changed.

Negotiating with the government system

In all the districts, women had interacted with various levels of staff of the health system. This was attributed to the knowledge and confidence they had received after joining the Manch.

Manch se hame jaankaari mili, saahas mila. (We got knowledge and confidence from the Manch)- MSAM member, Puranya, Mirzapur district

In one village, one MSAM member narrated an instance of how a few years ago, she had requested the local ANM to visit her daughter in law who was in labour, but the ANM had refused. The woman shared that this incident of denial of services motivated

her to join the Manch. Now, the situation is the opposite: whenever the ANM faces any problem, she approaches the MSAM members for help.

Haath jodke hamare paas aayi. (She came to us with folded hands) - MSAM member narrating an incident when the ANM needed support, Puranya, Mirzapur district

The MSAM members interacted most with the local ASHA and ANM, who are meant to provide services and information at the village level. Very often, these were complaints against poor quality of services offered by them or informal payments demanded. In many areas, according to the women, services had improved or informal payments had stopped after their intervention. One partner NGO who worked both in areas where the MSAM was formed and in villages where the Manch did not exist, stated that even now, the ANM did not visit the villages regularly in the area where the Manch was not active.

In one village, women had gone collectively to the PHC to demand payment of the cash assistance under the *Janani Suraksha Yojana* scheme that they had not received so far. According to them, the ANM at the PHC felt so intimidated seeing the number of women demanding payment that she immediately gave the cheques that were due to the women.

itne log dekhkar ghabra gayee, bolee bhago bhago bhago----- ab to aake bulaati hai. (She was scared seeing so many people, and asked us to run away---- but now comes here and calls on us to give the JSY cheque) - MSAM member, Jogibir, Kushinagar

In some areas, women had as a group also met the local medical officer or the CMO and placed specific requests/demands of the official. For example, in one area, women presented to their CMO the results of a study on household expenditure on health they had carried out. They demanded that a pediatrician be posted in the local CHC as the study had revealed that women were spending large amounts on the services of private pediatricians.

Women also seemed to be making good use of created spaces for such interaction with officials. SAHAYOG and partner NGOs have been organizing periodic district and state level dialogues with the health system officials - this was one forum which seemed to have resulted in positive outcomes. In some areas, women specifically recounted examples of improvements in quality of services in PHCs and CHCs following such meetings. These included doctors coming more regularly, improvements in infrastructure like provision of beds and generators.

The partner NGOs had also created a district forum in each district - this consisted of various other key stakeholders in the district related to maternal health care. These included in various districts lawyers, media persons, doctors etc. In some districts, ASHAs and some ANMs were also on the district forum. This was a space where MSAM women interacted with these other stakeholders with the help of the partner NGO.

Women also were making full use of all opportunities to interact with health care staff.. For instance, MSAM leaders in one district, Kushinagar, were being invited to the regular monthly meeting of the CMO with the ANMs and ASHAs of the district. These interactions helped the women forge closer relationships with their local health

care staff and also understand their side of various issues. In one village, women shared that they invited the local ANM to attend their MSAM meetings.

Women were also using their collective strength not only to negotiate with the health system, but also with officials of other development programmes - eg. NREGS, ICDS, PDS etc. In one village, women recounted how they had sat on a *dharna* in front of the Block Development Officer's office to get job cards under the NREGS.

Women also specifically mentioned that the collective strength of the numbers of the Manch gave them extra mileage while negotiating with the system. They felt what they could not do as individuals, they could achieve as a larger group, thus underscoring the effectiveness of the Manch as a strategy.

ham log sab jake gate pe baith gaye, to log kahne lage kaise aagaye, bhaago-bhaago, tab aake pooche kya chahiye, to bole job card, to bola bhijwa do andar, phir poora janon ke card banwa diye, paise nahin dena pada. (All of us went and sat at the gate, everyone said how did you reach here, go away, then asked us what we wanted, we said job cards, then they were told to send us inside, all of us who were there got job cards without having to pay any money) - MSAM member recounting her experience at the BDO office, Jogibir, Kushinagar

ham baarah jan gaye, pehle to CMO dara gaye, bole itne logon ke liye idhar kursi nahin hai, par dheere dheere mahilayen sab apnee haq le li, ek ek kar kursi pe baith gayeen (Twelve of us went, first the CMO felt scared, he said there weren't enough chairs for all of us, but gradually one by one all of us sat down in the chairs and we claimed our rights)- MSAM member narrating the experience of her visit to the CMO, Thithila, Kushinagar

Interactions with various officials also seemed to corroborate this increasing articulation of their rights by the women with the system. One of the people interviewed was a medical officer in charge of a CHC in one district, who had attended the district level dialogue with women held recently. Cases of poor maternal health care at government institutions resulting in maternal mortality and morbidity had been presented at this dialogue. According to the MO,

The women blew hot and cold at this event. (Khoob thanda garam hua). But their awareness (jagrookta) has definitely increased and this is good. The organization is very active (sakriya) - Medical Officer in charge, CHC, Hata, Kushinagar

Another medical officer of a PHC in the same district was not aware of the existence of MSAM when specifically asked. But during the course of the evaluator's conversation with her, she mentioned that women now approach her with complaints regarding poor services from some ANMs.

Thus, women's articulation of their rights vis a vis the health system definitely has increased. As seen in the examples above, while in some areas women have been able to negotiate for concrete changes with the system, they have not reached this level yet in many areas.

There were also some areas of concern that the evaluator noted when understanding

women's negotiation with the system. In many areas, women seemed to have internalized a feeling of confrontation when dealing with the system. Very often, women used words like *jhagda* (fight) when describing their interactions with the ASHA or ANM. In one area, women seemed to be proud that the CMO "shivered (*Kampte hain*)" whenever he heard the name of the local MSAM leader. In another, the partner NGO proudly recounted an instance where the Medical Officer of the local PHC had felt too intimidated to attend a meeting of the MSAM women and address them.

In a situation where the system has been failing the people consistently for very long and women have recently understood their rights, these reactions may be understandable. However, this sense of confrontation may prove counterproductive in the long run. During the debriefing session with the SAHAYOG team, when this aspect was shared, it was felt that negotiation could only be between equal partners - now that the MSAM had been recognized as a powerful force by the system, there may be more space available for negotiation.

Similarly, women seemed to be targetting the local ANM in many areas. Their demands from the health system seemed to be sometimes limited to demanding that the ANM visit their village regularly for immunization and stay in the subcentre. Very often, the ANM was portrayed in various interactions as someone who purposely refused to provide services and demanded bribes. In very few areas did women seem to have an understanding of the problems she faces as a front line worker working under extremely difficult circumstances. In one subcentre that the evaluator visited, 30 - 40 deliveries were being conducted every month by the ANM - but the evaluator found extremely constrained spaces, lack of basic equipment like sterile gloves, emergency drugs etc. This ANM also had to use her own vehicle to travel 4-5 kms to get to villages for immunization. Women did not seem to understand such systemic issues and seemed to be targetting the individual ANM in some cases, as opposed to asking for systemic changes.

Similarly, when asked what their long term vision regarding maternal health care was, very few women could think beyond a subcentre in their village or certain facilities in their PHCs. They did not seem to have a clear understanding of the potential and duty of the public health care system to deliver comprehensive health care. Larger issues like transport systems were also not articulated.

Use of media to 'amplify voice'

One of the objectives of the evaluation was to understand to what extent the local media had been able to amplify the women's 'voice' in order to highlight the condition of health services. This issue was addressed mainly by reviewing media clippings, looking at a report of evaluation of SAHAYOG's media advocacy efforts, discussions with the SAHAYOG team and partner NGOs, and a meeting with one reporter during the field visit.

Discussions with the women showed that they had not yet developed the capacity to interact with the media directly. Partner NGOs had facilitated women's interaction with the media during various events they organized. This had helped focus media attention on the women's issues regarding maternal health care.

The report on SAHAYOG's media advocacy revealed that both the number of reports on maternal health care and their quality of focusing on the issues has improved over

the last few years. There also seems to be good coverage of district level events organized by the partner NGOs. Some partner NGOs also seem to have developed a good relationship with certain media groups. The participation of media persons in the district forum meetings has also contributed to this.

The evaluator met one media reporter during the field visit. He felt that after the formation of MSAM, people are able to publicize health care issues and inform media about cases of health care rights violation, which then get highlighted in the media. This, he felt, also put pressure on the health system to improve. He narrated an instance of a woman in labour, who had been referred from a sub-centre to another centre, finally delivering on the road outside the sub-centre. His conclusion regarding this was that the woman had been referred out as she had not met the ANM's demand for informal payment. However, he did not make any recommendations from a health systems perspective, such as requiring all referrals to be made accountable, or transport to be made available to all women. So while the media recognizes and gives attention to specific cases of rights violation, there is a need to move ahead with a more systemic perspective that suggests solutions.

OBJECTIVE 3: Effectiveness and relevance of the capacity building of poor rural women leaders, specifically in monitoring and advocacy

SAHAYOG has conducted capacity building sessions for both partner NGOs and grassroots women since the formation of the Manch.

Impact of capacity building interventions

The capacity building sessions have gone beyond the original vision of rights and health to programmes on larger determinants of health like NREGS, PDS and ICDS and other useful areas for advocacy like the RTI Act. The women also seem to have a clear understanding of the inter-sectorality of various issues. When asked specifically what PDS or NREGS had to do with health, the women clearly identified them as underlying determinants of health.

Women have used the knowledge gained from these capacity building sessions extensively in their own villages. For example, in many villages, women have, after understanding their entitlements under the JSY scheme, demanded that they get their complete quota of cash assistance. Similarly, in many villages, women have started monitoring the quality of food served to children under the ICDS and mid day meal programmes. In one village the evaluator visited, one of the MSAM members who was also a victim of domestic violence had used the knowledge regarding the Domestic Violence Act she had gained from the training sessions to fight a legal battle against her marital family members.

Women also seem to have interwoven their understanding of these different aspects when planning and implementing action. For example, the RTI Act had been used extensively by women of the Manch in various districts to get information regarding their entitlements and this was then used as evidence for further advocacy. Women in one village, when faced with corruption in their PDS shop, complained to the concerned superior officer about it. But when no action was forthcoming, they have petitioned under the RTI Act asking information about action taken on their complaint. Similarly, women in many districts have used the RTI Act to find out information on how the Untied Funds allocated at various levels under the NRHM have been used.

Grassroots women also talked about attitude change that came about as a result of the capacity building . While most women talked about how the increased knowledge had led to increased self confidence, many women also talked about how various games and activities during the training had made them understand the strength of collectives over individuals. .

samajh aaya ki ekjuth rahenge to kuch bhi kar sakte hain. (We understood that if we stay together, we can achieve anything) - MSAM member, Jogibir, Kushinagar

hamari samasya hamara faisla rahega (We understood that we ourselves need to find solutions for our problems) - MSAM leader, Dhadha, Kushinagar

In addition, women seemed to place great value on their visits to the district headquarters and state capital Lucknow as learning experiences. Interactions with various stakeholders at various events organized in these places contributed to their deeper understanding of issues related to maternal health care, and enhanced skills in advocacy.

Some women had also been taken on an exposure visit to SUTRA , an organization working on women's health in Himachal Pradesh. But the women from UP seem to have perceived that the situation of women in HP was very different from their own and did not seem to think they had gained much from that visit.

Thus, in summary, women's capacities have been built in various issues around maternal health and programmes addressing its broader determinants, and women have used the knowledge in both monitoring and advocacy for better health care. However, the evaluator observed that maternal health was addressed only from a health care and health system perspective during the capacity building. Social determinants of maternal health like gender, caste, poverty had not been addressed in the training. Neither did women seem to work on these broader determinants towards maternal health. In one of the examples quoted above, a woman member of the Manch talked about violence in her own home and how her husband was supportive now. But the women had not initiated action collectively on domestic violence in their communities. Although one woman member who had faced violence herself had gone to court, this did not seem to be reflective of the broad views of the women and violence was still spoken of as if acceptable. Unless women are able to understand the social determinants of their health, they would end up only fighting with the system without tackling community level problems that contribute to poor maternal health and bringing in deeper social change.

There is also a need to delineate the areas where MSAM women clearly have insufficient knowledge and should not intervene.ⁱ More inputs into technical knowledge need to be given. It also highlights the need to regularly review the interventions that the MSAM women are making.

Presently, since the MSAM is functioning in only 11 districts, SAHAYOG has been able to contribute directly to the training sessions of the women. However, given the vision to expand this to further districts and given the logistics of staff turnover in both SAHAYOG and the partner NGOs, it may be useful to invest in a well-defined training module that even a trainer with a little experience may be able to use in the field. This will contribute to ensuring that the standard of the training is uniform all over the

various districts.

Review of capacity building module

A few of the capacity building modules in Hindi were shared with the evaluator - these included the module on the rights framework of safe motherhood and the one on advocacy.

The module on the rights framework includes sections on –

- a. what is safe motherhood,
- b. the current situation of maternal health,
- c. what are rights,
- d. what are the rights related to safe motherhood,
- e. where do we get these rights from,
- f. what are the reasons for non fulfillment of these rights, monitoring these rights.

In the section on what rights are, the example used is gender discrimination of the girl child in a household - this is then explained as a rights violation of the girl child. From here, an introduction to the concept of rights is extrapolated. The section on where these rights are got from makes a comparison of the state to a benevolent king, and how a state has the duty to bring in welfare measures like that of a benevolent king. In the next section on what rights are not fulfilled, there seems to be an overlap in the use of language where the word rights and facilities at government health institutions are used interchangeably.

It is stated that this module is used for training of grassroots women in the rights related to safe motherhood. Given that grassroots women would come from a background of imbibed patriarchy, challenging a deeply ingrained norm like gender may not be accepted at the first sitting - there need to be several attempts before such attitudinal changes can be brought. Having worked with rural women on health from a rights based framework, the evaluator feels that using such an established social norm to introduce the concept of rights may be confusing. It also runs the danger of the concept of rights being dismissed along with the one on gender. Similarly, the example of the benevolent king makes the concept of rights look like a dole out from the state unlike a duty that it has to fulfill. Also, the concept of inalienability of human rights for every human by virtue of his/her being a citizen of a state and a s a basic aspiration of every human for social justice is not brought out clearly. The evaluator did not have the opportunity to witness a training session directly, thus how the module plays out in real life is not clear.

While the initial idea was that SAHAYOG would train the partner NGO who would in turn train the grassroots women, in actual practice, SAHAYOG staff have been involved in all the trainings of grassroots women directly along with the partner NGO. The topics of these sessions according to the SAHAYOG team, has largely been need based depending on requests from partner NGOs and the Manch women.

Other related areas

Challenges faced by women in organization building

MSAM now has over 8000 members spread over 11 districts. According to SAHAYOG's documents, majority of these women are from socially marginalized sections like dalit,

tribal and Muslim. One aspect that the evaluator looked at was the challenges these marginalized women faced while organizing themselves into a collective force and what further support they would need in this aspect.

When specifically asked if they had faced difficulties on account of their gender initially, most women from the Manch replied in the affirmative. One woman who is an active MSAM leader, shared that she had never stepped out of the gate of her house before joining the MSAM. In a patriarchal society where women were expected to be home bound, their attending meetings etc was not looked upon kindly - they were even called 'loose women'. Some women said they also had to face physical violence at home when they went out for meetings.

pehle to lathi padte they (I used to be beaten with sticks initially) - MSAM member, Puranya, Mirzapur

Now, the situation is totally changed. Panchayat leaders approach them for support. The husband of the woman who quoted she was beaten brought her on a two wheeler to the meeting with the evaluator and sat through the meeting - in fact, he smiled sheepishly when she mentioned the violence. Men in their households are now actually interested in knowing what activity the MSAM women are engaged in. As one woman put it

afvah se hi vijay ka jhanda lehrata hai (The flag of victory is unfurled from rumours) - MSAM member and ASHA, Baldihan, Kushinagar

Women shared that their collective energy helped them keep at it. Some women who were more proactive served as role models for others. They also worked as 'entry agents' for expanding the partner NGO's work in particular villages.

Caste also seemed to play a role in the village dynamics. In one village, women shared that the higher caste group women did not join the Manch. According to them, these women had the wherewithal to access private hospitals for health care and therefore did not need to be a part of the struggles of the poor women. According to a staff of the partner NGO working in the area, there was initially opposition to the Manch's work from higher caste groups as it was seen as challenging power hierarchies. But now, since the Manch has large numbers and has achieved tangible results through its actions, they do not face active opposition any more, but there is no support either.

The evaluator also tried to probe to what extent the leaders of MSAM had been able to influence other women from the community to join their struggle. In one district, the staff of the partner NGO shared that women from villages where the Manch had not been formed were requesting Manch women that they be allowed to join the Manch. In one village in another district, women leaders of the Manch shared that they tried to talk to other women in the village and motivate them to join the Manch. While some 'aware' women did get influenced by the MSAM results and agreed to join, many women said they were already too caught up trying to make ends meet with no time to get into social action.

auraten jo samajhdar hain boltin hain hamko bhi sadasya banao, hame bhi mile iska labh kaafi kuch auraten kahti hain isse kya labh milega, kaam se fursat nahin milta, hame nahin jana (The women who are intelligent say we too

want to become members, so we can get the benefits too but quite a few women say what will we get from this, we don't get time off from work, we don't want to go) - MSAM leader talking about other women's reactions when asked to join the Manch, Baheri, Banda

According to documents of SAHAYOG reviewed by the evaluator, the women of the Manch had been given identity cards as members of MSAM - this was to give them a collective identity when negotiating with local leaders and officials of the system. But except in one village, none of the women the evaluator interviewed seemed to have these cards. In some places, the card had been retained by the partner NGO. In some, since the card was made of thick paper written with ink, the card had gotten soggy when wet and the ink had been washed off.

The SAHAYOG team also shared that efforts were now on to put in a democratic organizational structure within the MSAM. Leaders would be nominated at the village level and subsequently they will be federated at block, district and state level with leadership nominated at each level. There were also plans to rotate this leadership periodically in order to widen the base of MSAM. In one district the evaluator visited, issue specific leaders had been chosen at village level - one each to work on health, NREGA, PDS, ICDS and mid day meal - it was hoped that they would motivate more women to join them and focus energies on the particular issue.

Case documentation

SAHAYOG with help from partner NGOs and the grassroots women has been documenting cases of violation of maternal health rights - these are then used as evidence during advocacy with both media and policymakers to focus attention on the poor quality of care.

The evaluator was given some of the reports containing such case documentations for review. While a wide variety of types of rights violations have been documented, the standard of documentation was not uniform. Some of the documentations seemed to lack objectivity in terms of technical aspects of the cases. An excerpt from one of the cases is as below.

Suman told the nurse that she was still conscious, but they compelled her to lie on the operating table, scolded her when she protested and hit her when she started to cry. Suman felt them pull her legs and tie them, tie her hands and put a noose around her neck, while filling air in her ear. When they took the child out, she felt strong pains and her tongue rolled out. The doctor who was putting in stitches said, "Seems the patient is dead." Suman felt another wave of pain, and the doctor put in the stitches so hurriedly that they got infected.

While "tying of the legs" and the "noose around the neck" mentioned in the operating theatre may be the actual words of the woman and reflect her acute distress with her interactions with the health staff, these may be interpreted to actually be restraints normally placed on the legs and an oxygen tube around the neck used during such procedures. Using such words without clarification may detract from the veracity of the rest of the documentation and its acceptance by officials of the system.

The SAHAYOG team had shared that one of the challenges they face is inadequate technical knowledge during case documentations. It may be worthwhile building the

capacities of the team in this aspect. Also, the use of standard formats for case documentation, for eg. the verbal autopsy format of WHO, may be considered.

Review of documentary films

The evaluator received copies of 2 documentary films made by SAHAYOG - Citizens without Rights and Mother Courageous. These films have been made in Hindi with English subtitles to sensitize various constituencies on the issue of maternal health.

Citizens without Rights recounts the story of three different women who have experienced violations of their rights regarding health care - one, a woman who needed treatment after a miscarriage and was refused services in various government hospitals, two, the story of a woman dying during childbirth because of mismanagement by an unqualified provider and three, a woman who developed complications after family planning surgery. While the details of these three cases have been presented clearly, the story of the other side, the providers and the system, is absent. Also, some of the quotes target individuals rather than systems. For eg.

ek jola chhap doctor ne ek mahila ko maar diya (A quack killed a woman) - Comment on the second case

Doctor ne case kharab kar di (The doctor spoilt the case) - Comment on the third case

The second film, Mother Courageous, made after this earlier film but by the same film-maker, has addressed the above issues well. Interviews with officials from the health system bring out the apathy of the health system very well. The struggle of grassroots women for justice is also delineated vividly in this film.

NGO network's contribution/support/challenges

SAHAYOG has been working on maternal health issues in Uttar Pradesh from a rights based framework for over a decade now. The MSAM programme is implemented through partner NGOs selected in 11 districts. The evaluator tried to understand the contributions of SAHAYOG, the larger network Healthwatch Forum (HWF) and the partner NGOs to the MSAM programme, the various challenges faced and also support required / given. These were mainly done during discussions with the team at SAHAYOG and with staff at various partner NGOs.

SAHAYOG's team

SAHAYOG has a dedicated team working on maternal health issues. Presently, this consists of the Assistant Coordinator, 3 programme persons and one person from HWF working on case documentations. On discussions with the SAHAYOG team, it was understood that they have been facing a problem of high staff turnover with some senior, experienced staff leaving recently. This has resulted in a small team taking on the large responsibility of handling issues related to MSAM in addition to state level advocacy.

To a specific question on capacity building of the team, it was shared that this was mainly through internal orientation programmes and learning from participation in various events organized by SAHAYOG. In addition, some staff members had been

sent for training programmes on human rights, advocacy etc.

In addition to working through partner NGOs at the district level, the SAHAYOG team coordinates state level advocacy activities. This involves networking at the state level with Healthwatch Forum, organizing state level dialogues and campaigns, working with the media at state level and interacting with policy makers and programme planners.

Responding to a specific question, the team at SAHAYOG felt that the programme had changed their own perspectives over the years - earlier, they could only see the negative aspects of the health system, but now are able to appreciate small positive changes as steps forward. While earlier, they felt rights had to be snatched (*Cheenna padega*) from the state, they can now see the value of negotiations with the system. When asked if the systemic problems sometimes caused frustration in the team, they responded that even small changes seen as a result of their action encourages them to keep going.

To a specific question on the challenges faced by the team, the following were listed:

- The extreme political control of the bureaucracy that causes undue delays and problems in programme implementation
- Interactions with providers often turned confrontational - there was a need for NGOs and MSAM to internalize that negotiating with the system may be more fruitful rather than confronting.
- While the team was engaged in documenting cases of rights violation in maternal health care, very often, lack of concrete evidence in these cases hampered further progress in grievance redressal. Also, the team lacked the required technical knowledge for appropriate documentation of such cases.
- Inadequate human resources and high staff turnover - this also resulted in inadequate time for carrying out the work.
- Working with the differences in each of the partner NGOs - there were differences in the NGO's skills in negotiating with the health system. While some partners were better at negotiation with the government system, some continued with their history of confrontational strategies. However, the SAHAYOG team shared that they saw partner NGOs moving significantly from service delivery to a rights based approach. They also felt the partner NGOs were able to dialogue better with the system now compared to the earlier mode of constant confrontation.

Partner NGOs Perspectives

SAHAYOG works with eleven different partner NGOs in the various districts for the MSAM programme. The evaluator visited and met with 3 of the partner NGOs during the course of the field visits. These were

1. Purvanchal Grameen Seva Samiti, Kushinagar
2. Shikhar Prashikshan Sansthan, Mirzapur
3. Tarun Vikas Sansthan, Banda

All of the above NGOs had been involved with SAHAYOG's maternal health programme from before the formation of MSAM in 2006.

The criteria for selection of a particular NGO as the partner NGO according to the SAHAYOG team were the following:

- Rights based work
- Work on gender based issues
- Women's leadership in the organization
- Transparency within the organization
- Work with socially marginalized groups
- Geographic location of the group

Each of the partner NGOs has its own history of work prior to its association with SAHAYOG's maternal health care programme. *Purvanchal Grameen Seva Samiti (PGSS)* is a church based organization working in 7 districts including Gorakhpur and Kushinagar. This organization has been working for 24 years on empowerment of the communities and has consciously stayed away from charity based work. The organization has a history of forming *Mahila Mandals* in the villages to involve women in social issues and action. The *Shikhar Prashikshan Sansthan* in Mirzapur has a history of more than 10 years of work in the area - they have been involved in organizing women into self help groups and working with miners and forest dwellers against bonded labour and for forest rights. Similarly, the *Tarun Vikas Sansthan* in Banda has been working in the area for nearly a decade - while their work initially involved land rights of the poor, they have also been involved in organizing women into self help groups and working with adolescents.

This earlier history of the partner NGO seems to have influenced in a large way the functioning of the MSAM in the districts. For eg, the long history of Mahila Mandals supported by PGSS in Kushinagar seemed to have given the women a perspective on social issues that has resulted in women's leadership in several issues. Eleven ASHAs in the district are in fact members of the Manch. The partner organization also has a history of collaborative work with the government - in Gorakhpur, the partner NGO supports the NRHM through ASHA and VHSC training. In Kushinagar, the partner NGO is an invitee in the monthly meetings of the CMO with ANMs and ASHAs - this has created a space for Manch leaders also to sit in on these meetings.

On the other hand, in Mirzapur, where the terrain is more difficult and the system seems to be more unresponsive, the partner NGO has a history of being more confrontational. Here, the women's language and attitude to the system seems more antagonistic rather than based on negotiation. In Banda, the partner NGO seemed to be making efforts to develop consensus processes towards issues - ANMs were invited to meetings of the district Forum, and these meetings were conducted as often as required. .

Differences were also seen within districts based on some factors within the health system. Where the officials were more responsive, or where the District Programme Manager (under NRHM) had an NGO background and shared a good rapport with the partner NGO, the MSAM members were better able to conduct negotiations. The SAHAYOG team shared that in one district, Muzaffarnagar, because of the positive response from one particular PHC Medical Officer, the MSAM members had been able to bring about a lot of change.

Each of the partner NGO has participated in capacity building programmes run by SAHAYOG. In addition, SAHAYOG undertakes a supportive supervisory role through

quarterly reporting from the partner, and quarterly Partner meetings where challenges and achievements are shared and future planning done. SAHAYOG has also signed a partnership MoU with these NGOs and provides some minimal financial support for the MSAM programme activities.

In discussions with the various partner NGOs, the staff specifically shared that while each of them had been already involved in organizing women around various issues, working with SAHAYOG had given them a much clearer and sharper focus on health and specifically maternal health. They also rated highly the capacity building sessions they had received through SAHAYOG especially the ones on advocacy and case documentation. The opportunity provided to village women through SAHAYOG to interact with policy makers at the state level in Lucknow was seen as another very positive contribution to the women's confidence. The half-yearly meetings where MSAM women from 11 districts came together to share what they had done, was seen as a great opportunity for cross learning. One partner NGO staff specifically mentioned that they found the attitude of the SAHAYOG team extremely non-hierarchical and supportive, with a lot of space provided to voice differences and difficulties.

Regarding specific challenges they faced, the partner NGOs shared that funding and human resources were inadequate to take the programme forward in its natural course - very often, when they got a request from distant villages for case-documentation or expanding the Manch, the organizations were not able to fulfill these due to resource constraints. A specific request was for SAHAYOG to identify other sources that could be approached by the partner NGOs for funding support. Other requests were for more training in health and development related issues, and a system of communication of recent developments in policy and planning to the field, so that grassroots women could understand and participate in a programme at the planning phase itself.

Conclusion

It has been three years since the Mahila Swasthya Adhikar Manch has been formed. While SAHAYOG's work on maternal health predates this by several years, the present evaluation was to understand to what extent the formation of the Manch has been an effective strategy in promoting women's right to health care in Uttar Pradesh.

During the course of the field visits to 3 different districts in Uttar Pradesh, the evaluator met with grassroots women of the Manch and several other key players. From these interactions, it seems clear that in the short period of 3 years, the Manch has been able to bring attention to the issue of maternal health care in Uttar Pradesh and also change attitudes towards this situation as being unacceptable. The Manch leaders have received capacity building on the rights framework and also on their various entitlements related to health and programmes addressing its broader determinants. They have been able to articulate at various levels with both their local leadership and the health system the poor state of public health care services and the lack of accountability of both public and private health services. They have also been successful in some cases in negotiating for improvement in existing services. The Manch members have also taken this negotiation to a wider level where they have been able to act for their entitlements in programmes that address broader determinants of health.

Members of the Manch have also participated in gathering evidence for their advocacy through identification of cases of violation of health care rights and also through gathering information on health care entitlements like the use of untied funds and household expenditure on health care. They have also participated in dialogues and campaigns, at district and state level, on the poor state of maternal health care in Uttar Pradesh.

While women have thus been successful in negotiating for better health care at various levels, very often, their stance towards the system seemed confrontational. SAHAYOG and the partner NGO work from a very strong rights perspective - while women of the Manch speak the language of rights, a deep understanding of the rights framework does not seem uniform beyond the leaders of the Manch.. Women also seemed to be unable to envision a larger systemic change in the future and strategize towards this.

While women viewed their collective strength as important in their struggle for maternal health care, they have faced struggles arising from gender and caste discrimination in the initial stages of such organization. The natural leaders among women in the community seem to be actively involved in the Manch; the challenge now is to involve other women in the community in the Manch.

Overall, the Manch has achieved more than what would be expected realistically in three years' time. The women's enthusiasm and earnestness in their quest to realize their rights amid extremely adverse circumstances was a privilege to witness.

CHAPTER THREE: RECOMMENDATIONS FOR THE FUTURE

It is now three years since the Manch has been formed. Almost everyone the evaluator met including the team at SAHAYOG, the partner NGOs and the grassroots women seemed to agree that the issue of maternal health had started getting some attention and there was a need to expand the programme further, both within the eleven districts where the programme is functioning now, and to other districts.

The SAHAYOG team and partner NGOs envision the Manch developing as a movement, a Sangathan, an independent pressure group without the umbrella of the NGOs, with only technical support from the NGOs. As of now, both partner NGOs and the women have expressed that they need more capacity building on various development related issues, and also skills in monitoring and advocacy. Thus, it seems likely that SAHAYOG will have to provide both technical and financial support to this programme at least for the next 5 years.

Presently, the programme is funded as part of the WHRAP project by DANIDA - ARROW with supplementary grants from AJWS. Both the team at SAHAYOG and various partner NGOs saw the human resources and funding available as insufficient. Also, one partner NGO shared that women of the Manch have expressed that they would like to be paid an honorarium for the time spent by them on monitoring and advocacy activities. As the Manch spreads wider, such requests are only bound to increase. While there is a need for poor women as rights holders to struggle for their rights, one also has to give credit to the compulsions of their daily lives and livelihood. Thus, SAHAYOG will soon have to do a balancing act between voluntarism and financial support for these women who struggle.

Recommendations

Based on the findings of the evaluation as described earlier, a few recommendations are hereby suggested that would help the Manch attain its goal of using collective women's voice for focusing attention on women's health.

Consolidate and Deepen base

The MSAM which started initially in 5 districts has now spread to 11 districts. Both SAHAYOG and the partner organizations and the grassroots women themselves envisage expanding this to further districts. At present, within each district MSAM functions in a few villages with a membership ranging from 500 to 2000. It is well known that women with existing leadership skills, the "outliers", will be the first to make use of any opportunity that comes their way to make a difference. With MSAM too, it seems that the first phase has attracted such women with leadership and organizational skills. The second phase, in addition to focusing on expanding horizontally to other districts, must also make special efforts to involve more women from the community in the villages and districts where MSAM is already active. This will help give it the critical mass necessary to bring about systemic change.

Inculcate a deeper understanding of rights framework

While SAHAYOG and the partner organizations have a very strong 'rights perspective' guiding their work, the grassroots women's understanding of rights seems to lack such depth. The rights training module needs to be made stronger and include

aspects such as the roles of the state and non-state actors. Also, leaders of the Manch seem to have internalized the rights perspective better through extensive interaction with the SAHAYOG team and other key players at district and state level. SAHAYOG's plan to democratize the MSAM's organizational structure and rotate leadership may expose more women to the rights framework actually in action and thereby help with the objective of increasing the rights understanding among the women.

Develop a health system perspective in MSAM members

The MSAM members have taken action at village level on various issues including health care services, NREGA, PDS and ICDS. They have also negotiated for improvements at the local PHC / CHC level in terms of human resources and facilities. But overall, the women do not seem to be able to see the full potential of a functioning public health care system. This has in some places resulted in the women targetting individual personnel within the system rather than negotiating for systemic changes. SAHAYOG has facilitated the visit of the women to another women's organization to understand and learn how women can organize themselves effectively for change. A similar strategy, but perhaps to a place with a well functioning public health care system, (for eg. one of the southern Indian states), could provide some exposure to the myriad possibilities of such a system. This would then hopefully help them develop a larger long term vision and build strategies towards reaching it.

Broaden capacity building of Manch women

Capacity building for Manch women so far has included details of their entitlements from the public health system and ancillary programmes. In the next phase, more focus needs to be paid to women's capacity building on social determinants of health. Inputs are needed into how gender, caste, poverty etc affect women's health. Women's knowledge on some technical details of maternal health also needs to be increased.

Promote convergence of Manch with Panchayat Raj Institutions and spaces within NRHM

Some of the Manch leaders when spoken to seemed to have ambitions beyond the Manch - while one person said she was being asked to contest the local Panchayat elections, a few have already become ASHAs in their area. It is inevitable that when women's leadership skills are honed, they will occupy available spaces for such leadership. This has also been the experience in similar programmes in other states. This could also be a positive way in which women actively engage with the system. SAHAYOG needs to be aware of such possibilities and support the women in their endeavour for such leadership, be it in PRIs, as ASHAs or in VHSCs.

Develop a defined training module

So far, SAHAYOG has been making an effort to be directly involved in all trainings at the grassroots level. While partner NGOs have been trained by SAHAYOG, frequent staff turnover has been affecting their functioning too. With the MSAM set to expand to more districts, it seems unlikely that SAHAYOG would be able to directly involve itself in training as it did earlier. Investing in a module for Training of trainers and a training guide for grassroots women will help standardize the quality of training. It will

also help staff of the partner NGO in carrying out training sessions for grassroots women independently of SAHAYOG.

Build second line leadership in SAHAYOG and partner organization

Both SAHAYOG and partner organisations have been facing frequent staff turnover including of senior, experienced staff. The present team at SAHAYOG faces a human resource crunch with young staff members having to take on the load of capacity building and supportive supervision of the partner organisation and the Manch. Innovative means of attracting and developing young staff members who would be able to take on a second line leadership position have to be considered. A fellowship programme for early - mid career individuals, on the lines of those offered by a few organisations, may be one way of bringing in such persons. Capacity building of new staff through a structured programme also needs to be considered.

Increase technical knowledge in staff and standardize format for case documentation

Staff at SAHAYOG have expressed that their technical knowledge for appropriate documentation of cases of healthcare violations is inadequate. This is also reflected in some of the case documentations the evaluator scanned . Specific efforts at increasing such knowledge among staff of both SAHAYOG and the partner organisation need to be made - external resource persons or experts may need to be called in for this. In addition, standardization of documentation methodology on the lines of existing standard formats like the WHO verbal autopsy format may be useful.

Inculcate a systemic perspective in the media

Both the media advocacy evaluation report provided by SAHAYOG and interaction with one representative from the media suggested that while media coverage of maternal health care as an issue has increased, a deeper systemic perspective seemed to be lacking in the coverage. Such a perspective needs to be inculcated within the media as part of SAHAYOG's continuing work with it. Also, highlighting through the media examples of positive deviants within the health system, like the PHC medical officer in Muzaffarnagar, may be a useful strategy to promote change.

Financial sustainability

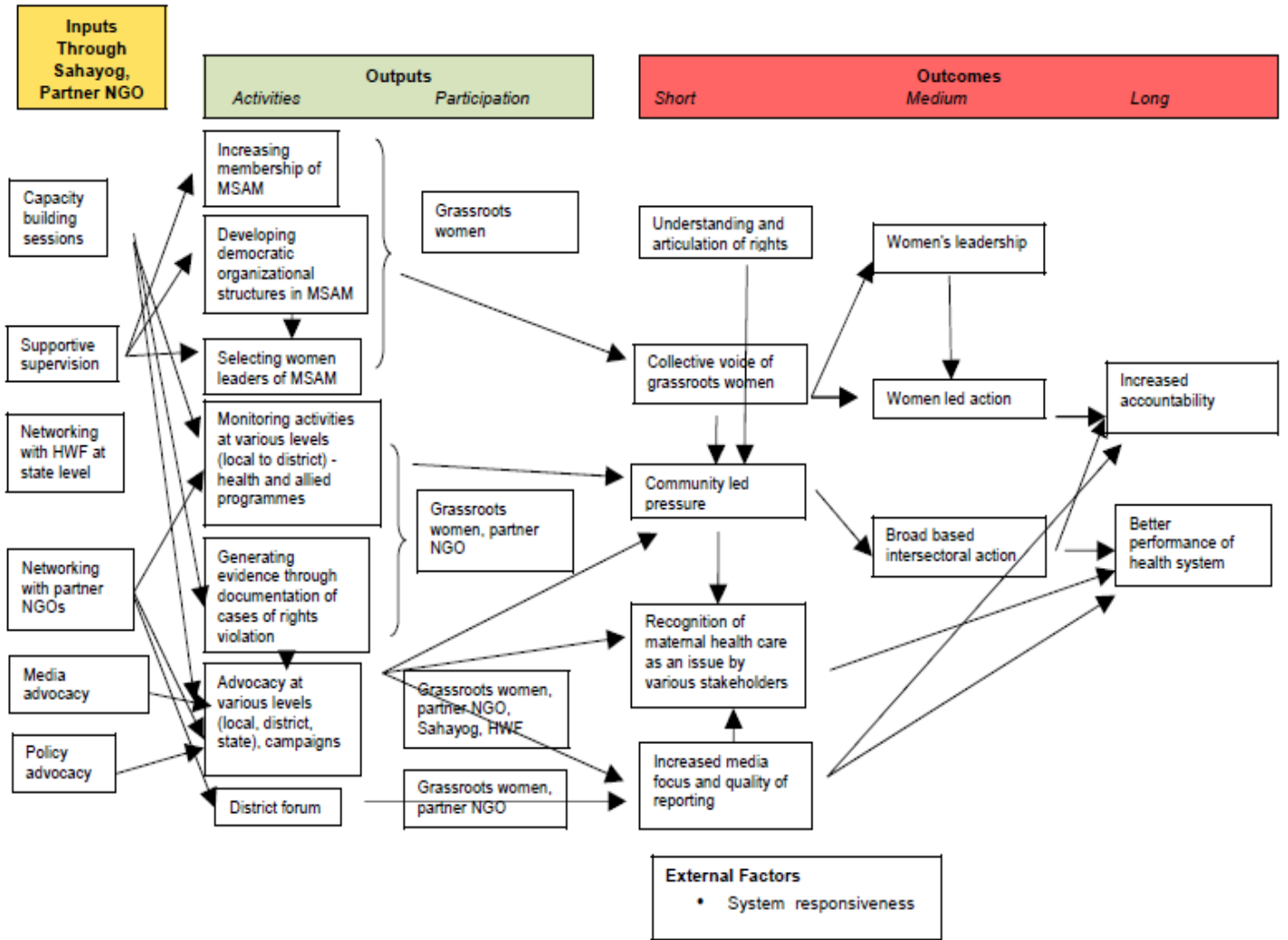
While the team at SAHAYOG wants to see the Mahila Swasthya Adhikar Manch evolve into an independent movement, it looks like a lot of capacity building and supportive supervision will be necessary for the next few years. Also, how effective will voluntarism be when poor women have to fight for their rights amidst their struggle for daily livelihood, is a question that will be answered with time. Women are already voicing demands for time compensation for their monitoring and advocacy work - such demands are bound to increase with expansion both horizontally and deeper of the Manch. Also, such expansion will mean investing in increased human resources both at SAHAYOG and the partner organizations. Therefore, plans for sustaining the programme financially need to be made realistically for the next few years.

Annexure - 1

Logic Model

Programme: **Mahila Swasthya Adhikar Manch**

Situation: **High maternal mortality in Uttar Pradesh, No lack of accountability, Poor health care system**



Annexure - 2
List of people met during the field visits

Date	Place	People met
22/12/09	SAHAYOG, Lucknow	Shakuntala Joshi, Mamta, Ekta, Ankita, Tithi (Team members)
23/12/09	Purvanchal Grameen Seva Samiti, Gorakhpur	Father GPN Jose (Director, PGSS)
	CHC, Hata, Kushinagar	Dr Sudarshan Sonkar (MO in charge), Seema Singh (ASHA, Dadha Panchayat)
	Jagannath tola, Gopalpur, Kushinagar	Chandrakesri Gupta (ANM), Savitri Devi (ASHA)
	PHC, Sukroli, Kushinagar	Dr Manisha Tiwari (MO)
	BDO Office, Sukroli, Kushinagar	Babban Upadhyay (BDO)
	Dhadha Bujurg, Kushinagar	Chhedi Yadav (Pradhan), Sabira Khatun (MSAM leader), Noora, Kunta, Mehrunnissa, Buddha Devi, Khairunnissa, Fatima, Munni (MSAM members)
	PGSS, Kushinagar	Surendra Singh (Pradhan, Dumri Malaon)
24/12/09	PGSS, Kushinagar	Sudha Rao, Girija Tiwari (Partner NGO staff), Arud Kumar Sahi (Lawyer, Member of District forum)
	Baldiham, Dhadha, Kushinagar	Bela Devi (ASHA)
	Thithila, Dhadha, Kushinagar	Surjawati, Nirmala, Kamlavati, Shubharti, Ramraji, Draupadi, Sademi, Panmati (MSAM members), Phoolmati (ASHA)
	Jogibir, Badiyan bujurg, Kushinagar	Pushpa, Kailasi, Kismati, Rajeswari, Anita, Saifunnissa, Nirmala, Manorama, Sursati, Vasanti Devi (MSAM members), Pyari (Community woman, not MSAM member), Mother in law of Sumitra (Woman who had a maternal death)
25/12/09	Shikhar Prashikshan Sansthan, Chunar, Mirzapur	Sandhya (Partner NGO staff)
	Puranya, Lahaura, Mirzapur	Kaila Devi, Gangajali, Manju Devi, Ranno Devi, Kishan Devi, Dulari Devi, Shivkumari, Khudwari Devi, Mankesra, Urmila, Jatila Devi, Munni Devi, Geeta Devi, Susheela, Parvati, Buddhan Devi, Amravati Devi, Kesra, Jhamman (MSAM members), Geeta, Sadaphal, Jwalaprasad Singh, Sunil (Partner NGO staff)

27/12/09	Nunoti, Mirzapur	Geeta Devi (ASHA), Asha Devi (Pradhan)
	Tarun Vikas Sansthan, Badausa, Banda	Uma Kushwaha (Partner NGO staff)
28/12/09	Baheri, Banda	Bimla Devi, Kalavati, Asha, Phoola (MSAM leaders) Ranjana (MSAM member), Ramdevi (Community woman, not MSAM member), Ramnaresh, Archana (Partner NGO staff)
	Udaipur, Banda	Ketiya (Pradhan)
	Subcentre, Badausa, Banda	Krishna Mishra (ANM)
	Dhuariya, Banda Tarun Vikas Sansthan, Banda	Nathiya, Chameliya (MSAM members) Riyazuddin (Media person - Hindustan), Ramnaresh (Partner NGO staff)
29/12/09	SAHAYOG, Lucknow	Shakuntala, Ekta, mamta, Ankita, Tithi (Team members)

Annexure - 3 ***Abbreviations***

MMR - Maternal mortality ratio
ANM - Auxiliary Nurse Midwife
FRU - First Referral Unit
NGO - Non governmental organisation
CBO - Community Based Organization
PHC - Primary Health Centre
CHC - Community Health Centre
CMO - Chief Medical Officer
MLA - Member of Legislative Assembly
ASHA - Accredited Social Health Activist
PDS - Public Distribution System
RTI - Right to Information
NREGS - National Rural Employment Guarantee Scheme
ICDS - Integrated Child Development Scheme
JSY - Janani Suraksha Yojana
NRHM - National Rural Health Mission
WHO - World Health Organisation
PRI - Panchayati Raj Institutions
VHSC - Village Health and Sanitation Committee

ⁱ For example, an MSAM member narrated an incident where a relative of hers had been advised a caesarean section in a government hospital after having been admitted with premature rupture of membranes. The MSAM member decided that the caesarean was unnecessary and took her to another private hospital and requested the doctor there to conduct the delivery normally, saying she would pay extra in that case. Subsequently, the woman delivered normally and mother and baby were fine. While the MSAM member's actions may be explained by the high number of unnecessary caesareans taking place now, she seems to have taken the decision without adequate technical knowledge. While in this particular instance the outcome was good, this could have proven dangerous.