

# Accountability in the delivery of maternal and infant health services: Nazdeek's approach to fight maternal and infant mortality

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## ORIGINAL

### Introduction

**Nazdeek is a legal empowerment organisation based in Delhi, India. Nazdeek works with communities in Delhi and Assam (north-east India) to demand accountability in the delivery of essential services, including maternal health care, housing and food. The following article describes Nazdeek's strategy, fusing training and community mobilisation with public interest litigation and advocacy.**

Access to health care is a fundamental right every human being is entitled to.

Framing health as a human right has specific repercussions on people's everyday lives. It means, first of all, that everyone must be ensured access to essential care regardless of their gender, ethnicity, economic status, sexual identity, age and so on.

International human rights laws, including the *Universal Declaration of Human Rights* (United Nations (UN) General Assembly 1948), the *International Covenant on Economic, Social and Cultural Rights* (UN General Assembly 1966), the *Convention on the Rights of the Child* (UN

General Assembly 1989) and the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) (UN Women 1979), as well as a number of laws and national constitutions, including the United Nations Human Rights (2004), spell out a country's State duties and obligations to ensure basic standards of care. This includes access to emergency obstetric care and receiving other life-saving treatment, such as blood transfusions, medicines, and qualified medical attention. International and domestic laws also recognise the prime role States play in ensuring people have access to basic health care. Specifically, States have a proactive duty to take progressive steps to, 'the maximum of [their]



Participants of EndMMNow project

available resources' (UN General Assembly 1966), to ensure the 'highest attainable standards' of health (UN General Assembly 1966). As a result, States are the primary respondents or, 'duty-bearers', to provide people with access to health care, especially those who are marginalised. This aspect crucially ensures legal protection for those who have been left out by the system.

### The right to health care in India

In India, the right to life is protected under Article 21 of the *Constitution of India* (1950) and has been interpreted to encompass various rights and protections including the right to health care and access to food. Indeed the Supreme Court has proclaimed:

*'the right to life in any civilized society implies the right to food, water, shelter, education, medical care and a decent environment. These are basic human rights known to any civilized society. The civil, political, social and cultural rights enshrined in the Universal Declaration of Human Rights and Conventions or under the Constitution of India cannot be exercised without these basic human rights'* (Chameli Singh v State of UP [1996] 2 SCC 549).

Five years ago, the Delhi High Court (Laxmi Mandal v Deen Dayal Haringer Hospital & Ors [2010]) expanded the right to life provisions to include the right to safe motherhood, recognising maternal death as a human rights violation.

In addition, because reproductive health services are primarily needed by women, the Indian government's failure to remove barriers blocking women's access to these services is a violation of women's right to nondiscrimination and special protection under Article 14 and 15 of the *Constitution of India* (1950).

Based on these legal obligations, the government enacted policies and programmes to curb maternal and infant mortality rates and guarantee universal health care. The main umbrella scheme providing a range of health care and food entitlements for pregnant and lactating women and their children is the National Rural Health Mission (now National Health Mission, (NHM)).

Under the NHM, pregnant women are entitled to a number of benefits, including free antenatal check-ups, free ambulance transport to and from the health facility, cash assistance after delivery and incentives to encourage hospital delivery. In recognition of the crucial link between nutrition and safe pregnancy, the NHM also provides for supplementary nutritious food and iron tablets.

However, as outlined below, insufficient budget allocation, weak implementation of policies and poor monitoring and oversight have resulted in gross violations of health rights.

### Shifting the focus on accountability

As is the case with other socio-economic rights (UN General Assembly 1966), health care is not only a right but also a commodity. This can pose a serious threat to the right to access health care for the poor. While the expansion of the health care industry in India has undoubtedly improved the availability and delivery of health care, privatisation (including through private-public partnerships) has led to States delegating their obligations to provide health care. And too often, with States withdrawing from their 'traditional' role, health care systems become less accountable to people.

Over the past few decades there has been an increase in privatisation of the health infrastructure, a trend that has affected both developed and developing countries. In some parts of the West, austerity measures are forcing States to reduce public expenditure by privatising essential, yet costly, commodities, such as health care. In developing countries, attempts to build solid and sustainable health infrastructures have been frustrated by questionable budget allocations and privatisation models imposed by international financial institutions (Bretton Woods Project 2014), donor agencies (Anderson 2014) and trade agreements (Hall 2015).

Despite an impressive annual growth rate of 6.9% (World Bank Group 2015), the Indian government spends a mere 1% of their gross domestic product on health care (WHO 2014).

Poor budget allocation has severely hindered the implementation of health policies. Indeed, despite its progressive legislation, India carries almost 20% of the global burden of maternal deaths (Anon 2014). Many health facilities, especially in rural areas, often lack equipment, staff, and the referral systems necessary to ensure safe motherhood and protect women and infants' lives. In urban settings the scenario is equally concerning. A recent report found that in Delhi, a capital city that:

*'boasts world class health care facilities,'* about '15% of children admitted to the hospitals' neo-natal and



Women in Balipara filed a complaint to access maternal health services

*pediatric ICU wards have died in the past five years. In some cases, the death rate has averaged 25%'* (Saxena 2015).

Amidst such egregious violations of their fundamental rights, women are too often unable to redress harm suffered. Access to mechanisms to ensure accountability for the delivery of essential reproductive health services is hindered at multiple levels. First of all, reproductive rights violations, including maternal and infant death, are often seen as fatal circumstances rather than the result of structural discrimination and rights violation. While the 'notion' of injustice is well understood, communities have poor awareness over their actual entitlements under the law. Secondly, communities lack ways to document and report violations of their rights to health care, including lack of access to food which can cause further unaddressed inequalities. Thirdly, existing remedies are either weak or not accessible to the poor. Administrative procedures, when actually functioning, are under utilised, due to poor literacy and legal awareness of right holders. Pro bono lawyers are often overwhelmed with cases who lack the financial and human resources to adequately tackle violations.

Reproductive rights violations are going unreported and unaddressed, which means the health system becomes unaccountable for those who need it the most.

### Reclaiming maternal health rights through a participatory approach: Nazdeek's work

Nazdeek is a human rights organisation working to bring access to justice closer to marginalised communities and individuals in India. Nazdeek believe that poverty and other related phenomenon such as maternal and infant mortality are the result of structural discrimination and rights denial. They also believe that community members are best placed to demand justice, while civil society organisations can facilitate the process but not drive it.

To advance maternal and infant health care Nazdeek works with communities to call on the State to adhere to its obligations to provide reproductive health care and ensure safe motherhood. The organisation has developed a range of strategies to identify, document, and redress reproductive rights violations:

#### a) Community monitoring and reporting on the delivery of health care through technology

Technology can be a powerful tool for community monitoring and oversight, offering cost effective solutions for data collection. In April 2014, Nazdeek, in partnership with the International Center for Advocates Against Discrimination (ICAAD) and the Promotion, Advancement, Justice and Human Rights of Adivasis (PAJHRA), launched 'End Maternal Mortality Now', a community reporting platform to document gaps in the delivery of health care in rural Assam (north-east India). The concept stems from 'crowdsourcing'. 'EndMMnow' allows volunteers to report incidents through coded SMSs. To date, about 40 Adivasi (indigenous) women have joined the programme. The coding system covers benefits women are entitled to under public health schemes, for issues such as, lack of free ambulance service, undue payments, inadequacy of health facilities (ie no electricity, water and toilets), lack of medical staff etc. Reports are mapped on a website (<http://www.endmmnow.org>), and data collected are periodically analysed and submitted to government authorities. An example of a report issued after six months of data collection can be accessed at: [http://issuu.com/endmmnow/docs/endmmnow\\_advocacy\\_final\\_press/1](http://issuu.com/endmmnow/docs/endmmnow_advocacy_final_press/1). EndMMNow has been well received by local authorities, who are committed to establishing Citizens Grievance Forums at Block level to address violations reported through the system.

#### b) Legal capacity building to address violations

EndMMNow volunteers also joined a legal capacity building programme of training sessions and practical field activities (such as ground documentation and advocacy work) carried out alongside Nazdeek staff. Training sessions, designed with participants, include an overview of domestic and international law on reproductive rights and related rights (food, water and sanitation), fact finding and documentation strategies, complaint drafting, administrative remedies and court processes and use of media for social justice.

#### c) Access to administrative complaints mechanisms

Through the capacity building programme, volunteers acquired skills and knowledge to adequately identify and document violations. Thanks to the EndMMNow platform, they are also able to map existing gaps in the delivery of health care. As a further step, community members can address these issues through existing administrative remedies. To do so, Nazdeek

assists women in filing complaints with relevant government departments to obtain access to maternal and infant health services. For example, in March 2015, women living in the Balipara Block of Assam filed several complaints regarding the failure of local Anganwadi centres (government-funded nutrition centres) to provide meals for pregnant and lactating women and children for almost six months. As a result, on 9 April 2015, 527 centres restarted the food distribution. Another filed complaint led to doctors visiting Anganwadi centres to weigh children and pregnant and lactating women and assess their health status.

In addition to complaints, volunteers have taken action, such as surveying the population in their respective areas, to demand an increased number of health staff, and formed women's committees that are pressurising local authorities to ensure subsidised food distribution and the appointment of skilled medical personnel.

#### d) Litigation

After exhausting administrative remedies, community members may recur to courts. Nazdeek supports community members with both direct legal counselling and links to local pro bono lawyers for assistance in filing court cases. Nazdeek also provides people with lawyers who have successful strategies in the litigation of reproductive rights violations, access to legal resource materials, and ad-hoc skills-building sessions on legal research and drafting. As a result, the capacity of local lawyers to address reproductive rights violation also increases, leading to more effective legal outcomes. In 2014, Nazdeek, assisted two pro bono lawyers and a group of activists in filing an individual case, *Rajesh Borah v Union of India & Ors* [2014], before the Guwahati High Court. The case concerns the maternal death of a woman at the local district hospital due to untimely medical care, particularly the lack of access to a blood transfusion. Currently pending before the Court, the lawsuit demands compensation for the family of the victim and the prompt implementation of NHM schemes, including the construction of a blood bank for the district.

#### Conclusion

Accountability is a central tenant of any health care infrastructure. It is crucial to ensure no one is left out by the system, especially the poor.

Nazdeek's grassroots work shows that when communities mobilise and organise to address reproductive rights violation, the potential for impact is greater and much more sustainable. Stressing the fact that health care is viewed as a human right before considering it as a commodity — and so must be treated this way by States — is an effective strategy to expand access to life saving treatment and ensure safe motherhood for all.

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