Namati Case Study – Nazdeek, India

Briefly describe the situation of the project you wish to feature as your case study:

With the highest number of maternal deaths in the world, India leads a quiet war against women. Ninety percent of these deaths are preventable, often caused by fatal delays in seeking and obtaining care. The North Eastern state of Assam leads the country with the highest maternal mortality ratio (MMR), and one of the highest infant mortality ratios (IMR) in India. These health indicators persist, despite the right to safe motherhood protected by the Indian Constitution and guaranteed under national laws and policies. Insufficient budget allocation, weak implementation of policies and poor monitoring and oversight contribute to a tragically high number of maternal and infant deaths.

These human rights violations are particularly prevalent for women hailing from Adivasi (tribal) communities who live and work in the tea gardens of Assam. Forcibly brought to work on the gardens more than 150 years ago, workers and their families live in a state of 'generational servitude' and lack access to services and facilities necessary to ensure safe motherhood. Contrary to statutory and constitutional obligations, tea garden workers, more than 50% of whom are women, are paid below minimum wage, earning a mere Rs 94/day as compared to the state minimum wage of Rs 169/day

Briefly describe the original problem:

The lack of data on the Adivasi community made it difficult to address gaps in the implementation of maternal and infant health policies for women living near tea garden areas. Unlike other Indian States, Adivasi communities living in Assam do not enjoy Scheduled Tribes status. As a result, the Government does not collect disaggregated data on the Adivasi community, the large majority of whom are tea garden workers. This condition is further exacerbated by low literacy

and awareness of health rights among Adivasi women, which affects their ability to report and monitor violations.

While Nazdeek in partnership with its local partner PAJHRA had been documenting instances of maternal and infant health violations in the Sonitpur District of Assam, we were struggling to capture macro and micro level data on the gaps in service delivery. As small NGOs, our resources are limited and we lacked the ability to map service delivery to demonstrate that barriers to access to health care in Assam for Adivasi women were systemic in nature. What was needed was a broader pool of activists identifying cases of violations, a greater awareness on the entitlements available by affected community members and an innovative tool to capture data on a systematic level.

Main people:

1) Government:

a. Health officials at the district and block level responsible for overall program funding, management and oversight
b. Frontline health workers responsible for service delivery (ASHAs, Anganwadi workers)
c. Medical personnel at health facilities, both public facilities as well as private tea plantations receiving public funding, responsible for delivery medical treatment at facilities

2) Women from the Community

The Project identified and trained a group of 40 Adivasi women volunteers living in Balipara and Dhekiajuli Blocks in the Sonitpur District of Assam on basic maternal health and infant health services. The women participants reported 70 cases of violations between May and November 2014 in tea gardens and rural areas in Sonitpur District.

The End MM Now volunteers were selected from different backgrounds and diverse geographic locations throughout the region. For instance, 54.5% of the volunteers live in a village, while the other 45.5% volunteers live in the tea gardens. Their occupations also vary; half of the participants work as housewives, 18.2% are employed as Government workers (Accredited Social Health Assistant or Anganwadi Worker), 22.7% serve as teachers or social workers, and the remaining 9.1% work in another profession.

Volunteers had varying education level as well; most volunteers have a class VI-X education level (54.5%); 27.3% have a class I-V level; and 18.2% have earned their Bachelors of Art. 40.9% of volunteers are Hindus, and 54.5% are Christians. As to the age group, about 35% volunteers are between 24-35 years of age, while 35% of the volunteers are older than 35 years of age. The youngest volunteer is 19 years old and the oldest 48 years old.

Describe the process of addressing the problem:

Launched in April 2014, the Project identified and trained a group of 40 women volunteers living in Balipara and

Dhekiajuli Blocks in the Sonitpur District of Assam. Project volunteers attended a series of training sessions on issues of maternal and infant health and rights and entitlements under the NRHM. From May to November 2014, volunteers collected and reported incidents when pregnant and lactating women could not access health and nutrition services and benefits required by the NRHM, the PLA, the Public Distribution System (PDS), and MOUs between the Central Government and tea gardens. Through a coding system, the volunteers reported 70 incidents via SMSs to the Project team based in Tezpur.

The veracity of all reports received was systematically assessed, either by phone or through field visits. Verified reports were mapped on an online platform and database and made publicly available at the End MM Now Project website (endmmnow.org). In December 2014, Nazdeek and PAJHRA conducted surveys and fact-finding investigations with victims, volunteers and health staff in several government and tea garden facilities located in Balipara and Dhekiajuli Blocks. Due to the project's focus on community monitoring, victims and their families were willing to speak openly about their stories. The 3-partner project established a framework that involved grassroots community perspective, legal advocacy and technical expertise, resulting in a truly unique partnership.

The partner organizations developed a system for coding over 30 different violations of the National Health Mission, the Plantation Labour Act, and the Public Distribution System (PDS). Categories of codes include: availability of services, conditions of facilities, JSY entitlements, and undue payment. In addition, recognizing the correlation between right to safe motherhood and right to food, the coding system also includes five codes specific to the availability of quality food rations through the PDS.

The most commonly reported violation was undue payment, or informal fees for medical services that should be provided for free to pregnant women (47%). After undue payment, the three most commonly reported violations were: lack of medical care, ambulance unavailability, and undue hospital referrals. The program captured 11 reports of newborn deaths or stillbirths, and 4 incidents of preventable maternal deaths. The project team conducted 8 intensive fact-finding investigations of cases representative of the total sample, which provided detailed information on the gaps in service delivery. This information proved essential for future advocacy and litigation actions.

Describe any major obstacles to resolving this problem, and how you attempted to overcome them:

Initially, there was a lack of awareness about the laws and policies among the women volunteers. Since the majority of the volunteers hailed from tea garden

areas with limited access to legal literacy trainings, a significant amount of time was spent in building up capacity on a rights-based approach to safe motherhood. Through substantive trainings, women volunteers began seeing the entitlements as rights. They then began sharing this information with women in their respective communities to start demanding health benefits and services from state officials and frontline health workers.

Another challenge was the lack of familiarity with technology and a community monitoring system. For many of the volunteers, it was their first time using a phone and/or texting. This required a sizeable amount of time working with paralegals to become comfortable texting.

Further, initially many paralegals and affected women were hesitant to report or share their cases of violations on the fear that the reports would go directly to the relevant authorities. As some of the women were also tea garden workers, we were highly sensitive to the power dynamics between employee-employer relations. With this in mind, we developed an anonymous reporting system in which the partner organizations had access to specific case details, however the names were not made publicly available on the endmmnow website.

What changed as a result of your organization's actions regarding this problem?

A community-based platform has been established for paralegals to report and map cases of maternal and infant health violations. Utilizing SMS and web technology, the project has collected around 70 cases in 6 months. The platform has become instrumental for women to raise grievances as to the delivery of health care services. A historic meeting was held on February 17, 2015 between 25 volunteer paralegals and the district officials including the Deputy Commissioner, the District Joint Health Services and the Medical Inspector of Plantations to discuss the findings of the first phase of reporting and offer concrete recommendations. It was very empowering for the women, with most of them sitting across the table from officials for the first time as equals, voicing demands on behalf of their community. As a result of the meeting the local authorities have agreed to hold periodic Citizens Grievance Forums in the 2 Blocks covered by the project, and have placed first priority on establishing a functional blood bank in the project area.

As one of the only projects in the world that are fusing social accountability, legal empowerment and technology with health, we believe there is great potential for scalability within India and around the world.

Quotation: *"Throughout my life I have seen pregnant women die, but I didn't see these deaths as violations of rights. I didn't think there was something I -- or we as a community -- could do to stop these deaths. But I'm learning that we can demand better services and*

medicines from the government. This is our right."

-Joshila S. Mobile Health Participant, Dhekiajuli

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